THE EFFECTS OF A SCHOOL-BASED COGNITIVE BEHAVIORAL THERAPY

CURRICULUM ON MENTAL HEALTH AND ACADEMIC OUTCOMES FOR

ADOLESCENTS WITH DISABILITIES

by

JAMES S. SINCLAIR

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Student: James S. Sinclair

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This dissertation has been accepted and approved in partial fulfillment of the requirements for the Doctor of Philosophy degree in the Department of Special Education and Clinical Sciences by:

John R. Seeley	Chairperson
Christopher J. Murray	Core Member
Kent McIntosh	Core Member
Hill M. Walker	Core Member
Elizabeth A. Stormshak	Institutional Representative

and

Scott L. Pratt	Dean of the Graduate School

Original approval signatures are on file with the University of Oregon Graduate School.

Degree awarded June 2016

DISSERTATION ABSTRACT

James S. Sinclair

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Title: The Effects of a School-based Cognitive Behavioral Therapy Curriculum on
Mental Health and Academic Outcomes for Adolescents with Disabilities

Transition age youth with disabilities are at an elevated risk to experience depression and anxiety compared to youth without disabilities. The current study evaluates the implementation feasibility, acceptability, and potential efficacy of the *Think, Be, Do* curriculum (a mental health curriculum) for transition age students in special education classrooms. The *Think, Be, Do* curriculum is a teacher delivered, ten-session mental health curriculum, based in cognitive behavioral and ecological theory, that promotes behavior activation and cognitive reframing of negative thoughts. A total of 11 classrooms were recruited and 115 students participated in a randomized controlled trial. Classrooms were randomly assigned to either treatment ($n = 7$) or control condition ($n = 4$). Treatment condition classrooms were exposed to the *Think, Be, Do* curriculum twice a week for five weeks. Control condition classrooms were instructed to continue business as usual. Results from the pre-post feasibility trial indicate that the *Think, Be, Do* curriculum was feasible to implement with high fidelity, and was acceptable to the teachers who implemented the curriculum and for student participants. In addition, student knowledge increased on common mental health concerns (e.g., depression and anxiety) for participants in the treatment condition. There were no clinically meaningful

differences found between conditions on the putative mechanisms (e.g., behavior activation, negative thoughts), internalizing and externalizing symptoms, and academic competence. Implications for research and practice are discussed, including the need for further curriculum adaptation, development of reliable and valid mental health measures, and the need for a more targeted implementation approach.

CURRICULUM VITAE

NAME OF AUTHOR: James S. Sinclair

GRADUATE AND UNDERGRADUATE SCHOOLS ATTENDED:

University of Oregon, Eugene, Oregon
Boston College, Chestnut Hill, Massachusetts
University of California Los Angeles, Los Angeles, California
Saddleback College, Mission Viejo, California

DEGREES AWARDED:

Doctor of Philosophy, Special Education, 2016, University of Oregon
Master of Arts, Mental Health Counseling, 2011, Boston College
Master of Arts, Applied Developmental and Educational Psychology, 2009,
    Boston College
Bachelor of Arts, Psychology and Political Science, 2007, University of
    California, Los Angeles
Associate of Arts, Psychology, 2005, Saddleback College

AREAS OF SPECIAL INTEREST

Secondary Special Education and Transition
Socio-Emotional Factors that Impact Student Outcomes
At-Risk and Marginalized High School Populations

PROFESSIONAL EXPERIENCE

Graduate Teaching Fellow, University of Oregon, 2011-2012

Developmental Medicine Fellow, Children's Hospital Boston, 2010-2011

Emergency Room Psychological Evaluator, MetroWest Hospital, 2010-2011

Research Assistant, Institute for Community Inclusion, 2009-2010

GRANTS, AWARDS, AND HONORS:

College of Education Doctoral Research Award, 2016

OSEP Leadership Award – Project RISE (2012-2016)

Florence Wolfard Scholarship, 2014

Rose Gross Scholarship, 2012

PUBLICATIONS

Poppen, M., Sinclair, J., Hirano, K. A., Lindstrom, L., & Unruh, D. K. (2016). Perceptions of mental health concerns for secondary students with disabilities during transition to adulthood. *Education and Treatment of Children*, *39*, 221-246.

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER I

INTRODUCTION

It is well documented that students with disabilities experience social, emotional and academic challenges during high school (Bond et al., 2007; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Hiebert, Wong, & Hunter, 1982). Students with disabilities are also at greater risk of being diagnosed with a mental health problem than students without disabilities (McMillan & Jarvis, 2013). The greater likelihood that students with disabilities will experience negative outcomes (i.e., developing mental health disorders, poor academic performance) has shifted national research interests towards developing and implementing evidence-based interventions in the contexts of schools that focus on prevention (Burns & Ysseldyke, 2009; Seeley, Severson, & Fixsen, 2014). Although there has been progress in the development of academic and behavior prevention interventions for students with or at risk of disabilities, school-based mental health prevention and intervention efforts for adolescents with disabilities is lacking. The current study examines how exposure to a school-based cognitive behavioral intervention affects mental health and school related outcomes among adolescents with disabilities.

Statement of the Problem

The growing youth population with mental health disorders is an important public health issue that has an economic impact on the United States of approximately 247 billion dollars annually (Center for Disease Control and Prevention, 2013). Other cost estimates suggest mental health services alone costs 11.75 billion dollars annually (The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001). The significant costs

associated with mental health disorders is due in part to the large number of youth (approximately 14.7 million) who experience a serious mental illness during their lifetime (U. S. Census Bureau, 2014; Merikangas et al., 2010).

Prevalence rates (i.e., proportion of a population who have [or had] a specific characteristic in a given time period) of mental health disorders are typically estimated within a period of time (e.g., the past year) or lifetime (i.e., proportion of population who at some point had the characteristic; National Institute of Mental Health, 2010). Current prevalence rates of mental health problems in children and adolescents vary depending on sampling techniques and sample population. The National Institute of Mental Health (2010) reported that approximately 13.1 percent of youth ages 8-15 have experienced one or more mental health disorders in the previous 12 months with the most prevalent being Attention Deficit Hyperactivity Disorder (ADHD; 8.6%), Mood Disorders (3.7%), Major Depression (2.7%), Conduct Disorder (2.1%), Dysthymia (1.0%), and Anxiety Disorders (0.7%). Among adolescents (ages 13-18), estimated lifetime prevalence rates of ADHD are similar to children (8.5%; Center for Disease Control and Prevention, 2013), but rates of Major Depression (11.7%), and General Anxiety Disorder (2.2%; Merikangas et al., 2010) for youth ages 13-18 are higher.

Some subgroups in the general population have been found to have higher prevalence rates of mental health disorders than the general population (e.g., young women, and Hispanic or Latino youth; Substance Abuse and Mental Health Services Administration, 2014). Youth with disabilities are two to three times more likely to experience a mental health disorder than the general population, with prevalence rates ranging widely from 3 – 50% (Dekker & Koot, 2003; Forness, Freeman, Paparella,

2

Kauffman, & Walker, 2012; Hassiotis & Turk, 2012). Although the exact reasons for why higher rates of mental health disorders occur among youth with disabilities is unknown, multiple studies have shown relationships between mental health problems and lower self-esteem (Bender, 1987), self-concept (Heath & Wiener, 1996), academic self-concept (Hiebert et al., 1982), and an external locus of control (Margalit & Shulman, 1986), all of which have also been associated with disability (Dalley, Bolocofsky, Alcorn, & Baker, 1992).

Although youth with disabilities may experience mental health problems at higher rates than youth without disabilities (Nelson & Harwood, 2011) only a fraction of all youth (with and without disabilities) diagnosed with mental health problems actually receive mental health services (Forness et al., 2012; Weist, 1999). Moreover, the majority of youth that receive mental health services do so in a school setting (Burns et al., 1995). Importantly, Slade (2002) reported that students with disabilities access mental health services at higher rates than their peers without disabilities. However, due to high prevalence rates, the demand for school-based mental health services has outpaced the supply (Kazak et al., 2010) leaving many schools in a position to find innovative practices to support the mental health needs of adolescents with disabilities (Masia-Warner, Nangle, & Hansen, 2006).

Current Needs

Mental health prevention research in schools has traditionally focused on elementary populations. This is logical, as mental health prevention programs at young ages have shown to be effective and have long-term positive impacts (Durlak & Wells, 1997; Masia-Warner et al., 2005; Quayle, Dziurawiec, Roberts, Kane, & Ebsworthy,

3

2001; Spence & Shortt, 2007). Yet, Essau, Conradt, and Petermann (2002) note that adolescence was a predictor of onset of anxiety. In addition, Cyranowski, Frank, Young, and Shear (2000) report that there is a significant increase in depression for boys and girls between the ages of 11 and 13. Thus, there are many secondary students who may be at-risk for developing mental health problems and are in need of evidence-based supports to prevent further progression of mental health problems (Forness, 2005).

Despite a dearth of intervention research on the mental health needs of adolescents with disabilities, there have been a considerable number of literature reviews and meta-analyses on school-based cognitive-behavioral mental health interventions for typically developing students. Some of these reviews have focused on evidence-based treatments for child and adolescent depression and anxiety (e.g., David-Ferdon & Kaslow, 2008; Maag & Swearer, 2005; Silverman, Pina, & Viswesvaran, 2008), others have focused on primary prevention and universal mental health programs for children and adolescents (e.g., Durlak & Wells, 1997; Wells, Barlow, & Stewart-Brown, 2003), and others have focused on evidence-based treatments for ethnic minority youth (Huey & Polo, 2008). The results of these reviews suggest generally positive outcomes for students who receive school-based cognitive behavioral interventions or treatment (Durlak & Wells, 1997; Hoagwood & Erwin, 1997).

In addition to the lack of representation of youth with disabilities in mental health research, there is also a paucity of school-based mental health research targeting students who may have sub-clinical levels of a mental health disorder. Universal prevention (tier 1) interventions have shown positive outcomes, but less is known about targeted interventions (tier 2 or tier 3). Due to the variety of variables that could potentially be

4

impacted by a mental health problem (e.g., academic performance, peer relationships), students may need additional support that is targeted to a youth's specific needs and ecological context.

One way to address this need is through the development of cognitive behavioral curriculum targeting the mental health needs of students with disabilities. There have been few attempts to develop and implement a curriculum using cognitive behavioral theoretical principles. One exception is the Adolescent Coping with Depression Course (Clarke, Lewinsohn, & Hops, 1990), a psycho-educational curriculum to treat depression in adolescents. Unlike traditional cognitive-behavioral therapy where a client is treated by a trained mental health professional, the course can be taught by teachers or other services professionals to implement the curriculum in a variety of settings. A meta-analysis of the effects of the Coping with Depression course (the original course from which the adolescent version was adapted by Lewinsohn et al., 1984) reported that the psycho-educational curriculum was an effective treatment modality for depression (Cuijpers, 1998).

The discrepancy between who needs services and who receives services may potentially be reduced with the use of a cognitive behavioral curriculum that can be implemented in a school setting. Teachers consistently report that they feel unprepared and do not have enough knowledge regarding mental health problems in the classroom (Reinke, Stormont, Herman, Puri, & Goel, 2011). As schools continue to be pressed for resources and rely on teachers, it becomes critical that teachers are provided opportunities and resources to learn about common mental health problems that may be present in the classroom.

Rationale for the Study

Adolescents with disabilities are at a heightened risk of experiencing mental health disorders (McMillan & Jarvis, 2013). Yet, there is a lack of school-based mental health services for students with disabilities. This leaves a gap in school's ability to serve students in need. Although schools are considered to be the primary provider of services for students who experience mental health problems (Burns et al., 1995; Kazak et al., 2010), they are challenged to match the demands of services for students who experience mental health problems. In addition, schools have limited access to implement evidence-based practices for students in need of mental health services. Despite a large body of research that has focused on school mental health programs and interventions, there remains limited research on school mental health interventions conducted within secondary school settings, and an even smaller fraction of studies that have focused on school based mental health interventions for students with disabilities. Furthermore, as schools begin to rely more on teachers to help with systems of support that focus on prevention, the amount of research on teacher implemented mental health prevention interventions becomes even smaller.

This study utilized cognitive-behavioral theory and ecological theory as theoretical frameworks to address the mental health needs of students with disabilities. The *Think, Be, Do* curriculum, an adapted version of the Adolescent Coping with Depression course, was used as a targeted prevention intervention specifically for students with disabilities. Mental health knowledge, internalizing and externalizing behaviors (e.g., depression, anxiety), and academic competence was measured to understand the effects of the teacher delivered cognitive behavioral curriculum.

CHAPTER II

LITERATURE REVIEW

This chapter reviews the literature pertaining to the implementation and effects of

school-based mental health interventions for children and adolescents. First, definitions

of key concepts are reviewed. Second, theoretical frameworks for understanding school-

based mental health interventions are discussed. Third, a review of school-based mental

health intervention research is presented, along with a summary of findings. Next,

individual studies using cognitive behavioral therapy with individuals with disabilities are

reviewed. Lastly, a rationale for a school-based mental health intervention for students

with disabilities is presented.

Definition of Key Concepts

Mental health. Mental health in childhood and adolescence has been defined as

the "achievement of expected developmental cognitive, social, and emotional milestones

and by secure attachments, satisfying social relationships, and effective coping skills"

(U.S. Department of Health and Human Services, 1999, p. 123). Another common

definition used by the World Health Organization (2004) defines mental health as "a state

of well-being in which the individual realizes his or her own abilities, can cope with the

normal stresses of life, can work productively and fruitfully, and is able to make a

contribution to his or her community" (p. 12). In the current paper the term mental health

is defined as a state of well-being in which the individuals realizes his or her abilities to

cope with normal stresses of life and achieve expected developmental cognitive, social,

and emotional milestones, while being a productive member within his or her

community. Contrary, a mental health problem (e.g., depression or anxiety) is considered a threat to one's mental health.

Depression. The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V) describes major depressive disorder as characterized by discrete episodes in the past two weeks involving clear changes in affect, cognition and neurovegetative functions and inter-episode remissions (American Psychological Association, 2013). Chronic forms of depression can be diagnosed when the mood disorder persists over the past two years in adults and past one year in children (American Psychological Association, 2013). Individuals who experienced a major depressive episode are often describe themselves as "depressed, sad, hopeless, discouraged, or down in the dumps" (American Psychological Association, 2013, p. 163). Students can also exhibit symptoms such as irritability, loss of interest in pleasurable activities, or insomnia (Forness, Walker, & Kavale, 2003).

Anxiety. Anxiety is the anticipation of future threat and is associated with muscle tension and vigilance in preparation for future danger and can be portrayed by cautious or avoidant behaviors (American Psychological Association, 2013). The diagnosis of generalized anxiety disorder is characterized by excessive worry that is out of proportion with the actual likelihood of an event. Prior to diagnosis, clinicians use cultural contextual factors to establish whether a client fits the diagnostic criteria (American Psychological Association, 2013). Forness et al. (2003) state that worrying must cause clinically significant impairment in an adolescent's social and academic functioning to be considered for a diagnosis.

School-based mental health programs. "School mental health is a broad category that describes many different psychosocial interventions and services that are designed specifically to be learning supports for students with social, emotional, and learning challenges" (Franklin, Kim, Ryan, Kelly, & Montgomery, 2012, p. 973). School based mental health programs focus on enhancing access to mental health treatment by housing mental health professionals within the school environment (Cheney, Cumming, & Selemrod, 2014). In addition, school-based mental health programs are collaborative in nature, promoting efforts by a variety of individuals (e.g., community professionals, families, and school professionals) to use evidence-based practices that span a continuum of care for students (Michael, Bernstein, Owens, Albright, & Anderson-Butcher, 2014). In the current paper, school-based mental health programs include cognitive behavioral interventions that target depression, anxiety, or mental health as outcomes.

The National Dissemination Center for Children with Disabilities defined cognitive behavioral interventions (CBI) as "a behavior modification approach that promotes self-control skills and reflective problem-solving strategies. Interventions combine elements of behavior therapy with cognitive approaches to teach individuals to recognize difficult situations, think of possible solutions, and select the most appropriate response" as cited in (Cheney et al., 2014, p. 354). In this review, cognitive behavioral interventions are included if the authors describe the intervention as a CBI, or the intervention is based on cognitive behavioral theory.

Multi-tiered systems of prevention. School mental health interventions can be categorized using an intervention continuum from universal public health initiatives, for early intervention of at-risk populations, and to targeted treatment for more severe

problems (Adelman, 1993). Desrochers (2014) endorsed the idea of a continuum of services and suggests that schools with well developed systems of supports for mental health will demonstrate positive academic, emotional, and behavioral outcomes for students.

Prevention. The field of prevention science uses applied research across a multidisciplinary array of fields including public health, education, and medicine (Durlak, 1995). Across the fields of research, it is common to find prevention models aligned with three tiers. In addition, the three-tiered model is frequently found in prevention text regarding academic and behavioral interventions (Seeley et al., 2014; Walker & Shinn, 2010). In education, the multi-tiered system of support (MTSS) model is designed to ensure all students receive the appropriate level of intervention (academic, behavioral) necessary to experience success. It is widely accepted that the majority (approximately 80 percent) of students would benefit from universal prevention interventions, and a smaller proportion (approximately 15 percent) would need selective prevention, and an even smaller proportion (approximately 5 percent) would need indicated prevention. The three-tiered model has been included as a school-based mental health service delivery model as well (Evans, Simonsen, & Dolan, 2013). Mental health is in constant flux and to achieve maximum effectiveness, prevention-based interventions (universal and targeted approaches) can be used in schools address the mental health needs in the students they serve (Walker et al., 1996).

Universal prevention. Universal prevention is a proactive way to reach all students through the use of empirically validated interventions and curricula (Shepard, Shahidullah, & Carlson, 2013). Interventions are broad and do not require students to be

at-risk (Macklem, 2014), rather interventions focus on enhancing protective factors (e.g., teaching coping strategies) so students don't become at-risk (Walker et al., 1996). In addition, because all students receive the universal intervention, it can decrease the stigma attached to some interventions (e.g., pull out mental health counseling, going to the special education classroom).

Selective prevention. Selective prevention approaches support universal prevention approaches by targeting students who do not respond to the universal or school-wide intervention (Shepard et al., 2013). Selective prevention includes interventions that focus on academic support and/or behavioral or emotional skills training (Walker et al., 1996). This tier of prevention involves prompt involvement for students at-risk or students who hold a sub-clinical level of identification of a mental health problem (e.g., depression; Bradshaw, Bottiani, Osher, & Sugai, 2014; Durlak, 1995). Selective interventions focus on five to fifteen percent of the school population, small group instruction or individualized classes are typically used to support provide students with the extra support needed.

Indicated prevention. Indicated approaches are the most intensive prevention approaches used for students who are severely at-risk and who have not responded to universal or selective prevention approaches. Interventions target approximately five percent of the school population and are used to reduce the intensity of a problem and potentially take a longer period of time to implement. To support students receiving indicated supports, a group of individuals (e.g., teachers, parents, and administrators) work together to individualize the necessary supports (based off of assessment data) to support student success (Walker et al., 1996).

Theoretical Frameworks

Two theoretical frameworks are pivotal in understanding successful school-based cognitive behavioral interventions. The use of cognitive behavioral theory and ecological theory to frame a school-based mental health intervention is rationalized two-fold. First, cognitive behavioral therapy (CBT) is considered an effective practice to reduce depressive and anxiety symptomatology in children and adolescents (Hollon & Beck, 2013; Ryan, 2005; Swan, Cummings, Caporino, & Kendall, 2014). Second, an ecological approach is essential to understanding an individual's interaction with his or her environment.

Cognitive behavioral theory. The cognitive-behavioral theoretical framework is a combination of diverse and subtle interventions that must be understood from the social learning perspective (Compton et al., 2004). CBT blends processes of cognition and behavioral strategies, resulting in cognitive and behavioral change. Bandura (1977) states "a theory that denies that thoughts can regulate actions does not lend itself readily to the explanation of complex human behavior" (p. 10). The perspective of cognitive behavioral theory indicates a relationship between three components cognition, behavior, and the environment (Ghafoori & Tracz, 2001; Hupp, Reitman, & Jewell, 2008; Martell, Addis, & Jacobson, 2001).

Within the cognitive behavioral theoretical framework both cognitive and behavioral strategies are used in treatment. The cognitive theoretical framework suggests that cognitions can stimulate behavioral and emotional consequences (Dobson & Dozois, 2010; Hupp et al., 2008). Specifically, the cognitive framework has focused on individual's distorted and unrealistic thinking of events, which could impact the

individual's feelings and behaviors. A premise of cognitive theory is that many of the distorted thoughts that can have a negative impact on an individual are automatic. This typically presents itself through cognitive structures called schemas, which are thought patterns that have developed over the lifespan (Dobson & Dozois, 2010). Therefore, many cognitive interventions focus on the identification and changing thoughts that have a negative impact on an individual's life (Macklem, 2011) with more realistic and adaptive thoughts or appraisals.

The behavioral theoretical framework suggests that focus should be on the observable phenomena rather than the conscious thought (Hupp et al., 2008). By concentrating on the observable there is an ability to identify what environmental factors impact human behavior. Therefore, behavior change becomes the premise of therapy that was built upon the classical principle of operant conditioning (Dobson & Dozois, 2010). One of the most recognized concepts to emerge from behavioral theory is that humans tend to repeat behaviors that are reinforced. There are two forms of reinforcers used in behavioral theory; positive and negative reinforcement. Positive reinforcement occurs when an individual repeats a behavior when something of high value to the individual is added to a situation, while negative reinforcement also increases the likelihood of repeated behavior but through the removal of something aversive to the individual (Hupp et al., 2008). Consequently, an individual is less likely to change behaviors without awareness of how the behavior is being reinforced (Bandura, 1977) and in what setting. This has resulted in viewing antecedents of behavior as residing in the interaction with the environment and not solely within the individual (Bandura, 1977).

Ecological theory. As Bandura (1977) and Martell et al. (2001) suggest, the environment plays a critical role on human behaviors. In addition to cognitive behavioral theory, it is also critical to understand the ecological systems influencing adolescents. The premise of the ecological perspective is that human development occurs within a nested arrangement of systems. These systems are dynamic, and include the self's interaction with the micro- (i.e., immediate setting containing the learner), meso- (i.e., the interrelations among the major settings containing the learner), exo- (i.e., social structures, both formal and informal that impinge upon or encompass the immediate settings containing the learner), and macro-systems (i.e., overarching institutions of the culture or subculture; Bronfenbrenner, 1976). Schools have their own ecology that students must navigate.

Walker et al. (1996) analogizes schools as an example of a complex ecological system that represents the organization of people, environment, policies, and procedures that should function together as one. A school-based systemic approach to understanding student mental health is critical to understanding the impact the environment has on students and the services available for students in need (Kratochwill et al., 2012). Furthermore, Walker et al. (1996) posits that the interactive and interconnected systems collectively work together so students can learn and teachers can teach. In addition to the school-based services implemented in schools, it is important to understand the factors that impact a student's interaction with the school's ecological environment. For example, individual psychological factors such as locus of control and self-esteem can impact a student's interpersonal relationships with teachers and their own academic performance (You & Sharkey, 2009). It has also been documented that as students enter

14

middle and high school they become less engaged, due to a lack of "fit" between the student's own development and the schools systemic structure (Eccles & Roeser, 2011).

Understanding the environmental context a student interacts with ensures a holistic approach to proper mental health intervention. Durlak (1995) suggests that there are a multitude of social and organizational influences that impact behavior and that behavior cannot be considered outside for its ecological context. This is one critical overlap between these two theoretical frameworks (CBT and Ecological). Walker et al. (1996) postulates that schools are considered their own ecological system, thus implementation of a mental health intervention seamlessly within that system is critical to improve mental health outcomes for students.

School Mental Health

Public schools are considered to be the primary location to identify and serve the mental health needs in children and adolescents (Connors, Arora, Curtis, & Stephan, 2015; Farmer, Burns, Phillips, Angold, & Costello, 2003). School-based mental health prevention programs have a considerable history in the United States. Beginning in the 1920s, prevention-oriented mental health programs were implemented in schools (Durlak, 1995). It is believed that mental health programs embedded in schools provide a continuum of care for a range of students with a range of needs (e.g., mental health status, disability; Michael et al., 2014). The continuum of care is delivered by a variety of personnel (e.g., school professionals, community professionals, and families) who actively participate in the implementation of the continuum of care (Michael et al., 2014). Having the services within the school setting creates an opportunity that is optimal to address the challenges students face throughout their development (Evans, 1999).

Due to the vast amount of research on school-based mental health interventions an overall summary of findings is needed. A comprehensive literature search was conducted to find school-based mental health programs and cognitive behavioral interventions within the past twenty years. The University of Oregon's library article search function was used for the primary literature search. A secondary search was conducted using specific article databases, including PsychNet, ERIC, and PubMed. Search terms included, *school-based mental health, mental health, high school, middle school, depression, anxiety, disability, Coping with Depression, Coping with Depression Course, Adolescent Coping with Depression Course,* and *intervention research.*

There are two major sections in this review of the literature. First, this literature review summarizes the overall effects of school-based mental health interventions in the form of a comprehensive evaluation of nineteen literature syntheses and meta-analyses. Second, this literature review synthesizes individual articles not found within the literature syntheses and meta-analyses. To be included in both sections of this review, four criteria were required, (a) the main intervention implemented across studies must be cognitive/behavioral, (b) the study must implement the intervention on children or adolescents, (c) the study must be implemented in a school setting, and (d) the study must include depression and anxiety as an outcome variable.

Effect sizes were reported using a variety of statistics (e.g., standardized mean difference, Phi, Cohen's *d*). The categorization of effect sizes into small, medium, and large effects are determined by the grouping rules of the statistic used. For example, Kavanagh et al. (2009) used Cohen's *d,* as an effect size estimate, which suggest that an effect size of 0.20 is small, 0.50 is medium, and 0.80 is large (Cohen, 1988). Twelve out

of nineteen reviews reported the effect sizes (i.e., post-treatment effects) from the individual studies that met inclusion criteria for each review.

Review of Syntheses

Durlak and Wells (1997, 1998) conducted two of the first reviews of school-based mental health programs. These two reviews focused on universal and selective level mental health interventions, respectively. The universal intervention review included 169 studies and found that person centered interventions (i.e., affective education and interpersonal problem solving) improved children's social and behavioral adjustment. Both interventions (affective education and interpersonal problem solving) were more successful for children between the ages of two and seven (affective education ES = 0.70; interpersonal problem solving ES = 0.93) than children and adolescents older than seven (affective education ES ranged from 0.24 - 0.33; interpersonal problem solving ES = 0.49; Durlak & Wells, 1997). The selective review included 130 studies that used behavioral, cognitive behavioral, and non-behavioral interventions. The included studies also found positive effects. Overall effects were small for ages 7 - 11 (ES = 0.28), while effects were considered medium-large for ages younger than seven (ES = 0.63), and medium for ages older than 11 (ES = 0.43). Overall, the mean effect size was 0.51 for behavioral treatment studies, 0.53 for CBT studies, and 0.27 for non-behavioral studies (Durlak & Wells, 1998).

Wells et al. (2003) conducted an additional review of universal interventions, which included 17 articles; seven studies took place in elementary schools, four studies took place in middle schools, and three studies took place in high schools. Interventions in the review included conflict resolution curriculum (e.g., problem solving), educational

intervention to prevent depression, and an emotional literacy curriculum. Results included interventions that had no effect on improving mental health promotion and interventions that had 75% of participants respond positively from the cognitive behavioral intervention (Wells et al., 2003).

In addition to specific levels of prevention, other reviews focused on global school-based mental health interventions. Hoagwood and Erwin (1997) conducted a ten-year review on the effectiveness of school-based mental health services. Studies included in this review took place in elementary, middle, and high school settings, using a variety of interventions including cognitive behavioral therapy. Seven out of sixteen studies measured the effects of cognitive behavioral therapy on a variety of outcomes including depressive symptomatology and adaptive behavior skills. Five of the seven studies determined CBIs to be an effective intervention and two studies determined CBIs to have mixed results.

Rones and Hoagwood (2000) included 47 studies in their review of school-based mental health services. All interventions took place in school settings, yet limited participant characteristic were reported. Three out of five interventions that targeted emotional and behavioral problems were found to be effective and two out of five interventions were found to have mixed results. In addition, of the six studies that targeted depression, three were found to be effective, one had mixed results, and 2 indicated no effect.

Neil and Christensen (2009) more recently reviewed school-based mental health and early intervention prevention programs effects on child and adolescent anxiety. Thirty-one studies were included in their review; 18 studies were universal prevention, 10

18

studies were selective prevention, and three were indicated prevention. The majority of interventions were cognitive-behavioral (73%); other interventions were psycho-educational in nature. Overall, the authors found cognitive behavioral therapy was an effective way of reducing anxiety symptomatology. Positive effects (calculated using Phi) were found in 21 of 27 studies (ES = 0.11 – 1.37, median = 0.57).

Calear and Christensen (2010) included 42 studies in their review on CBIs effects on depression; 26 were universal prevention, six were selective prevention, and 10 were indicated prevention. Overall, 23 of the 42 (55%) identified trials significantly reduced participants depressive symptoms at post-test or follow-up with effect sizes ranging from 0.21 to 1.40. Cognitive behavioral therapy was used in the majority of interventions (76%); other intervention types were psycho-educational in nature. Eighteen out of 32 studies that used CBT intervention found positive effects in reducing depressive symptoms (d = 0.21 – 1.40). Overall effect sizes ranged (d = 0.31 - 1.40) for studies that included adolescents only, while effect sizes ranged (d = 0.48 – 1.05) for studies that only included children.

Weare and Nind (2011) conducted a review on mental health promotion and problem prevention in schools. School-based interventions included those that were implemented in schools but also involved families and community. Participants ranged from four to 19 years of age. Overall, interventions had positive effects. Nine out of 52 reviews in this review focused on improving depression and anxiety in school settings, and had treatment effects that ranged in effect sizes from 0.10 to 1.70.

Other reviews specifically focused on cognitive behavioral interventions rather than global mental health programs. Ghafoori and Tracz (2001) looked at the

effectiveness of 27 studies that used cognitive behavioral therapy in reducing classroom disruptive behaviors. Participants in each study ranged from 5 to 13 years of age. An overall mean d was calculated on the effect sizes (difference between pre- and post-CBT) to determine the effectiveness of the CBT intervention. Overall, CBT had a small effect ($d = 0.29$) on reducing classroom disruptive behaviors.

Maag and Swearer (2005) reviewed 23 studies that examined the impact of cognitive behavioral interventions on depression across clinical settings (e.g., counseling offices, university clinics, and public middle or high schools). Only three of the 23 studies included in the review looked at adolescent youth in middle and high schools. These three studies measured depression as an outcome using a variety of depression scales. In the review, Maag and Swearer (2005) report that participants in all three studies showed a significant positive results for decreasing depression after receiving a cognitive behavioral intervention.

Spence and Shortt (2007) included twelve studies in their review that used a variety of interventions such as cognitive behavioral therapy, the Penn Prevention Program, and cognitive restructuring to help children and adolescent's overall mental health and depression. Overall, the students (grades five through 10) that received the school-based mental health intervention showed significantly lower rates of depression symptomatology as compared to control conditions. Intervention effect sizes (using Cohen's d) ranged from -0.09 – 1.27, which suggests that the universal prevention programs reviewed had a range of impact on reducing depressive symptomatology in children (Spence & Shortt, 2007). The authors also reported that effects were strongest for students with sub-clinical depression scores prior to intervention.

David-Ferdon and Kaslow (2008) reviewed studies that intervened on children and adolescents at-risk for depression or with depression using a cognitive behavioral intervention. Fourteen out of 18 adolescent studies reported a significant reduction in depressive symptomatology after receiving a cognitive behavioral type intervention. Effect sizes across all 18 studies ranged from no significant effect to a large effect (ES = 1.05). The three adolescent studies that were conducted in a school setting all found significant reduction in depressive symptomatology after treatment. Eight out of ten studies that included only children reported a significant reduction in depressive symptomatology after receiving a cognitive behavioral type intervention (David-Ferdon & Kaslow, 2008).

Kavanagh et al. (2009) reviewed 17 studies on the effectiveness of cognitive behavioral interventions in children and adolescents (ages 11 – 19) on depression and anxiety. Nine studies were universal prevention and eight studies were indicated prevention. Standardized mean difference (SMD) was used to measure effect size across studies. Thirteen out of 17 studies reported interventions were effective at post-treatment (SMD = -0.16), which is equivalent to reducing a Beck Depression Inventory (BDI) score by 1.44 points. The three-month post-treatment effect size (SMD = -0.21) was greater than immediate post-treatment, and is equivalent to reducing a BDI score by 1.9 points (Kavanagh et al., 2009). Six out of 17 studies that included school personnel (e.g., teacher) as the intervention agent were also effective (post-treatment effect size was SMD = -0.18, or a reduction in a BDI score of 1.62). The three-month post-treatment effect size (SMD = -0.21) was greater than post-treatment, and is equivalent to reducing a BDI score by 1.9 points (Kavanagh et al., 2009).

In addition to school mental health programs and cognitive behavioral interventions, some reviews focused on particular outcome areas or populations. Hoagwood et al. (2007) examined the school-based mental health interventions that targeted both mental health and academic outcomes. This was the only review that included academic functioning in the inclusion criteria. Sixty-four studies were included in the review; 24 studies examined both mental health and academic outcomes, and 40 included only mental health outcomes. Effect sizes were not reported but the authors found positive effects for 15 out of 24 studies that measured both academic and mental health outcomes. Thirty-eight out of 40 studies found positive effects for mental health outcomes. The author's indicated that one limitation of their review was "the majority of school-based mental health intervention studies failed to include even rudimentary measures of school-related outcomes" (Hoagwood et al., 2007, p. 66).

Cuijpers (1998) conducted a meta-analysis on the effects of the Coping with Depression course, a cognitive behavioral therapeutic curriculum, on depression across all ages. The overall mean effect ($d = 0.65$) is a moderate to high positive effect, suggesting that individuals who received the Coping with Depression course compared to a control condition had a significant reduction in depression symptomatology. Effect sizes were large ($d_{improve} = 1.08 - 1.58$; $d_{improve,}$ effect size of the improvement made from pre- to post-intervention) for three studies including adolescents based on improvement from pre- to post-treatment.

Cobb, Sample, Alwell, and Johns (2006) conducted the only review that included students with disabilities. The primary disability categories identified in the articles reviewed were Emotional Disturbance, Behavior Disorder, Learning Disability, Attention

22

Deficit/Hyperactivity Disorder, Opposition Defiant Disorder, Autism, and Other Health Impairment. Participant mean ages ranged from 13 to 19 years old. The overall mean treatment effect ($d = 0.55$) of CBIs on episodes of depressive episodes, aggressive behaviors, and enrollment status, was statistically significant for the eight between-group studies.

Huey and Polo (2008) reviewed evidence-based psycho-educational treatments for ethnic minority youth. Inclusion criteria for this review required that ethnic minority students consisted of 75% of the sample population. A variety of settings were included (e.g., clinical settings, schools) and youth ranged from six to 18 years of age. Only one study measured anxiety in a school setting. The effect of the school-based group CBT on student's anxiety was large ($d = 0.71$). No studies with the outcome variable of depression took place in a school setting were included in this review.

Farahmand, Grant, Polo, and Duffy (2011) conducted a systematic review of the effectiveness of behavioral and mental health programs for low-income, urban youth. Sixteen studies were included in the review, nine of which had mental health as a primary outcome measure. The overall mean effect size of interventions on internalizing problems was 0.28 (effect size calculated using standardized mean difference). The effect of the mental health intervention on internalizing disorders for Latino youth (ES = 0.49) was twice as large than for African American youth (ES = 0.23).

Lastly, Franklin et al. (2012) conducted a systematic review to examine the extent to which teachers participated as a primary mental health provider in the classroom. Franklin et al. (2012) reviewed 49 studies that included teachers as part of the school-based intervention. Of the 49 included articles, 23 were universal prevention, 14 were

selective prevention, and 12 were indicated prevention. Most of the prevention studies

took place in an elementary school setting (38.8%). Middle school and high school

prevention studies were also included (24.5%, 28.6% respectively). Effect sizes for the

studies that included teachers as the sole intervention agent ranged from having no effect

to a large effect ($d = 1.21$). The overall effect sizes across prevention tier (i.e., universal,

indicated, selective) had all small effects (Franklin et al., 2012).

Summary of School Mental Health Interventions

Summary of reviews. Three out of 19 reviews focused solely on universal

school-based mental health prevention interventions. Five reviews synthesized the

research on school-based mental health programs (Calear & Christensen, 2010;

Hoagwood & Erwin, 1997; Neil & Christensen, 2009; Rones & Hoagwood, 2000; Weare

& Nind, 2011). Five reviews specifically analyzed the effects of cognitive-behavioral

interventions on mental health outcomes in children and adolescents (David-Ferdon &

Kaslow, 2008; Ghafoori & Tracz, 2001; Kavanagh et al., 2009; Maag & Swearer, 2005;

Spence & Shortt, 2007). Lastly, six reviews focused on specific content or populations

(e.g., low income urban youth; Cobb et al., 2006; Cuijpers, 1998; Farahmand et al., 2011;

Franklin et al., 2012; Hoagwood et al., 2007; Huey & Polo, 2008). See appendix A for a

summary table of reviews and individual studies included in each review.

Summary of studies. A number of reviews included what level of prevention

(e.g., universal, selective, indicated) each intervention was targeted. There were a total of

40 studies that were considered a universal prevention intervention. Of the universal

studies, 18 had small effect sizes, 11 studies had medium effect sizes, four studies had

large effect sizes, two studies had a negative effect, and five studies did not report for

post-treatment effects. There were a total of seven selective prevention interventions. Four studies had small effects, one study had a medium effect, one study had a large effect, and one study did not report for post-treatment effects. There were a total of 26 studies that were considered an indicated prevention intervention. Eleven studies had small effect sizes, five studies had medium effect sizes, six studies had large effect sizes, and four did not report for post-treatment effects. Additionally, there were 67 studies that did not report prevention level type. Of the studies that did not report prevention level type, seven had small effects, eight had medium effects, 30 had large effects, and 22 did not report post-treatment effects.

Participant age groups included children, adolescents, or children and adolescents. There were 29 studies that included only children. Of these studies, eight had small effect sizes, five studies had medium effect sizes, ten studies had large effect sizes, one had a negative effect size, and six studies did not report post-treatment effects. Twelve studies included children and adolescents. Seven of these studies had small effect sizes, one medium effect size, and four did not report post-treatment effect sizes. Lastly, 70 studies included adolescents only in the intervention sample. Fifteen studies found small effect sizes, 16 studies had medium effect sizes, 15 studies had large effect sizes, one study had a negative effect size, and 23 did not report post-treatment effects. There were a total of thirty individual studies that did not report age, or included adults and elderly individuals.

Intervention type was divided among four categories, (a) cognitive behavioral focused only (excluding the Coping with Depression Course), (b) a combination any other behavior intervention with CBT, (c) a general school-based mental health program, and (d) the Coping with Depression Course. There were a total of 59 studies that used

CBT as a primary intervention. Twenty studies found small effects, 11 studies found medium effects, 12 studies found large effects, one study found a negative effect, and 14 studies did not report post-treatment effects. Thirty-six studies used a combination of CBT and another behavioral intervention. Six of these studies found small effects, 10 studies found medium effects, nine found large effects, and 11 did not report post-treatment effects. Eighteen studies used a school-based mental health program as the primary intervention. Nine of these studies found small effects, one study found a medium effect, two studies found a large effect, and six studies did not report post-treatment effects. Lastly, 24 studies used the Coping with Depression Course as the primary intervention. Four studies using the Coping with Depression course found small effects, three studies found medium effects, 16 studies found large effects, and one study did not report post-treatment effects.

Overall, there was not a large amount of variability among the number of studies that found small, medium, or large effects across the 142 school-based mental health studies included in the twelve reviews. Forty studies found small effects, 26 studies found medium effects, 41 studies found large effects, two studies found negative effects, and 33 studies did not report post-treatment effects.

Promising Individual Studies

More recently there has been additional studies that examined the impact of cognitive behavioral therapy for adolescents. A few studies not included in the previous reviews of the literature are Stice, Rhode, Seeley, and Gau (2008), Gingsburg, Becker, Drazdowski, and Tein (2012), and Possel, Martin, Garber, and Hautzinger (2013). Stice et al. (2008) conducted a randomized efficacy trial with 341 high-risk adolescents

comparing a cognitive behavioral intervention with group supportive-expressive intervention, bibliotherapy, and an assessment only control group. Results of the study indicated that adolescents who received the cognitive behavioral intervention had greater reduction in depressive symptomatology and better social adjustment compared to the other three groups (supportive-expressive, bibliotherapy, and assessment only control group). In addition, the number of sessions adolescents attended was positively correlated with greater reduction in depressive symptomatology, indicating that consistent attendance helps with treatment effects.

Gingsburg et al. (2012) conducted a pilot study on the effects of CBT on anxiety symptomatology and global functioning. Thirty-two youth in inner-city schools participated in the study. Seventeen youth were included in the CBT group, which was administered using a modular format that could be individualized to each student. Fifteen students were included in the usual care group (control), which used supportive or art therapy. Results indicated that there was no significant difference between the two groups, yet both groups had significant decreases in anxiety post-treatment.

Possel et al. (2013) performed a randomized controlled trial of a cognitive behavioral program on 518 high school students. Students were placed in one of three conditions (cognitive behavioral, nonspecific control, no intervention control). Possel et al. (2013) found that the cognitive behavioral intervention was effective in reducing depressive symptomatology post-intervention, and that students receiving the cognitive behavioral intervention had significantly lower depressive scores compared to both control groups.

Cognitive Behavioral Therapy for Individuals with Disabilities

Three studies (Ehrenreich-May et al., 2014; Reaven, Blakeley-Smith, Culhane-Shelburne, & Hepburn, 2012; Wood et al., 2009) conducted randomized controlled trials to understand the effects of cognitive behavioral therapy on anxiety in children and adolescents with autism in clinical settings. Across all three studies, youth who received a cognitive behavioral treatment intervention had a significant decrease in anxiety and anxiety symptomatology compared to control groups. Other findings included treatment gains were maintained one-month post intervention (Ehrenreich-May et al., 2014) and that there was a significant reduction in child anxiety as measured by parent-report (Wood et al., 2009). Results are promising that CBT is an effective treatment in reducing anxiety for children and adolescents with autism. Yet, it is still unknown if the same treatment effects would be observed in an applied setting (i.e., high school), as the previous studies were conducted in clinical environments.

What can be summarized is, over the past twenty years studies have repeatedly shown that school-based mental health and cognitive behavioral interventions have had positive impacts on a variety of outcomes (e.g., depression, anxiety, problem behavior, attendance, and academics). This is encouraging as considerable attention is turning towards implementing practices that impact academic and social and emotional learning. From the previous reviews, one intervention stands out as having particularly strong impact on reducing depression and depressive symptomatology; the Coping with Depression Course. Specifically, two-thirds of the studies that used the Coping with Depression course as the primary intervention yielded large effects. Due to the potential

clinical significance the Coping with Depression Course has, further examination of its utilization is warranted.

Coping with Depression Course.

The Coping with Depression course is a well-known psycho-education intervention used to prevent and treat depression. Findings from the Cuijpers (1998) literature review suggests that the Coping with Depression Course has significant clinical value in treating depression. An additional literature search conducted for interventions that use the Coping with Depression Course intervention, revealed a limited number of articles since the last review in 1998. The following section briefly describes intervention research that used the Coping with Depression Course and the Adolescent Coping with Depression Course.

Cuijpers, Muñoz, Clarke, and Lewinsohn (2009) examined the efficacy of the Coping with Depression Course by reviewing 25 randomized control trials that used the course as an intervention. Four studies in this review were included in the previous review (Cuijpers, 1998). All other studies used adults in clinical settings to examine the efficacy of the course. Ten of the fourteen studies not previously reported on in the original review found the Coping with Depression course was effective in reducing depression and depressive symptomatology in adult participants (Cuijpers et al., 2009).

Swan, Sorrell, MacVicar, Durham, and Matthews (2004) conducted an uncontrolled group case series with seventy-six adults (18-65 years old) that met diagnostic criteria for chronic or recurrent depressive disorder. Swan et al. (2004) measured the effect of the Coping with Depression Course on depression, general mental health symptomatology burden, and quality of life. Intervention completers had a

statistically significant reduction in depression, mental health symptomatology burden, and a statistically significant increase in self-reported quality of life. In addition, the positive effects of the intervention persisted for 26 weeks post-treatment (Swan et al., 2004).

Allart-van Dam, Hosman, Hoogduin, and Schaap (2003) conducted a randomized controlled trial on the effectiveness of the Coping with Depression course on 102 adults (mean age = 45.5 years old) with sub-clinical depression. The Beck Depression Inventory was used to measure depression at pre- and post-treatment. Results indicated that the Coping with Depression course had a large effect (ES = 0.80) in reducing depressive symptomatology in adults with sub-clinical level of depression compared to the control group (Allart-van Dam et al., 2003).

Haringsma, Engels, Van Der Leeden, and Spinhoven (2006) also studied the effectiveness of the Coping with Depression Course on 110 adults (mean age = 64.2 years) with either diagnostic or sub-clinical levels of depression. Depression was measured using the Dutch version of the Center for Epidemiologic Studies Depression Scale (CESD), The within-group effect size ($d_{improve}$, effect size of the improvement made from pre- to post-intervention) for adults with major depressive disorder (MDD) was 1.14 compared to adults with no MDD diagnosis ($d_{improve} = 0.50$). Effect sizes were greater for individuals with MDD at 2-month and 14-month follow-up compared to the non-MDD group (Haringsma et al., 2006).

Adolescent coping with depression course. The Adolescent Coping with Depression course (CWD-A) was designed by Clarke et al. (1990) as an adaptation of the original Coping with Depression Course. The course uses cognitive behavioral theory as

a theoretical foundation. In addition, Clarke et al. (1990) uses the Integrative Model of Depression as an additional model to understand the etiology and maintenance of depression (see Figure 1).

The Integrative Model of Depression views the process of becoming depressed starts with an antecedent event (A) that evokes some form of depressive symptomatology. What occurs after the depression-evoking event is a disruption in the individual's pattern of positive reinforcement from naturally occurring contingencies within the environment (B and C). At the same time, there is an increase in avoidant behaviors and self-criticism, which could lead to additional negative outcomes such as intensification of dysphoria (D and E). With the intensification of the negative consequences (e.g., depressed mood) behavioral, cognitive, and emotional shifts occur (F), which continues the cycle that maintains the depressive state.

The model implies that effective treatment of depression begins by changing a persons actions and a necessary awareness that environmental factors impact a person's behavior, which may disrupt the depressive cycle. Due to the person-environment interaction it is intentional that the relationship between actions, thoughts, and feelings is discussed throughout the CWD-A curriculum. For example, it is taught that the reduction in pleasant activities can negatively impact an individual's feelings; actually enhancing depressive symptomatology than rather alleviating it.

The CWD-A has 16 sessions that focus on a variety of learning opportunities and strategies to combat depression. Sessions include topics on how to change negative thinking, problem solving, and relaxation techniques for stressful times. Table 1 provides a synopsis of the content in each session.
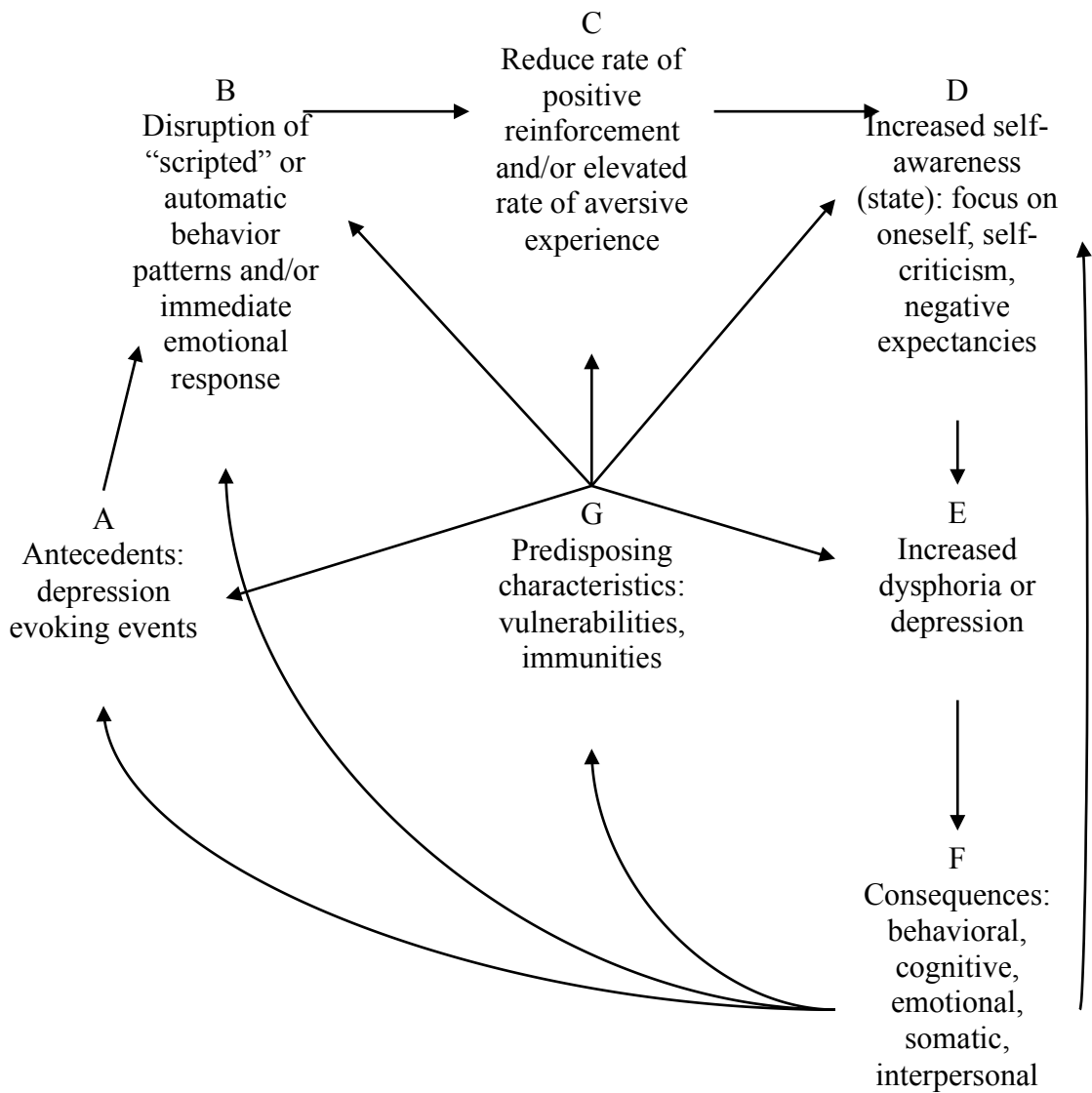
Figure 1. Integrative Model of Depression.

Table 1

Adolescent Coping with Depression Course Summary.

Session Title	Session Synopsis
Depression and social learning	Session 1 is an introductory lesson that begins to discuss the relationship between actions, thoughts, and feelings. Lesson 1 also explains the connection between our feelings and actions through the visualization of emotional spirals. The target of this lesson is to begin to understand how feelings impact actions, and to explain that participants have control of those actions.
Self-observation and change	Session 2 begins with instruction on developing social skills (e.g., practicing how to start a conversation). In addition, lesson 2 instructs adolescents how to monitor their moods and pleasant activities.
Reducing tension	Session 3 continues social skill instruction by integrating an additional scenario on how to greet and meet new people. Session 3 also teaches adolescents what tension is, and how to use the Jacobsen relaxation technique to help alleviate tension.
Learning how to change	Session 4 instructs students how to review and analyze the data they have collected for daily mood and pleasant activities. This lesson also teaches adolescents how to set appropriate goals to increase participation in pleasant activities.
Changing your thinking	Session 5 begins with discussing how to ensure success in achieving the goals set in session 4. Following that, there is a quick social skills lesson on enhancing conversation skills. The last part of the session instructs adolescents on how to control their thinking. To accomplish this last objective, participants are asked to identify how frequently they have negative and positive thoughts. Adolescent participants are also taught how to identify activating events, which could trigger the negative thoughts.
The power of positive thinking	Session 6 helps adolescents identify what positive and negative thoughts are. The second part of the session provides instruction on how to change negative thinking into positive thinking. This instruction is provided on the basis that controlling thoughts can impact feelings. The session later teaches participants to identify irrational thoughts, and to challenge irrational thinking.

33

Session Title	Session Synopsis
Disputing irrational thinking	Session 7 begins by reviewing what irrational thinking is and identifying what the activating event is, the beliefs that one might have, and the consequences of how the event makes someone feel. This session uses comics to focus on the relationship between how irrational beliefs about the activating event can impact someone's feelings (e.g., consequence).
Relaxation	Session 8 uses the Benson technique to teach adolescents how to relax. The technique follows six steps 1) sit quietly, 2) close your eyes, 3) focus on your breathing, 4) say your word as you breathe out, 5) progressively relax your muscles, and 6) do this for 10 to 20 minutes, then sit quietly for a few minutes.
Communication, part 1	Session 9 reviews the ABCs of irrational thoughts (Activating event, Beliefs, and Consequences). The session then discusses the types of communication styles. The session stresses the importance of active listening. Lastly, the session considers the differences between judgmental and understanding responses.
Communication, part 2	Session 10 stresses the importance of being able to state feelings. The session works through self-disclosure of positive and negative feelings. The meaning behind self-disclosure is that by stating how one feels, one can often change activating events.
Negotiating and problem solving, part 1	Session 11 rationalizes the importance of developing problem-solving skills in the event that conflicts between friends and family occur. Eight steps in defining the problem are reviewed.
Negotiating and problem solving, part 2	Session 12 has participants continue learning problem-solving skills by brainstorming what solutions to problems that may arise between adolescents and parents. Participants are then asked to evaluate the solutions from the brainstorming session and pick the best one. Then write a contractual agreement to solve the problem.
Negotiating and problem solving, part 3	Session 13 is an entire session committed to problem solving role-playing. Participants use communication skills and problem solving skills from previous lessons.
Negotiating and problem solving, part 4	Session 14 continues from session 13 and has participants continue to practice problem solving through role-plays.
Life goals	Session 15 discusses with participants the need to have long-term goals that are realistic. Participants fill out the Life Plan worksheet then discuss fears and potential obstacles that could be faced in the future.

Session Title	Session Synopsis
Prevention, planning, and ending	Session 16 reviews the works that has been completed over the past 15 sessions and discusses with participants how to maintain gains, and plan for emergencies (e.g., major life events) that could impact our mood.

Rohde, Clarke, Mace, Jorgensen, and Seeley (2004) examined the efficacy and effectiveness of the CWD-A with adolescents who were diagnosed with both depression and conduct disorder. Ninety-three experimental youth were randomly assigned to the CWD-A course or a non-treatment life skills course. Depression was measured using the Hamilton Depression Rating Scale (HDRS) and the Beck Depression Inventory-II (BDI-II). Rohde et al. (2004) found adolescents in the treatment group had statistically significant better recovery rates for depression compared to the life skills group; there was no significant difference found for students with conduct disorder. In addition, there was a significant reduction in depression (measured by both HDRS and the BDI-II) for the treatment group compared to the life skills group (Rohde et al., 2004).

Limitations in School-based Mental Health Research.

One limitation to summarizing overall findings across the reviews and individual studies is researchers utilized a variety of interventions and measures to indicate the overall effectiveness of a school-based mental health intervention. For example, reviews that included all universal level interventions (e.g., Durlak & Wells, 1997) grouped studies by intervention type (person-centered or environment centered). Results of the meta-analysis were positive, yet little is known about the specifics of the active components in the interventions included in the review. In addition, the summary of results of some reviews provided little information regarding the effects (e.g., effect sizes) of the school-based intervention on reducing mental health outcomes. Another

concern was some reviews calculated overall effects for CBIs on children and adolescents including clinical and school settings without disaggregating the two, which can limit the generalizability of the findings for future consideration of implementation in the schools.

Second, research has suggested that there is a dynamic relationship between mental health and a variety of variables including academic performance. Yet, only one review (e.g., Hoagwood et al., 2007) included academic outcomes as part of the review. If mental health can have negative impact on school performance, it is critical then to understand how school mental health interventions impact academic performance.

Another gap in the research was the limited number of studies that measured both depression and anxiety as an outcome variable. Both depression and anxiety are highly prevalent within the adolescent population. It is theorized that a comprehensive treatment for depression/depressive symptomatology could also have effects on anxiety/anxiety symptomatology. Measuring both and monitoring both pre-post intervention can help clarify this phenomena.

Lastly, a major gap in school-based mental health research is the lack of inclusion of students with disabilities. Students with disabilities have a potential to benefit from a psycho-educational course like the CWD-A. Adelman and Taylor (2010) state, "mental health education helps protect, promote, and maintain the well-being of students" (p.113). One rationale is students with disabilities are at higher risk for developing mental health problems than students without disabilities (McMillan & Jarvis, 2013) and mental health problems can be difficult to diagnose depending on the disability (Maag & Behrens, 1989; McGilvery & Sweetland, 2011). The complexity of the overlap between mental health and disability is summarized by Forness (2011); "we have in mind that the

children we serve under the label of behavioral disorders are primarily children with problems such as noncompliance, negativity, aggression, or other acting-out behavior characteristics of ODD of CD, in actual fact, we are indeed serving children with a full range of mental health or psychiatric disorders" (p. 42).

As Cuijpers (1998) and Cuijpers et al. (2009) point out the Coping with Depression course has had a considerable impact on reducing depression and depressive symptomatology across settings and ages. Yet there has been no research conducted on developing, adapting, or implementing an individualized cognitive behavioral course like the Coping with Depression course for adolescents with disabilities, specifically in a school settings. Prior research suggests that a cognitive behavioral course, taught by teachers, in a school setting, for a population at-risk (i.e., students with disabilities) of developing or having mental health problems would be effective in reducing depression and anxiety symptomatology.

Rationale for a Cognitive Behavioral Course

There are multiple benefits of school-based mental health services including increased accessibility to services, reduced stigma, increased opportunity for prevention and reduced costs (Durlak, 1995; Macklem, 2014; Weist, 1999). In addition, school based mental health programs help schools create safer learning and social environments for their students (Shepard et al., 2013). Shepard et al. (2013) suggests this is accomplished as schools become competent in areas such as: "principles of learning and behavior, effective team problem solving, evidence-based interventions, effective service delivery, and mental health systems of care" (p. 11).

There is a need for universal and selective prevention programs for adolescents (Macklem, 2014). Lewinsohn, Clarke, and Hoberman (1989) state that individuals impacted by depression/depressive symptomatology typically do not seek treatment for their depression, and future treatment attempts should focus on a delivery system that is non-stigmatizing and outside traditional clinical settings. One avenue to address the needs of individuals suffering from depression is through a psycho-educational course (e.g., CWD-A), which is relatively non-stigmatizing. Lewinsohn et al. (1989) also suggest that individuals typically resistant to treatment are more willing to participate in an educational treatment format where they can learn coping skills.

Furthermore, school personnel are an important component in identifying students who may be depressed (Maag & Reid, 2006) and should be included as intervention agents. Teachers are in a critical position to understand a connection between a student's behaviors, relationships, and academic performance, which are easily observed in a classroom setting (Maag & Reid, 2006). Weare and Nind (2011) report that school-based mental health professionals may be more successful in implementing prevention programs, but for prevention programs to be sustained teachers must be involved in the implementation. Cobb et al. (2006) suggest the reduction in problem behaviors due to cognitive behavioral interventions "must be considered by teachers and education administrators as a green light to go forward and expect similar results when CBIs are implemented in their schools" (p. 272). In addition the results found by Franklin et al. (2012), also suggest that the impact teachers can make when implementing a school-based mental health intervention can be significant.

Purpose of the Study

By implementing a teacher led school-based mental health intervention for students with disabilities and measuring depression, anxiety, and academic outcomes, this project is filling multiple gaps in school-based mental health research. The purpose of this study is to examine the feasibility and acceptability of implementing a CBT curriculum (i.e., *Think, Be, Do* curriculum) within special education classrooms to students with disabilities and secondary to determine curriculum impact on student outcomes. Specifically, the following questions are addressed:

1. Is it feasible for teachers to implement the *Think, Be, Do curriculum* in self-contained high school classrooms and transition programs?

2. Is the *Think, Be, Do* curriculum acceptable to the teachers and students with disabilities?

3. Does the *Think, Be, Do* curriculum impact student mental health and academic outcomes?

4. Is there an association between increased ratings on fidelity of implementation and acceptability, and student outcomes?

CHAPTER III

METHODOLOGY

Research Design

Feasibility and acceptability. One priority for this study was to determine the feasibility and acceptability of implementing the *Think, Be, Do* curriculum in high school special education settings by teachers. To understand the feasibility of implementing the *Think, Be, Do* curriculum, teachers completed a fidelity form after every session they taught. Additionally, observers observed three or four classroom periods while the curriculum was being taught to measure fidelity of implementation. Student's mood and activity chart was also used to evaluate feasibility of curriculum implementation. To evaluate acceptability teachers were asked to complete the Abbreviated Acceptability Rating Profile to measure the social validity of the curriculum after the entire curriculum was finished. Lastly, the students who received the curriculum were given a five-question social validity questionnaire.

Randomized group design. The second priority of this study was to evaluate the potential efficacy of the *Think, Be, Do* curriculum on students with disabilities on a variety of mental health and academic outcomes. This was accomplished utilizing a randomized group design. During recruitment teachers were told they would be randomly assigned to either a treatment or control condition. Teachers were assigned to condition (treatment or control) by a flip of a coin, which gave each teacher a 50 percent chance to be assigned to either group. The teachers assigned to the treatment condition implemented the *Think, Be, Do* curriculum, and teachers assigned to the control condition conducted their classroom as usual. Random assignment "creates two or more groups of

units that are probabilistically similar to each other on the average" (Shadish, Cook, &

Campbell, 2002, p. 13). This suggests that any differences seen between the two

conditions after treatment are likely due to the treatment. Effects of the curriculum were

determined by the use of a pre-post design to compare between and within condition

differences on a variety of mental health measures including the (a) Student Knowledge,

(b) Behavior Activation for Depression Scale, (c) Automatic Thoughts Questionnaire, (d)

Center for Epidemiological Studies Depression Scale, (e) State Trait Anxiety Inventory

for Children, and (f) Social Skills Improvement System (academic competence,

internalizing and externalizing behaviors subscales).

Participants and Procedures

Classroom recruitment began once the University of Oregon Internal Review

Board (IRB) approved the study for implementation to work with transition age (14-21)

youth across the state of Oregon. School districts were then contacted to approve

participation of the study within their high school classrooms. Once school district

approval was received, special education teachers and transition specialists within the

district were sent an email with a description of the study to inquire about participation.

Teachers were informed about the study design (i.e., randomized controlled trial) and

were given the opportunity to agree to participate in the study, knowing they had equal

opportunity of being in either the treatment or control condition. When a teacher

suggested they were interested, a phone call was conducted to describe the study and

responsibilities of the teacher and students in more detail. Teachers (i.e., special

education teachers and transition specialists) were offered financial reimbursement

($225.00 for treatment condition and $125.00 for control condition) for the time they

41

committed to participating in the study. Financial reimbursement was determined by paying teachers an average hourly teaching rate of $25.00 per hour, multiplied by the estimated time that teachers would need to complete training, complete forms, and prepare for each session. Teachers were also told that they would receive training on the curriculum and curricular materials for participation in both treatment and control conditions.

Once teachers agreed to participate, the curriculum developer and recruited teachers discussed the study, in each classroom to recruit student participants. Depending on school district requirements, passive or active informed consent was used for approval to collect data on student participants. A recruitment flyer along with the consent form was given to each student to take home. For passive consent, caregivers of student participants were given a week to opt their student out of the study. After caregiver consent was established, students were asked to participate in the study and sign a consent form (if 18 years or older) or assent form (if under the age of 18). Students were told they would receive a $10.00 gift card to a local store (e.g., Target, Walmart, Dollar Tree, Amazon) for completing both pre- and posttest measures.

Initial recruitment for this study included 11 classrooms. Seven classrooms were randomly assigned to the treatment condition and four classrooms were randomly assigned to the control condition. A total of 115 students (74 treatment, 41 control) were recruited for the study. One teacher in the treatment condition opted out of continuing the implementation of the study due to experiencing health related issues. See Figure 2 for Consort flow diagram for recruitment and analysis samples.
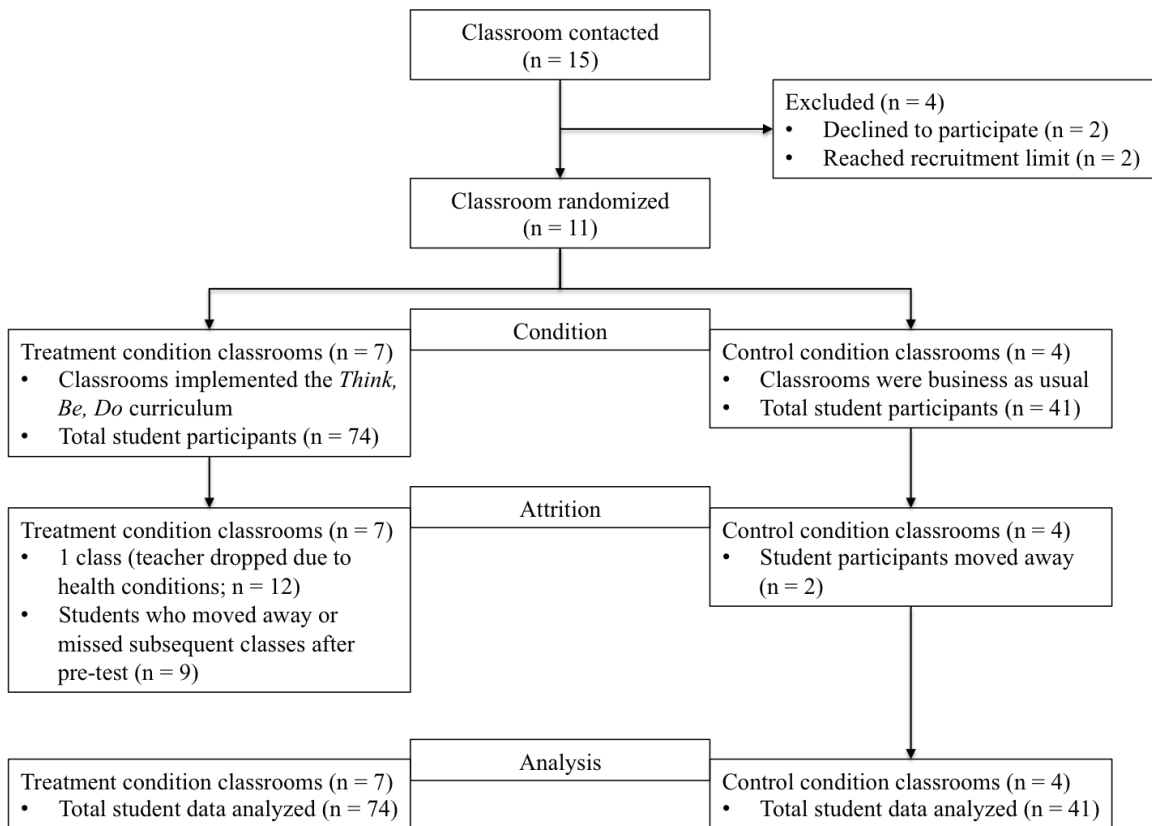
Figure 2. Consort flow diagram of participants through each stage of the experiment.

Teachers. Two special education teachers were recruited initially to participate in phase one of the Quality Implementation Framework (QIF) to address intervention feasibility, implementation, and give expert opinion on practicality of the curriculum. Teachers that were recruited for the study were allowed to participate in the study if they were the instructor of a self-contained classroom for transition age students with disabilities. A total of 11 teachers and agreed to participate in the study. See Table 2 for complete teacher demographics.

Table 2

Teacher Demographic Information

	n	*%*
Gender		
Female	5	45.5
Male	5	45.5
Transgender	0	0.0
Prefer not to specify	0	0.0
Missing	1	9.0
Race/Ethnicity		
African American	0	0.0
Latino/Latina/Hispanic	0	0.0
Asian	1	9.0
Pacific Islander	0	0.0
American Indian/Native American	0	0.0
White	9	82.0
Prefer not to specify	0	0.0
Missing	1	9.0
Sexual orientation		
Heterosexual	9	82.0
Lesbian/Gay/Bisexual	1	9.0
Other	0	0.0
Prefer not to specify	0	0.0
Missing	1	9.0
Age		
25 - 29	0	0.0
30 - 34	3	27.0
35 - 39	2	18.0
40 – 44	3	27.0
45 – 49	0	0.0
50 - 54	1	9.0
55 – 59	1	9.0
60 +	0	0.0
Missing	1	9.0
Highest degree earned		
Associates	0	0.0
Bachelor's	3	27.0
Master's	6	55.0
PhD or other professional degree	1	9.0
Missing	1	9.0

	n	%
Years in classroom		
0 – 4 years	1	9.0
5 – 9 years	4	36.0
10 – 14 years	3	27.0
15 – 19 years	1	9.0
20 + years	1	9.0
Missing	1	9.0

Teacher training. For teachers to participate in the study, they were required to

receive a two-hour training on delivering the pre- and posttest measures and the *Think,*

Be, Do curriculum. The teachers were trained on how to deliver the student measures and

teacher-report measures. The teachers were also trained on how to implement the

curriculum in the classroom, which included: (a) the expectations of the curriculum; (b)

the format of each session; (c) the main concept(s) of each session; (d) the activities in

each session; and (e) the main student outcome(s) for each session. See appendix C for

the teacher-training checklist.

Teacher coaching. The teachers were provided an opportunity for additional

coaching on the curriculum and instructional strategies if the observer rated them

implementing the curriculum below 80 percent fidelity. During coaching, teachers were

given the opportunity to discuss what was difficult to implement or problem solve issues

with time management. Coaching consisted of reviewing future lessons and a reminding

the teachers of the main components and messages that should be conveyed to the

students for each future lesson.

Observers. Five observers were recruited to observe classrooms implementing

the *Think, Be, Do* curriculum. Four observers were female and one observer was male.

All observers were graduate students in special education. Observers were trained on the

Think, Be, Do curriculum and to use the observer fidelity form in an independent setting

45

from the observed classroom, to rate teacher's fidelity of implementation of the *Think, Be, Do* curriculum. In addition, the author and observer completed the first observation together to ensure there was agreement when conducting a classroom observation.

Student participants. Two criteria were used to select student participants: (a) students must receive special education services including students currently on an Individualized Education Plan or on a 504 plan, and (b) students must be transition age (ages 14-21). Because students with disabilities are identified as vulnerable to mental health problems they are considered a selected prevention population. No mental health diagnostic screening criteria were used as inclusion or exclusion criteria. In addition, data were not used on students whose disability impacted their ability to comprehend the curriculum and measures (this was determined by the student's teacher). Table 3 provides demographic information on students who participated in the study.

Table 3

Student Demographic Information

	Treatment		Control	
	n	*%*	*n*	*%*
Gender				
Male	53	71.6	25	61.0
Female	19	25.7	15	36.6
Transgender	0	0.0	0	0.0
Prefer not to specify	0	0.0	0	0.0
Missing	2	2.7	1	2.4
Race/Ethnicity				
White	50	67.6	25	61.0
African American	7	9.5	2	4.8
Latino/Latina/Hispanic	6	8.1	5	12.2
American Indian/Native American	5	6.8	3	7.3
Prefer not to specify	3	4.1	3	7.3
Asian	2	2.7	2	4.8
Pacific Islander	0	0.0	0	0.0
Missing	1	1.4	1	2.4

	Treatment		Control	
	n	*%*	*n*	*%*
Sexual orientation				
Heterosexual	43	58.1	25	61.0
Prefer not to specify	15	20.3	8	19.5
Other	7	9.5	4	9.8
Lesbian/Gay/Bisexual	5	6.8	2	4.8
Missing	4	5.4	2	4.8
Student age				
14	6	8.1	0	0.0
15	13	17.6	1	2.4
16	15	20.3	4	9.8
17	6	8.1	7	17.1
18	17	23.0	8	19.5
19	7	9.5	7	17.1
20	5	6.8	11	26.8
21	5	6.8	2	4.8
Missing	1	1.4	1	2.4
Grade				
9th grade	16	21.6	0	0.0
10th grade	13	17.6	1	2.4
11th grade	8	10.8	7	17.1
12th grade	16	21.6	7	17.1
18-21 year old program	19	25.7	24	58.5
Missing	2	2.7	2	4.8
Special education label				
Autism	19	25.7	3	7.3
Learning disability	13	17.6	10	24.4
Multiple disabilities	10	13.5	12	29.3
Other health impairment	7	9.5	0	0.0
Emotional/Behavioral disorder	1	1.4	0	0.0
Intellectual disability	4	5.4	6	14.6
Speech or language impairment	2	2.7	2	4.8
Hearing impairment	1	1.4	0	0.0
Traumatic brain injury	1	1.4	1	2.4
Visual impairment	0	0.0	0	0.0
Orthopedic impairment	0	0.0	0	0.0
Do not know	11	14.9	5	12.2
Missing	5	6.8	2	4.8
Academic competence				
Below average	4	5.4	4	9.8
Average	50	67.6	26	63.4
Above average	12	16.2	10	24.4
Missing	8	10.8	1	2.4

	Treatment		Control	
	n	*%*	*n*	*%*
Elevated depression				
Elevated	36	48.6	21	51.2
None	29	39.2	19	46.3
Missing	9	12.2	1	2.4

Setting

Teachers and students were recruited from high schools and transition programs across six different districts in the state of Oregon. District data was retrieved from the Oregon Department of Education annual reports last updated in 2014. Classrooms were recruited from six districts. Table 4 provides data from the recruited school districts including racial/ethnicity demographics, total enrollment, and percent of students receiving free or reduced priced lunch.

Table 4

District Demographic Information

	District 1	District 2	District 3	District 4	District 5	District 6
% Racial and ethnic diversity						
White	84.3	86.3	68.3	70.0	48.4	61.8
Black	0.5	0.7	2.2	1.9	5.7	1.1
Hispanic	8.3	8.0	18.9	14.1	25.3	33.7
Asian/ Pacific Islander	1.5	1.5	2.7	3.7	13.8	1.8
American Indian	1.3	1.6	1.6	1.3	0.9	1.2
Multicultural	4.1	2.5	6.4	9.2	5.9	0.3
% Eligible free and reduced lunch	41.2	31.9	56.8	39.8	71.1	56.9
District total enrollment	2,398	1,107	5,614	16,891	6,184	6,620

Study Conditions

      Treatment condition classrooms. The Coping with Depression Course has strong evidence to support its effectiveness in ameliorating depressive disorders and symptoms (Cuijpers et al., 2009). The Adolescent Coping with Depression Course (Clarke et al., 1990), an adaptation of the original curriculum to target youth, also has evidence to promote mental health and ameliorate depressive disorders and symptoms.

      The adaptation of the Adolescent Coping with Depression Course for students with disabilities was a multi-stage iterative process. The process included (a) identifying key components of previously effective interventions (e.g., intervention length and content); (b) outlining curriculum content to include core components of cognitive behavioral techniques for both depression and anxiety; (c) decreasing the number of sessions to align the curriculum with other common brief psycho-educational interventions (i.e., ten sessions); (d) developing and reviewing preliminary lesson content utilizing the integrative model of depression as a theoretical framework; and (e) reviewing sessions for appropriateness of use in special education classrooms (i.e., student workbooks using appropriate language and visuals).

      The second step initiated Phase I of the QIF (see Table 5; Meyers, Durlak, & Wandersman, 2012) to obtain information from current special education teachers regarding implementation feasibility and plan for intervention implementation. Once the development of the curriculum was completed, Phase I continued by engaging two special education teachers in multiple feedback sessions regarding the adapted curriculum. The two special educators were asked to evaluate sessions of the new curriculum on design, amount of content per sessions, and feasibility of implementation

(i.e., specifically teaching content through scripts and activities). Once feedback was received changes were made to the sessions and were reviewed again by both special educators. This iterative cycle was completed three times. Both special educators agreed that the final curriculum could be implemented in transition age classrooms.

Phase II of the QIF continued with engaging the two special educators in a discussion about the proposed implementation model, which included reviewing how to train teachers on the curriculum, implementation timeline, and pre-post assessments. Phase III of the QIF included planning ongoing support with intervention agents during intervention implementation. Coaching on the curriculum was offered to teachers who were implementing the curriculum and were observed scoring below 80 percent on implementation fidelity. Lastly, Phase IV of the QIF utilized post-intervention questionnaires, self-report fidelity of implementation questions to evaluate the curriculum.

Table 5

Quality Implementation Framework

Quality Implementation Framework
Phase One: Initial considerations regarding the host setting
Assessment strategies
1. Conducting a needs and resources assessment
2. Conducting a fit assessment
3. Conducting a capacity/readiness assessment
Decisions about adaptation
4. Possibility for adaptation
Capacity-building strategies
5. Obtaining explicit buy-in from critical stakeholders and fostering a supportive community/organizational climate
6. Building general/organizational capacity
7. Staff recruitment/maintenance
8. Effective pre-innovation staff training

Phase Two: Creating a structure for implementation
    Structural features for implementation
        9. Creating implementation teams
        10. Developing an implementation plan
Phase Three: Ongoing structure once implementation begins
    Ongoing implementation support strategies
        11. Technical assistance/coaching/supervision
        12. Process evaluation
        13. Supportive feedback mechanism
Phase Four: Improving future applications
        14. Learning from experience

Note. Table from Meyers, Durlak, & Wandersman (2012).

The adaptation process resulted in the creation of the *Think, Be, Do* curriculum. The curriculum is ten-sessions (consistent with brief and effective CBT interventions), administered by teachers in special education classrooms. The curriculum was designed and structured to work within a 50-minute classroom period, and incorporates a companion student workbook for students to reference even after the intervention is completed. Table 6 provides a synopsis of the *Think, Be, Do* sessions. See appendix B for the complete *Think, Be, Do* curriculum.

Table 6

Think, Be, Do Curriculum Summary.

Session Title	Session Synopsis
What is Mental Health?	Session 1 introduces the *Think, Be, Do* curriculum and covering what the expectations are for the students receiving the curriculum. It introduces what mental health is and the mood and activity chart, which are present in all following sessions.
Actions, Thoughts, and Feelings	Session 2 covers how actions, thoughts, and feelings are connected and discusses how each individual interacts with their environment and how that might change depending on how the individual feels.
Locus of Control	Session 3 discusses what locus of control is, and teaches students to be aware of what they have control of, including their actions, thoughts and feelings.

Session Title	Session Synopsis
Pleasant Activities – Part 1	Session 4 reviews actions, thoughts, and feelings and encourages students to identify pleasant activities that they have complete control over. Session 4 then identifies a goal setting strategy, so students can begin setting goals around doing activities that are positively reinforcing.
Pleasant Activities – Part 2	Session 5 builds upon session 4 and continues the process of goal setting. Students are asked to set goals and action plans to achieve their goals by the time the curriculum is completed.
Negative and Wise Thoughts	Session 6 explains to students what automatic thoughts are and how to change automatic negative thoughts into wise rational thoughts.
Depression	Session 7 teaches students about depression. Then the session discusses how depression can impact the student's environment and his or her own academics and schooling.
Anxiety	Session 8 teaches students about anxiety. Then the session discusses how anxiety can impact the student's environment and his or her own academics and schooling.
Coping Strategies	Session 9 provides an opportunity for students to learn and practice two different coping strategies to help their minds and bodies during times of stress.
Problem-solving	Session 10 introduces a problem-solving technique for students to use when they are faced with difficult situations.

Control condition classrooms. Control condition classrooms were instructed to conduct business as usual. Once posttest data was collected, teachers from the control condition were trained on the *Think, Be, Do* curriculum so they may use the curriculum in their classroom in the future. In addition, observers were not instructed to observer classrooms in the control condition.

Measures

Teacher fidelity, observer fidelity, and social validity measures were used to determine overall implementation feasibility and acceptability of the *Think, Be, Do*

curriculum. Students completed the Behavioral Activation for Depression Scale – Short Form; Automatic Thoughts Questionnaire; Center for Epidemiological Studies - Depression Scale; and State Anxiety Inventory for Children to determine the overall efficacy of the *Think, Be, Do* curriculum on mental health outcomes. The student measures were combined and used to fill out as one survey (see appendix D). Furthermore, students in the treatment condition completed a daily mood and activity chart (see appendix E) as a measure of progress throughout curriculum implementation. In addition, teachers completed three subscales (internalizing disorders, externalizing disorders, and academic competence) of the Social Skills Improvement System to evaluate the potential efficacy of the *Think, Be, Do* curriculum on mental health and academic outcomes. Lastly, students completed a student knowledge questionnaire to determine knowledge acquisition after completing the *Think, Be, Do* curriculum.

Fidelity. Fidelity of implementation was measured using a custom designed feedback form for teachers to complete after every lesson (see appendix F). This form is designed to measure the teacher's level of fidelity of implementation, perceptions of feasibility, level of overall student engagement, level of teacher mastery on the curriculum, and perceived effectiveness of the curriculum on a 1 to 4 Likert agreement-scale. In addition, observer fidelity was measured using a custom designed observer fidelity form (see appendix G), which independent observers evaluated the teacher's percentage of fidelity of implementation of the *Think, Be, Do* curriculum on a 1 to 5 scale. Reliability analysis on the teacher fidelity form across all ten sessions resulted in moderate to strong internal consistency ($\alpha = .762$ to $\alpha = .951$).

Social validity. Social validity was measured using the Abbreviated Acceptability Rating Profile (AARP; see appendix H). The AARP measure is an eight-item measure that has been adapted to be quicker and more simplistic than other education social validity measures, rated on a 1 to 6 scale of agreement. The AARP is a single factor measure with item loadings ranging from .89 - .98 and a reported internal consistency of 0.98 (Carter, 2010). Reliability of the AARP for this teacher sample resulted in good reliability (α = .853). A five-item unique student social validity (SSV) measure was used to assess student participant perceptions of the curriculum (see appendix I). Initial reliability calculated for the SSV measure resulted in strong internal consistency (α = .923).

Student Knowledge Questionnaire (SQ). A ten-item knowledge questionnaire developed to assess student's knowledge of the *Think, Be, Do* curriculum's core principles. The SQ was delivered to both treatment and control condition at pretest and posttest in order to determine if students in the treatment condition learned and comprehended the material taught during the *Think, Be, Do* curriculum as well as to determine if students in the control condition learned any core principles during business as usual. The SQ was scored using percent correct at pretest and posttest. See appendix J for the SQ.

Mood and Activity Chart (MAC). The MAC chart was used throughout the curriculum by students to self-monitor their daily levels of mood and activity. The MAC chart ratings were discussed and reviewed during the implementation of the *Think, Be, Do* curriculum. Students rated their moods on a scale of 1 to 7: a 1 indicates a feeling of anxiety and depression; a 7 indicates the absence of anxiety and depression and the

feeling of happiness and positivity. Students also rated their activity level on a scale of 1 to 7: a 1 indicates very minimal activity and low motivation to engage in pleasant activities; a 7 indicates engagement in and high motivation for pleasant activities.

Behavioral Activation for Depression Scale (BADS). The BADS is a measure of behavior change during the time in which an individual is receiving treatment for depression. The BADS was developed to track changes in weekly behaviors hypothesized to be associated with depression (Manos, Kanter, & Luo, 2011). The nine-item short form has a two-factor structure, which includes avoidance and activation. Internal consistency was acceptable for the community sample (α = .776) and undergraduate sample (α = .844). Initial reliability for the BADS for the sample population was poor (α = .544). A component analysis was conducted to evaluate if item deletion would result in higher overall reliability for the sample population. The avoidance sub-measure was reverse coded while the activation sub-measure was not. Deletion of four variables that made up the avoidance sub-measure of the BADS resulted in a moderate to good reliability (α = .722). Subsequent analysis used the five-item activation sub-measure for the BADS.

Automatic Thoughts Questionnaire (ATQ). The ATQ assesses negative thoughts associated with depression. The ATQ uses a 30-item measure asking individuals how often certain thoughts occur on a five-point Likert scale from *not at all* (1) to *all the time* (5). Internal consistency of the ATQ, as measured by an alpha coefficient was .96 and Spearman-Brown coefficient (a reliability measure used to determine reliability after a length of a measure was changed) of .94 (Kazdin, 1990). A 12-item ATQ short form was developed using the personal maladjustment/desire for change and negative self-concept/expectations subscales (Stice, Rohde, Seeley, & Gau, 2010). Rohde et al. (2004)

found the short form showed internal consistency (α = .93) and had a strong positive correlation (r = .98) with the full ATQ. The initial analysis of the ATQ for the sample population resulted in strong reliability (α = .897).

Center for Epidemiologic Studies Depression Scale (CESD). The CESD is used to measure current levels of depressive symptomatology (Radloff, 1977). A ten-item version has been revised to fit the DSM criteria for depressive disorders (Haroz, Ybarra, & Eaton, 2014) and was used in this current study. Haroz et al. (2014) tested the psychometric properties of the 10-item revised CESD on two populations and found high internal reliability for both conditions (α > .90). The initial analysis of the CESD for the sample population resulted in good reliability (α = .877).

State-Trait Anxiety Inventory for Children (STAIC). The STAIC – State subscale (a 10-item measure) was used to measure student's current state of anxiety. The measure has been found to be sensitive to effects of CBT in adolescents (Kirisci & Clark, 1996). Initial reliability for the STAICs two sub-measures reported high alpha (anxiety present = 0.87 and anxiety absent = 0.89). The internal consistency of the STAIC for the sample population resulted in a moderate alpha (α = .714).

Social Skills Improvement System (SSIS). The SSIS was used to measure academic competence (AC), teacher internalizing behavior scores (TIB) and teacher externalizing behavior scores (TEB). The teacher form was used to measure student's internalizing behaviors, externalizing behaviors, and academic competence. The SSIS has strong reliability for the teacher form problem behaviors (internalizing alpha coefficient = .90, and externalizing alpha coefficient of .94), and academic competence = .96, when used with secondary students (Gresham & Elliot, 2008). The initial reliability analysis of

the SSIS resulted in good reliability for the internalizing ($\alpha = .857$), externalizing ($\alpha = .880$), and academic competence ($\alpha = .846$) subscales. In addition, the SSIS has been validated on students with a variety disabilities (e.g., Attention Deficit Hyperactivity Disorder, Developmental Delay, Emotional Disturbance, Intellectual Disability, Autism Spectrum Disorder, Specific Learning Disability, and Speech Language Impairment; Gresham & Elliot, 2008).

Data Analysis

Missing data. Data was screened for errors prior to running analyses. To account for missing data one data set was imputed. Although it is not possible to definitively know whether data were missing at random (MAR), the inclusion of additional predictors in the imputation model can reduce bias and make the MAR assumption more plausible (Allison, 2009; Rubin, 1996). Therefore, the imputation model included a number of auxiliary variables (e.g., gender, age, SPED status) as a means for strengthening its generality. Sequential regression imputation was used to impute the data set using the IVEware software V0.2 (Raghunathan, Solenberger, & Van Hoewyk, 2002).

Analytic technique. Data analysis was conducted using SPSS 23.0 for MAC (IBM Corp., 2015). To answer the proposed research questions and address each hypothesis, different analytic techniques were used. To determine implementation feasibility and acceptability (hypotheses one through five) descriptive statistics (i.e., means and standard deviations), analysis of teacher comments, and bivariate correlations on teacher fidelity of implementation, observer fidelity of implementation, teacher social validity, and student social validity were analyzed. Second, analysis of covariance (ANCOVAs) was used to determine support for between-condition differences

hypotheses (i.e., hypothesis six through nine). ANCOVA is typically used when determining the effects of an intervention, while controlling for additional continuous variables that could influence the dependent variable (Field, 2013). Lastly, bivariate and partial correlations are used to determine support for association-based hypotheses (i.e., hypotheses 10 and 11). Similarly, partial correlations also control for additional variables that could influence the dependent variable (Field, 2013).

Power analysis. A sensitivity analysis was conducted to evaluate the power of the study design. With an average of five classrooms per condition, alpha set to .05, a covariate $r = .50$, intraclass correlation ranging from 0 to 0.20, there is sufficient power (.80) to detect and individual effect size of d ranging from $0.53 - 1.02$. Because the feasibility trial is under powered to detect clinically meaningful effects, $d \geq .30$ was used to evaluate intervention effects on the outcome measures rather than statistical significance.

Research Hypotheses

1. Is it feasible for teachers to implement the *Think, Be, Do curriculum* in self-contained high school classrooms and transition programs?

    Hypothesis 1: Teachers will implement the *Think, Be, Do* curriculum with high fidelity as measured by greater than or equal to an overall mean score of 3.0 on a four-point Likert scale and greater than or equal to an overall mean score of 3.5 on a five-point observer scale.

    Hypothesis 2: The *Think, Be, Do* curriculum will be feasible to implement as measured specifically on items two (*scripts used*), three (*feasible to implement*), and four (*activities were implemented*) of the teacher fidelity

form with a greater than or equal to item mean score of 3.0 on a four-point Likert scale.

Hypothesis 3: Students will engage with the *Think, Be, Do* curriculum by monitoring their moods a minimum of ten times over a five-week period.

2. Is the *Think, Be, Do* curriculum acceptable to the teachers and students with disabilities?

Hypothesis 4: Teachers will rate the *Think, Be, Do* curriculum as an acceptable intervention as measured by an overall mean item score greater than or equal to 4.0 on the AARP.

Hypothesis 5: Students will rate the *Think, Be, Do* curriculum as an acceptable curriculum as measured by an overall mean score greater than or equal to 7.0 on the 10-point SSV.

3. Does the *Think, Be, Do* curriculum impact student mental health and academic outcomes?

Hypothesis 6: Students in the treatment condition will demonstrate greater change on student knowledge compared to students in the control condition ($d \geq .30$).

Hypothesis 7: Students in the treatment condition will demonstrate greater increase on the BADS and greater decrease on the ATQ compared to students in the control condition ($d \geq .30$).

Hypothesis 8: Students in the treatment condition will demonstrate a greater reduction on mental health symptomatology measures (i.e., CESD,

STAIC, TIB, and TEB) compared to students in the control condition ($d \geq$

.30).

Hypothesis 9: Students in the treatment condition will demonstrate a

greater increase in AC compared to students in the control condition ($d \geq$

.30).

4. Is there an association between increased ratings on fidelity of implementation

and acceptability, and student outcomes?

Hypothesis 10: Increased fidelity of implementation scores (teacher and

observer) will be positively associated with student outcomes.

Hypothesis 11: Increased social validity scores (teacher and students) will

be positively associated with student outcomes.

CHAPTER IV

RESULTS

This study examined the feasibility and acceptability of implementing the *Think, Be, Do* curriculum in self-contained high school classrooms and 18-21 year old programs. In addition, the study examined the potential efficacy of the *Think, Be, Do* curriculum on multiple mental health and academic outcome measures. This chapter will present findings from preliminary analysis of the data, results for each hypothesis from the four research questions, and additional post-hoc analyses on specific subsections of the student participants.

Preliminary Analysis

Baseline equivalence. Baseline equivalence across conditions was tested using Chi-square test for dichotomous variables and independent samples t-test for continuous variables. To determine baseline equivalence for demographic variables (a) gender (male, female), (b) race (white, non-white), (c) sexual orientation (heterosexual, other), and (d) special education label (high incidence, low incidence), dichotomous variables were computed in order to have adequate cell sizes. Chi-square difference tests across conditions indicated no statistically significant differences at baseline. To determine baseline equivalence for age, grade, and student outcome measures, independent samples t-test were used. Results indicated that treatment and control conditions differed significantly by age, $t(110) = -3.59$, $p < .01$, and grade $t(108) = -4.60$, $p < .01$. Baseline equivalence tests for student outcome measures yielded no statistically significant differences between conditions.

Differential attrition. Data were screened for missing data. A total of 83 student participants (72.2 percent) had complete data and 32 student participants (27.8 percent) had at least one missing posttest measure. Chi-square differences tests were conducted to examine differences in missingness on treatment condition and student demographic data. Treatment condition was the only Chi-square difference test that had a statistically significant result $\chi^2(1) = 10.359$, $p < .01$, indicating there greater attrition in the treatment condition (37.8%) compared to the control condition (9.8%). This was an expected result as one entire treatment classroom dropped due to teacher health concerns.

Assumptions. Specific violations of normality including outliers, linearity, and homoscedasticity were analyzed. Frequency scores on all variables were analyzed for any outliers in the data. Skewness and Kurtosis were examined and fell within the acceptable range of -1.96 to +1.96 (Field, 2013). Homogeneity of variance was analyzed and Levene's tests were conducted on each outcome variable and did not find any statistically significant differences in variance across treatment condition. Table 7 reports skewness, kurtosis, and Levene's statistic (based on the mean), for each outcome variable.

Intraclass correlations (ICC). Due to the nested nature of the data collected, unconditional means models with a random intercept were estimated for the outcome variables in order to determine if there was systematic variation in the outcome variables at the classroom level and to estimate the intraclass correlation at the classroom level. ICC coefficients range 0 to 1, and are used as an estimator of the degree of statistical dependency within the data (O'Dwyer & Parker, 2014). Results of the models show no significant variation associated with the classroom for any posttest measure. With the exceptions of the SQ, TIB and TEB measures, the ICCs = .00. See Table 8 for ICCs.

Table 7

Assessment for Normality.

Variable	Skewness	*SE* of skewness	Kurtosis	*SE* of kurtosis	Levene statistic	*p*
SQ	-0.42	.23	-0.69	.45	8.72	.004
BADS	-0.19	.23	-0.28	.45	0.01	.936
ATQ	0.73	.23	-0.47	.45	2.27	.135
CESD	0.92	.23	0.45	.45	0.09	.766
STAIC	0.09	.23	-0.48	.45	0.03	.874
TIB	0.77	.23	0.71	.45	1.17	.282
TEB	1.17	.23	1.13	.45	0.03	.874
AC	-0.06	.23	0.13	.45	1.90	.170

Note. SQ = Student knowledge questionnaire. BADS = Behavior Activation for Depression Scale. ATQ = Automatic Thoughts Questionnaire. CESD = Center for Epidemiologic Studies on Depression. STAIC = State Trait Anxiety Inventory for Children. TIB = Teacher Internalizing Behavior. TEB = Teacher Externalizing Behavior. AC = Academic Competence. All tests based on df(1, 113).

Table 8

Intraclass Correlations for Condition Data.

Measure	ICC	Estimate	*SE*	*z* - value	*p* - value
SQ	.16	0.70	0.45	1.53	.06
BADS	.00	0.00	NA	NA	NA
CESD	.00	0.00	NA	NA	NA
ATQ	.00	0.00	NA	NA	NA
STAIC	.00	0.00	NA	NA	NA
TIB	.13	2.52	1.99	1.27	.10
TEB	.16	5.94	4.23	1.41	.08
AC	.00	0.00	NA	NA	NA

Note. SQ = Student knowledge questionnaire. BADS = Behavior Activation for Depression Scale. ATQ = Automatic Thoughts Questionnaire. CESD = Center for Epidemiologic Studies on Depression. STAIC = State Trait Anxiety Inventory for Children. TIB = Teacher Internalizing Behavior. TEB = Teacher Externalizing Behavior. AC = Academic Competence.

Correlations between outcome variables. Correlations were run on the entire

sample (*n* = 115) to determine if there was association between outcome variable scores

(see Table 9). Medium to large statistically significant associations were found at pretest

63

between the CESD, ATQ, and STAIC. Correlations between pretest outcome measures suggests students who reported they were more 'behavioral activated' (higher BADS score) reported fewer depression ($r = -.24$, $p < .05$) and anxiety symptoms ($r = -.40$, $p < .01$). Furthermore, correlations show that students who self-reported greater depression symptomatology also self-reported more negative thoughts ($r = .74$, $p < .05$), and greater anxiety symptomatology ($r = .64$, $p < .01$). In addition, students who self-reported more negative thoughts also reported greater anxiety symptomatology ($r = .56$, $p < .05$). Student self-reported depression symptomatology and anxiety symptomatology was also correlated with teacher reported internalizing behavior ($r = .28$, $p < .05$; $r = .22$, $p < .05$) respectively.

Table 9

Bivariate Correlation between Pretest Outcome Variables (n = 115).

	1	2	3	4	5	6	7	8
1. SQ								
2. BADS	-.08							
3. ATQ	-.01	-.23*						
4. CESD	.03	-.24*	.74*					
5. STAIC	.08	-.40*	.56*	.64*				
6. TIB	-.15	-.22*	.22*	.28*	.22*			
7. TEB	-.15	.06	.14	.13	.19*	.07		
8. AC	.04	.03	.04	-.01	.06	.00	-.12	

Note. SQ = Student knowledge questionnaire. BADS = Behavior Activation for Depression Scale. ATQ = Automatic Thoughts Questionnaire. CESD = Center for Epidemiologic Studies on Depression. STAIC = State Trait Anxiety Inventory for Children. IIB = Teacher Internalizing Behavior. IEB = Teacher Externalizing Behavior. AC = Academic Competence. * $p < .05$

Feasibility

Hypothesis one. Fidelity of implementation was measured using the custom teacher fidelity form. Teachers completed this form after every session. An overall average was calculated for each session on a four-point Likert scale (1 – 4). A value of 1 indicates the teacher strongly disagrees they implemented the session with fidelity and a value of 4 indicates the teacher strongly agrees they implemented the session with fidelity. In addition, observers rated level of implementation fidelity on a five-point scale (1 – 5) on 30 to 40 percent of the treatment classrooms. A value of 1 indicates the session was implemented with 59 percent fidelity or less and a value of 5 indicates the session was implemented with 90 to 100 percent fidelity. Table 10 reports the overall means and ranges for teacher and observer fidelity for each session.

Hypothesis one indicated that teachers would implement the *Think, Be, Do* curriculum with high fidelity as measured by a score greater than or equal to 3.0 and an observer fidelity score greater than or equal to 3.5. Seven out of ten sessions met the teacher fidelity of implementation criteria and eight out of ten sessions met the observer fidelity of implementation criteria. Session six was the only session that fell below the hypothesized fidelity scores by both teacher and observers. Overall mean fidelity scores for teachers were 3.02 and observers were 3.99. In addition, there was a significant association between teacher fidelity and observer fidelity ($r = .52, p < .001$). These findings support hypothesis one that the *Think, Be,* Do curriculum intervention is feasible for teachers to implement with fidelity.

Table 10

Fidelity of Implementation Descriptive Statistics.

Session	Teacher Fidelity			Observer Fidelity		
	Mean	Min.	Max.	Mean	Min.	Max.
1	3.02	2.62	3.63	4.86		
2	3.29	2.75	3.88	3.69	3.00	4.86
3	2.95	2.13	4.00	4.05	3.86	4.29
4	3.02	2.50	3.88	4.14		
5	3.09	2.38	4.00	3.71		
6	2.92	1.88	4.00	3.40	2.71	4.14
7	3.09	2.75	4.00	3.30	2.57	4.14
8	3.05	2.50	3.88	3.72	2.86	4.14
9	2.91	2.38	3.88	4.86		
10	3.15	2.75	4.00	4.14		
Overall	3.02	2.46	3.92	3.99	3.00	4.31

Note. Total range for teacher fidelity 1 – 4. Total range for observer fidelity 1 – 5.

Hypothesis two. Feasibility of the *Think, Be, Do* curriculum was established by examining teacher report on items two, three, and four on the teacher fidelity form. Hypothesis two indicated that overall mean scores for all three items would be greater than or equal to 3.0. Item two, *"the scripts and examples given in the lesson were used to achieve the learning outcomes,"* had an overall mean score of 3.16 (*min.* = 2.60, *max.* = 4.00, *SD* = 0.40). Item three, *"overall this lesson was feasible to implement with my students,"* had an overall mean score of 3.08 (*min.* = 2.40, *max.* = 4.00, *SD* = 0.48). Item four, *"the activities were implemented as described in the lesson plan,"* had an overall means score of 3.04 (*min.* = 2.50, *max.* = 3.90, *SD* = 0.43). These results support hypothesis two that specific implementation procedures (e.g., scripts and activities) were feasible to implement.

In addition to examining descriptive statistics on the feasibility of the *Think, Be, Do* curriculum, teachers and observers were asked to complete three open-ended questions as part of the fidelity form including (a) Describe areas in the activities that

went well?; (b) What parts of the lesson were difficult to implement? Describe anything that was confusing to you or the students; and (c) If adaptations were made to the lesson related to materials or the activities, please describe them. Due to limited data, a full thematic qualitative analysis of the open-ended responses could not be conducted.

Summary of Open Ended Feasibility Questions

Curriculum positives. Across the sessions, teachers reported that the actions, thoughts, feelings triangle and the mood spirals were positives in the curriculum. In addition, students were engaged in discussions around depression and anxiety. Teachers also enjoyed the relaxation technique in session nine and the problem solving technique in session 10, with one teacher stating "I am going to use this as my problem solving process!!!"

Curriculum difficulties. There were a few issues that teachers struggled with when implementing the curriculum. First, teachers continued to state that the sessions were too long for the time they had to complete the sessions. Second, the sessions would be better focusing in on one content topic at a time. Third, using the SMART goal setting technique was difficult for their students and they were unlikely to continue discussing student goals after session five, when student's set their own goals. Finally, the amount of writing requested of the students was problematic, as most teachers indicated that writing was difficult for their students.

Curriculum adaptations. Teachers used additional visuals and multimedia to explain concepts being covered in each lesson. In addition, teachers utilized class discussions, rather than only teacher instruction, to cover session content. Finally,

multiple classrooms dropped the goal setting activity of the curriculum. Table 11 reports an overall summary for each lesson.

Hypothesis three. Feasibility of the *Think, Be, Do* curriculum was also measured by the frequency which students interacted with the MAC chart as a way to monitor their moods and activities during curriculum implementation. Hypothesis three states that students would interact with the MAC chart a minimum of ten times over a five-week period. The percentage of students who completed the MAC chart a minimum of 10 times was 68.9 percent (*min.* = 0.00, *max.* 42, Mood $M = 17.6$, $SD = 12.97$, Activity $M = 17.7$, $SD = 12.89$).

MAC chart ratings were on a scale of 1 (very poor mood and low activity level) to 7 (very good mood and high activity level). Student participants had an overall mean mood score of 5.29 (*min.* = 2.69, *max.* = 6.88, $SD = 1.18$). Student participants had an overall mean activity score of 5.31 (*min.*= 2.57, *max.* = 6.88, $SD = 1.36$). This suggests that student participants in the treatment condition had average to positive mood to average to high level of activity throughout the curriculum. Correlations between mood and activity suggest a strong association between the two variables ($r = .89$, $p < .001$). These findings support hypothesis three that it is feasible for students to engage and participate in the *Think, Be, Do* curriculum by monitoring their moods during curriculum implementation.

Table 11

Open Ended Fidelity Questions and Answers.

Session	Summary of Teacher Response	Summary of Observer Response
Describe areas in the activities that went well?		
Session 1	• Students were engaged in discussion around environment, behavior, and stressors. • The mood rating scale went well.	• Discussion around what mental health is. • Students understood the main concepts of lesson. • Actions, thoughts, and feelings. • Upward and downward spirals.
Session 2	• Downward and upward spiral went well. • Actions, Thoughts, and Feeling. • Students embraced the ATF triangle and demonstrated understanding of the spirals.	• The scripted scenarios and the students saying STOP! • Actions, Thoughts, and Feelings triangle. • Using examples from students and pop culture for ATF triangle.
Session 3	• External and internal locus of control – talked about super heroes that have strong internal locus of control. • Internal control and resilience strategies seemed to resonate with students.	• Review of ATF triangle. • Brainstorming who has control over student's lives.
Session 4	• Review of Actions, Thoughts, and Feelings. • Students engaged in a good discussion about internal versus external locus of control.	• Students wanted to share examples of the ATF triangle. • Students sharing social and success activities.
Session 5	• Review of ATF triangles and mood spirals. (2) • Social and success brainstorm. • Sharing goals and positive perspectives.	

Session	Summary of Teacher Response	Summary of Observer Response
Session 6	• The scenarios in the lesson. • Discussions and group activity. (2) • Automatic thoughts activity went well. • Negative and wise thoughts fostered some discussion.	• Discussion of feelings and ratings. • Students did well with negative and wise thoughts activity. • Reviewed ATF triangle.
Session 7	• Water diagram. • Partner discussion. • Overall this was the most successful lesson so far. • Students were very engaged and generated great ideas.	• Students demonstrating how to talk to a teacher or counselor. • Students understood the symptoms of depression.
Session 8	• Describing anxiety and defining what it means. (3) • Comparing and contrasting depression and anxiety in order to form discussion.	• Students seemed to be able to understand and describe anxiety. • Review of depression. • Students engaged in the activity.
Session 9	• Relaxation activity. (4)	• Teacher went over wise thoughts and asked for examples from students. • Relaxation technique – students vocalized effectiveness and usefulness of this technique.
Session 10	• Loved the Think, Be, Do problem solving strategy. • Working through the Think, Be, Do chart was fabulous! • Discussion and group activity.	

Session	Summary of Teacher Response	Summary of Observer Response

What parts of the lesson were difficult to implement? Describe anything that was confusing to you or the students.

Session	Summary of Teacher Response	Summary of Observer Response
Session 1	• Supportive classroom environment was a bit wordy and has already been covered. • More examples of the mood scale. • I need better prep. • A lot of concepts for students at one time. • Unable to complete in 70 minutes. • Scripts were lengthy.	• MAC chart was a little confusing and took long to cover scale. • Some students had difficulty separating thoughts and feelings.
Session 2	• A lot of writing and thinking on own, which is hard. • Scenarios were difficult to track for some students although they came up with good strategies. • Students with ASD are challenged with perspective taking. The scripts are too "other focused" for them.	• The person-environment interactions could be explained better. • Mood spirals. • Large versus small events and looking at events from different perspectives.
Session 3	• I am having trouble finishing lessons in a day. (2) • Definitions of new terms. • Students were confused in class even though it had previously been discussed.	• Some issues around understanding more control equals more success. • Resilience was a difficult concept overall. • Did not do last activity.
Session 4	• Activity domains were difficult. • The SMART goals process was difficult. (3). • Rating social and success activities with amount of control. • Needed a lot of guidance on social goals for students with ASD. • Could be more visual.	• SMART goals – instructor had a difficult time following the script when teaching it.

Session	Summary of Teacher Response	Summary of Observer Response
Session 5	• SMART goals were hard/difficult (3). • Goal setting that is relevant to long-term goals. • Students were stuck on "I do nothing"	• Some issues around understanding SMART goals.
Session 6	• Just a lot going on and I felt fragmented. • Keeping on track with open-ended ideas. • Very time consuming had to split into two lessons. • Despite nice discussion, some students had a difficult time grasping negative thoughts into wise thoughts.	• Students had a hard time coming up with negative thoughts they tell themselves. • The way the information was presented or scripted seemed to be a challenge for the students. • There were too many options.
Session 7	• We are screwing up the long-term goal portion. • Goal setting that fits into long term goals. • Activities take longer than time allotted. • The goals, this group really struggles with this.	• Keeping students on track. • Did more review of SMART goals. • Discussed what if there is not best way to talk to someone?
Session 8	• Students had difficulty generalizing the CHARGE strategy. • Need more clarity on the CHARGE, students were not embracing the strategy (maybe too many variables to think about). • I am not doing well on the long-term goals. (2)	• Had difficulty keeping students on track. • Could have had more structured conversation around the Venn diagram. • Was hard to get students through the CHARGE activity. • There was no check-in on goals.
Session 9	• Journaling was not great. • Writing is difficult for our students. (4) • Trouble engaging students in meditations.	
Session 10	• Too much writing. (2) • The long-term goal planning. • Problem solving with such different ability levels.	• Partner activity was difficult, students tended to have very different ideas.

Session	Summary of Teacher Response	Summary of Observer Response

If adaptations were made to the lesson related to materials or the activities, please describe them.

Session	Summary of Teacher Response	Summary of Observer Response
Session 1	• More multimedia visuals (e.g., TED talks) • Provided more time for generating ideas and writing. • Referred to emotional health instead of mental health. • Shortened some scripts.	• Added in a sliding scale as an intro to the spiral (timeline of actions).
Session 2	• Extended the lesson. • Went through person-environment interaction section very quickly due to time constraints. • Made the conversation student focused rather than script focused.	• Used overhead and whiteboard to show examples.
Session 3	• Changed from school to more life events. • A lot of conversations and examples	• Gave examples of what external and internal locus of control was. • Gave examples of employment.
Session 4	• Having more visuals. • Lots of discussion and review of terms. • Students confused by difference between social and success. Would be easier to discuss social and achievement.	• Displayed pictures and diagrams on board.
Session 5	• We set goals, but many already have and are monitoring social emotional goals so they will continue to monitor outside context of TBD. • Lots of discussion and sharing	• Changed success activities into "what activates fill your cup?"

Session	Summary of Teacher Response	Summary of Observer Response
Session 6	• Translated negative and wise thoughts into negative and positive thoughts.	• Had students come up with two events and used a smaller scale
Session 7	• Had to drop strategy to use. • Lots of discussion.	• Highlighted the connection between Actions, Thoughts, and Feelings. • Used a person instead of a rock in the example. • Used celebrity examples.
Session 8	• Skipped goals and focused on anxiety and taking charge.	• Not a lot of discussion around academics, but more so around life and extracurricular activities. • Didn't review strategy to use. • Class worked together through the CHARGE activity.
Session 9	• Did a lot of review on anxiety. • Journaling difficult for some students due to writing, maybe look at choice of drawing.	• Reviewed anxiety and asked students to define it.
Session 10	• Connected the Think, Be, Do strategy to popular culture (e.g., NFL renaming of team). • Skipped goals to spend more time on TBD.	

Acceptability

  Hypothesis four. Social validity was used to evaluate if the *Think, Be, Do* curriculum was an acceptable intervention. Teachers completed the AARP to evaluate the acceptability of the curriculum as a treatment for students in their classrooms. The overall mean score for the AARP was 5.18 (*min.* = 4.25, *max.* = 5.88, *SD* = 0.54) rated on a 6-point scale. No teacher disagreed in any capacity to any of the items. Results support hypothesis four, that teacher would rate the *Think, Be, Do* curriculum greater than or equal to a 4.0 on the AARP.

  Hypothesis five. In addition, students completed a five-item SSV form after the completion of the curriculum to determine the acceptability of the *Think, Be, Do* curriculum. Mean scores indicate that there were slightly more students who enjoyed participating in and learned from the *Think, Be, Do* curriculum than students who did not. The overall mean score for the SSV was 6.81 (*min.* = 1.80, *max.* = 10.00, *SD* = 2.20) rated on a 10-point scale. The highest mean score was for item three, "I would recommend that this curriculum is taught to other students," suggesting that there is social importance to the curriculum and it would be advantageous for other students to participate in the *Think, Be, Do* curriculum. Results were marginal and do not directly support hypothesis five that students would rate the *Think, Be, Do* curriculum greater than or equal to 7.0. Table 12 provides descriptive statistics on teacher and student social validity.

  Association between feasibility and acceptability. Bivariate correlations were conducted to examine the association between fidelity of implementation and self-reported social validity (teacher and students). Results indicate that there were

strong positive associations between fidelity of implementation and teacher social

validity. Teachers that rated themselves higher on fidelity of implementation were more

Table 12

Teacher and Student Social Validity Descriptive Statistics.

Variable	M	SD	Min.	Max
AARP				
1. This is an acceptable treatment for my child's behavior.	5.40	0.82	4	6
2. The treatment should be effective in changing the child's behavior.	4.68	0.85	4	6
3. The child's behavior is severe enough to justify the use of this treatment.	4.91	0.69	4	6
4. I would be willing to use this treatment with my child.	5.40	0.82	4	6
5. This treatment would not have bad side effects for the child.	5.60	0.49	5	6
6. I liked this treatment.	5.40	0.82	4	6
7. The treatment was a good way to handle the child's problem.	5.06	0.91	4	6
8. Overall the treatment would help the child.	5.04	0.68	4	6
9. Overall AARP score.	5.21	0.53		
SSV				
1. I really enjoyed participating in this curriculum.	6.40	2.72	1	10
2. I learned a lot about mental health by participating in this curriculum.	6.98	2.41	2	10
3. I would recommend that this curriculum is taught to other students.	7.24	2.59	1	10
4. I was always engaged when my teacher taught the TBD curriculum.	6.62	2.49	1	10
5. I will use the strategies that I have learned from the curriculum in the future.	6.82	2.35	2	10
6. Overall SSV score.	6.81	2.20		

Note. AARP scale 1 to 6 where 1 = Strongly Disagree and 6 = Strongly Agree. SSV scale 1 to 10 where 1 = disagree and 10 = agree. Teacher response (*n* = 6). Student response (*n* = 50).

likely to perceive that this curriculum had higher social validity. In addition, teacher and student social validity also had a positive association. However, there were no statistically significant associations between fidelity of implementation and student social validity. Table 13 provides the bivariate correlations between fidelity of implementation and social validity.

Table 13

Bivariate Correlations between Fidelity of Implementation and Social Validity.

	AARP	SSV
	r	r
Session 1 fidelity	.55***	-.09
Session 2 fidelity	.76***	-.02
Session 3 fidelity	.71***	-.01
Session 4 fidelity	.69***	.03
Session 5 fidelity	.26*	-.23
Session 6 fidelity	.84***	.12
Session 7 fidelity	.53***	.24
Session 8 fidelity	.58***	.13
Session 9 fidelity	.35**	-.02
Session 10 fidelity	.63***	.09
SSV	.30*	

Note. *p < .05, **p < .01, ***p < .001. AARP = Abbreviated Acceptability Rating Profile. SSV = Student Social Validity.

Potential Efficacy of the Think, Be, Do Curriculum

In addition to understanding the feasibility and acceptability of the *Think, Be, Do* curriculum, ANCOVAs were used to determine curriculum impact on (a) student knowledge (SQ), (b) the putative mechanisms that impact student mental health (e.g., BADS, ATQ); (c) student symptomatology of mental health (e.g., CESD, STAIC, TIB, TEB), and (d) student academic competence (AC). Analysis of covariance was used to control for student's pretest scores as well as to control for age.

Hypothesis six to nine. Hypothesis six suggests that students in the treatment condition will demonstrate a greater increase in their mental health knowledge compared to students in the control condition. Hypothesis seven suggests that students in the treatment condition will demonstrate a greater increase on the BADS and a greater decrease on the ATQ, compared to students in the control condition. Hypothesis eight suggests that students in the treatment condition will demonstrate a greater reduction on mental health symptomatology measures (i.e., CESD, STAIC, TIB, and TEB) compared to students in the control condition. Hypothesis nine suggests that students in the treatment condition will demonstrate a greater increase in academic competence compared to students in the control condition. Results for each ANCOVA are presented in Table 14. Figures 3 through 10 provide a visualization of the mean differences between groups for each of the eight outcome measures.

A clinically meaningful between condition effect was found for student knowledge, which represented a small to medium effect size $d = 0.44$, $F(1, 112) = 5.11$, $p < .05$. This supports hypothesis six and suggests that the students in the treatment condition demonstrated a greater increase in mental health knowledge, as discussed in the *Think, Be, Do* curriculum, than students in the control condition. All other hypotheses (seven, eight, and nine) were not supported, as evidenced by not meeting the clinically meaningful threshold of $d \geq .30$. Although the effect size for the ATQ was greater than the clinically meaningful threshold of $d \geq .30$, the direction of the effect was not as hypothesized. Although the only clinically meaningful between condition outcome was student knowledge, closer examination of the descriptive statistics and paired sample t-

tests show a reduction in self-reported CESD scores in the treatment $t(73) = -2.383$, $p <$ .05 and control condition $t(40) = -2.181$, $p < .05$.
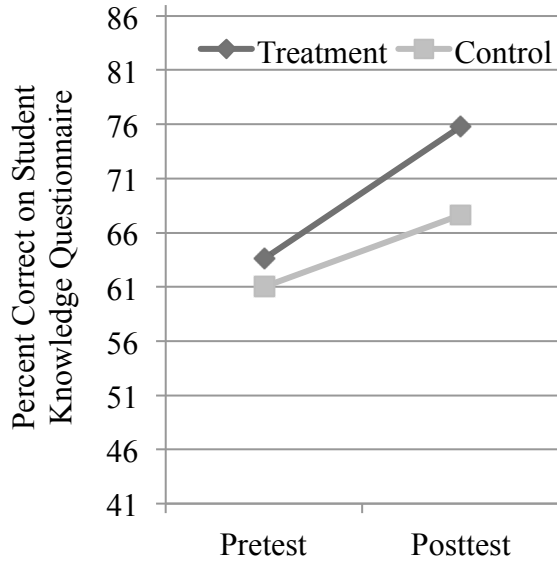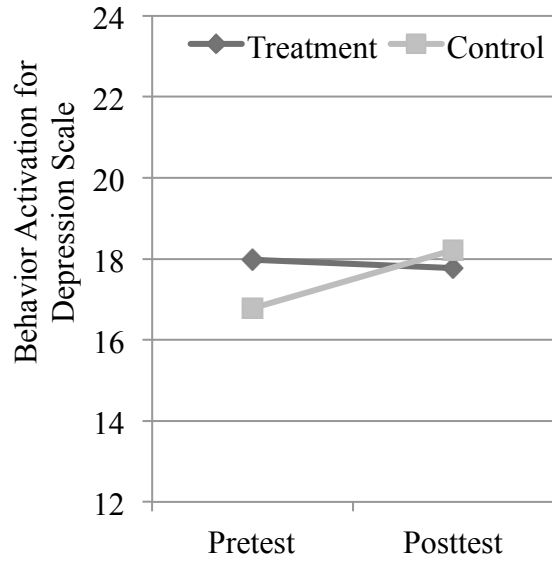

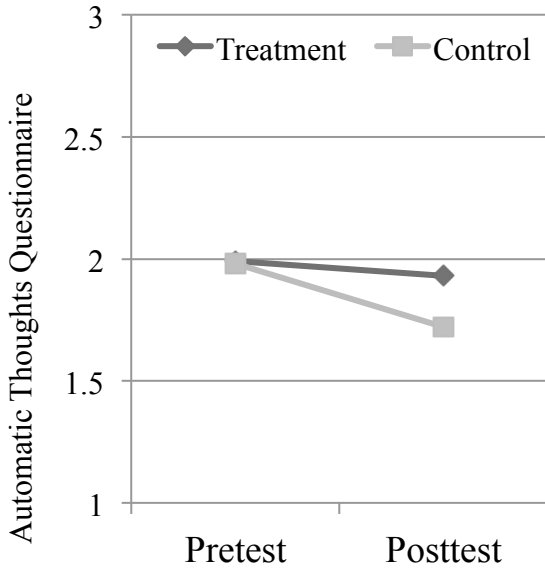*Figure 3.* Student Knowledge Means

Figure 4. BADS Means.
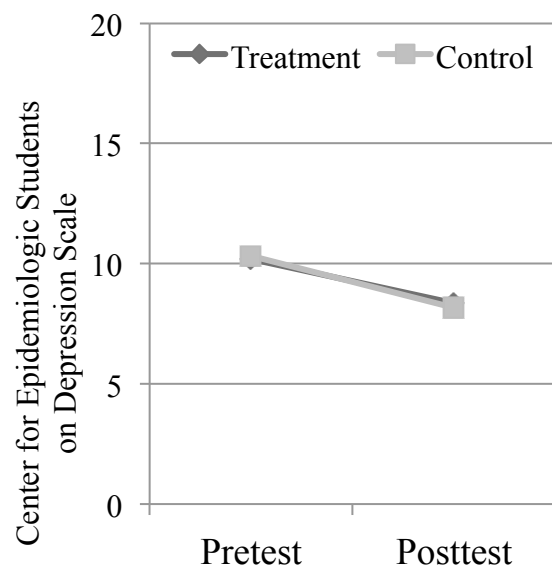

Figure 5. ATQ Means.

Figure 6. CESD Means.
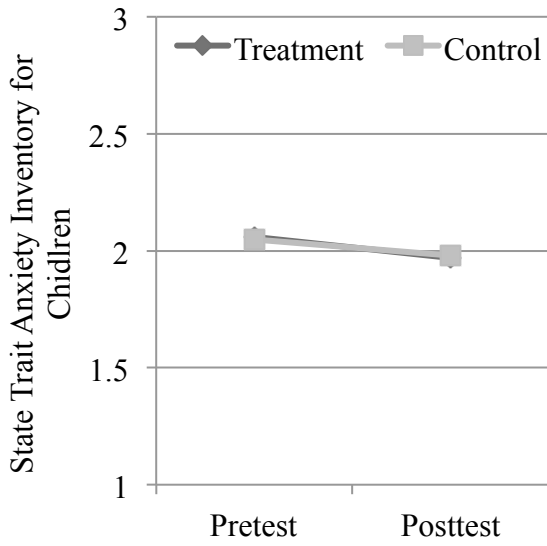
Figure 7. STAIC Means.
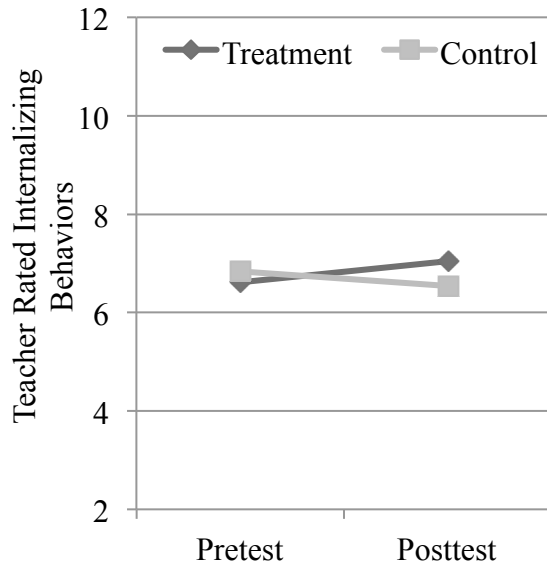
Figure 8. Internalizing Means.
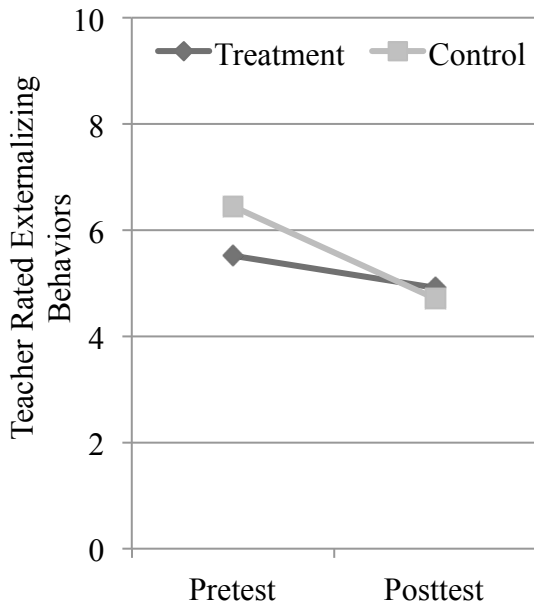
Figure 9. Externalizing Means.
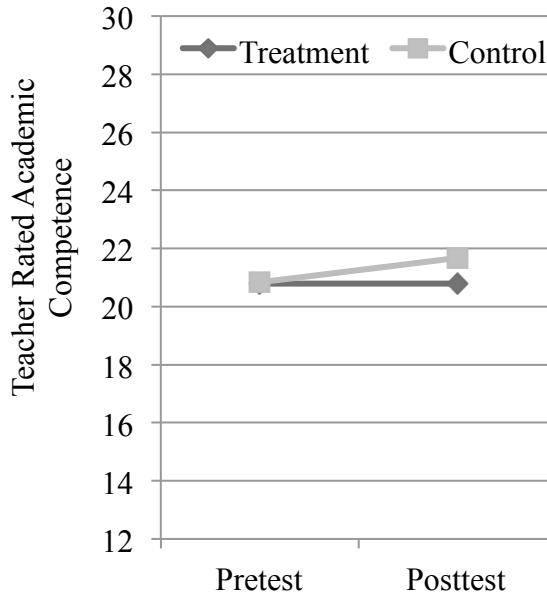
Figure. 10. AC Means.

Table 14

Between Condition Analysis of Covariance.

Measure	Treatment			Control			Condition Effect		Effect Size
	Pre-test M (SD)	Post-test M (SD)	$M_{Adj.}$	Pre-test M (SD)	Post-test M (SD)	$M_{Adj.}$	F (1, 112)	p-value	d
Hypothesis 6: Knowledge									
SQ	63.6 (21.1)	75.8 (19.9)	75.8	61.0 (21.6)	67.6 (22.0)	67.6	5.11	.026	0.44
Hypothesis 7: Mechanisms									
BADS	17.97 (5.97)	17.77 (5.41)	17.78	16.78 (6.01)	18.22 (5.73)	18.21	0.15	.695	0.07
ATQ	1.99 (0.78)	1.93 (0.86)	1.96	1.98 (0.81)	1.72 (0.71)	1.70	5.07	.026	0.44
Hypothesis 8: Symptoms									
CESD	10.19 (7.80)	8.36 (8.13)	8.54	10.32 (9.45)	8.17 (8.21)	7.98	0.21	.649	0.09
STAIC	2.06 (0.49)	1.97 (0.52)	1.99	2.05 (0.55)	1.98 (0.51)	1.96	0.05	.825	0.04
TIB	6.61 (4.53)	7.05 (4.43)	7.15	6.83 (3.63)	6.54 (4.35)	6.44	1.70	.195	0.26
TEB	5.52 (5.95)	4.91 (5.94)	5.34	6.44 (4.82)	4.71 (6.12)	4.28	1.48	.226	0.24
Hypothesis 9: Academics									
AC	20.70 (5.53)	20.79 (5.18)	20.99	20.83 (6.72)	21.68 (7.98)	21.50	0.34	.564	0.12

Note. SQ = Student knowledge questionnaire. BADS = Behavior Activation for Depression. ATQ = Automatic Thoughts Questionnaire. CESD = Center for Epidemiologic Studies on Depression. STAIC = State Trait Anxiety Inventory for Children. TIB = Teacher Internalizing Behavior. TEB = Teacher Externalizing Behavior. AC = Academic Competence.

Fidelity and Acceptability Related to Outcomes

Hypothesis ten. Hypothesis ten states increased fidelity of implementation scores (teacher and observer) will be positively associated with student outcomes. Partial correlations were conducted between teacher and observer fidelity scores and student posttest outcome measures, while controlling for student pretest outcome measures. Partial correlations yielded no significant associations ($r = -.13 - .14$). These findings do not support hypothesis ten.

Hypothesis eleven. Hypothesis eleven suggests increased social validity scores (teacher and students) will be positively associated with student outcomes. Partial correlations were used to determine if there were associations between teacher and student social validity and student posttest outcome measures while controlling for student pretest outcome measures. Results indicate significant associations between increased BADS posttest scores and teacher social validity ($r = .32$, $p < .05$) and student social validity ($r = .37$, $p < .05$); decreased internalizing behaviors and increased teacher social validity ($r = -.30$, $p < .05$); and decreased externalizing behaviors and increased teacher social validity ($r = -.30$, $p < .05$) and student social validity ($r = -0.50$, $p < .001$). These results provide partial support for hypothesis eleven.

Post-Hoc Exploratory Analysis

Due to the lack of clinically meaningful findings between treatment and control conditions, post-hoc exploratory analyses were conducted to further understand underlying rationales of the non-significant effects. Four variables were of particular interest: student's academic competence, student's level of depression symptomatology, student's level of anxiety symptomatology, and student's disability category. Each

82

student characteristic was selected because of the potential influence it could have had on how students responded the *Think, Be, Do* curriculum.

Four new variables were computed (a) high academic competence (i.e., students who were rated equal to or greater than the median score); (b) elevated depression symptomatology (i.e., students who rated themselves equal or greater than an eight on the CESD); (c) elevated anxiety symptomatology (i.e., students who rated themselves equal to or greater than the median score on the STAIC); and (d) high versus low incidence disability. ANCOVAs were run on each new variable for treatment condition students controlling for pretest outcome measure scores. Results from the ANCOVAs (not tabled) yielded no clinically meaningful differences between students who were rated with higher academic competence, students who self-rated higher depression symptomatology, students who self-rated higher anxiety symptomatology, or students with high incidence disabilities (all ds < .30).

CHAPTER V

DISCUSSION

Students with disabilities have an increased likelihood of experiencing a mental health problem in their youth compared to students without disabilities (McMillan & Jarvis, 2013). Yet, there is a lack of targeted interventions or approaches to help students prevent and/or ameliorate common mental health problems during their adolescent development. If schools continue to be the main provider of mental health services for youth in the United States (Burns et al., 1995), interventions and services must be developed that can be implemented in a school setting to help support students with disabilities.

This study addressed four main research questions:

1. Is it feasible for teachers to implement the *Think, Be, Do* curriculum in self-contained high school classrooms and transition programs?

2. Is the *Think, Be, Do* curriculum acceptable to the teachers and students with disabilities?

3. Does the *Think, Be, Do* curriculum impact student mental health and academic outcomes?

4. Is there an association between increased ratings on fidelity of implementation and acceptability, and student outcomes?

The following sections synthesize the study findings for each research question, address the study limitations, discuss lessons learned, and consider implications for research and practice.

Feasibility

Fidelity of implementation. To answer the first research question, responses from teacher and observer fidelity of implementation measures were examined. Fidelity of implementation findings indicated that teachers varied in their self-reported fidelity. Overall, the curriculum fidelity had a mean score of greater than or equal to 3.0 rated on a 4-point scale, indicating that teachers generally agreed that they had implemented the sessions with fidelity. Three sessions (3, 6, and 9) had mean scores of less than 3.0 indicating that the teachers were less likely to endorse that those sessions were taught with fidelity. Only one teacher was confident in their implementation fidelity to rate themselves with the highest score (i.e., 4.0). These results indicate there is room for improvement across classrooms for better fidelity of implementation. In addition, observers rated teachers lower than the optimal implementation fidelity score of 5.0 (i.e., 90 to 100 percent fidelity), but higher than the a priori benchmark criterion greater than or equal to 3.5. Overall, observers rated teachers with high fidelity of implementation (M = 3.99, on a 5-point scale).

Further examination of the fidelity data revealed a few reasons for less than perfect implementation fidelity. First, it was repeatedly indicated by teachers that they did not have enough time to complete an entire session during a class period. The lack of time forced teachers to complete sessions the following day or drop portions of sessions to maintain within the implementation timeline of the study (twice a week for five to six weeks). In addition to the time limitation that teachers experienced, it was reported that sessions were often filled with too many concepts and activities for the students in their classrooms. Having too many concepts to cover often made teachers move through

concepts quickly, and some teachers even reported they were not able to give concepts the necessary classroom discussion time in order to get through the entirety of the session.

Another point of concern that teachers mentioned was that some activities were not conducive for their classroom population due to a variety of issues including reading, writing, and perspective taking, which were difficult for some students with disabilities (e.g., students with learning disabilities or autism spectrum disorder). An additional issue for teachers and students was the lack of clarity in some activity directions and/or lack of instructions on how to modify activities for students with a variety of disabilities. Confusing instructions left teachers to make adaptations for their students that included reducing the range of the scales used for some activities, or utilizing whole class discussion instead of partner or individual work. Furthermore, implementation issues seemed to occur mostly around the goal settings activities (found in sessions four, five, seven, eight, nine, and ten). Teachers reported two main problems (a) there was difficulty distinguishing between success and social goals, and (b) the SMART goal strategy (an acronym to teach goal setting where goals are specific, measurable, achievable, relevant, and timely) was a difficult concept for students to grasp. Instructions for this particular activity asked students to come up with four different goals that were either social (i.e., doing something with friends) or success (i.e., doing something that makes you feel accomplished) goals. Feedback indicates that this activity resulted in the creation of typically one goal in sessions four and five, and in subsequent sessions teachers did not follow-up with students goals as indicated in the curriculum. One teacher mentioned that the goal-setting portion seemed out of place within the curriculum.

One explanation for why teachers felt the goal setting was "out of place" is insufficient development of the session and/or insufficient training around goal-setting sessions and activities. Recognizing that goal-setting was not implemented fully is a critical finding because the theoretical framework used to frame this study states that individuals who are more active in positively reinforcing activities and behaviors are more likely to change their mood than individuals who are not active and receiving positive reinforcement from those actions (Martell et al., 2001). It was intended that through goal setting, student participants would increase positive reinforcing behaviors.

Although there were issues with implementation fidelity for specific items across different sessions, overall ratings from teachers and observers were positive. The difficulties that seemed to arise were not due to the inability for teachers to teach the components of the curriculum in special education settings, rather difficulties came from the design, structure, training, and session scripts or directions. Given these findings, the *Think, Be, Do* curriculum would benefit from further development and input from special educators, students with disabilities, and school mental health professionals. Additional feedback and development would follow the suggestions in both phase one (e.g., obtaining explicit buy-in from critical stakeholders) and four (e.g., improving future applications by learning form experience) of the QIF (Meyers et al., 2012).

MAC chart. Forty-six student participants (68.9 percent) completed the MAC chart at the criterion level established in hypothesis three (i.e., a minimum of 10 entries over a five-week period). By monitoring moods, students are able to become emotionally aware and see on a scale how many good and bad days they had. Another purpose was for students to visually see how by participating in the *Think, Be, Do* curriculum they

87

become more active and in turn their mood becomes better. The association between the two variables is conveyed by a strong correlation between student's moods and activities ratings ($r = .89$), which is another key factor in building evidence that behavior activation is essential for increasing positive moods.

Acceptability

Social validity is also important to consider when determining the acceptability of implementing a new intervention. Social validity can be used to understand the social significance of the goals of treatment, the social appropriateness of the treatment procedures, and the social importance of the effects of treatment (Carter, 2010; Wolf, 1978). In this study, the AARP was used to evaluate teacher ratings on social validity. The AARP was given to teachers to complete after the entire *Think, Be, Do* curriculum was administered to their classroom. Ratings on the AARP were high, with mean scores ranging from 4.91 to 5.60, on a scale of one to six (overall mean score for the AARP was 5.20). Teachers agreed that the *Think, Be, Do* curriculum is an a*cceptable treatment for their students*, the *curriculum should be effective in changing student behaviors*, and that *they liked* the *Think, Be, Do* curriculum. The high social validity scores reported by teachers suggests that even with issues they faced during the implementation of the curriculum, they felt that the curriculum was valuable in helping teach students about what mental health is and how to cope with mental health concerns.

Student participants were given the five-item SSV scale to complete that focused on feedback regarding their learning, enjoyment, and engagement during their time interacting with the *Think, Be, Do* curriculum. Students reported a range of disagreement to agreement on the social validity items, with mean scores between neutral and

88

agreement. The overall mean score for the SSV was 6.81, just under the a priori benchmark score of an acceptability rating greater than or equal to 7.00 (on a 10-point scale). Interestingly, the social validity item with the highest mean score was *I would recommend that this curriculum is taught to other students* ($M = 7.24$). The higher social validity score for that item could suggest student participants felt the curriculum was an experience worthy of recommendation to other students even if students had lower overall mean scores on being engaged, having learned a lot, or intending to use strategies in the future. Fidelity scores and positive feedback from teachers and student participants implies that it is feasible and acceptable to implement a mental health curriculum like the *Think, Be, Do* curriculum.

Potential Efficacy

Durlak and colleagues (2011) and the Collaborative for Academic, Social, and Emotional Learning (CASEL) reports that the most effective strategies for social emotional learning are "(a) sequenced – connected and coordinated activities to foster skills development, (b) active – active forms of learning to help students master new skills, (c) focused – containing a component that emphasizes developing social and emotional skills, and (d) explicit targeting specific social and emotional skills" (p. 8). The *Think, Be, Do* curriculum attempts to fulfill all four requirements laid out by Durlak et al. 2011 and CASEL guidelines. Unfortunately, between condition clinically meaningful treatment effects were not found as a result of implementing the *Think, Be, Do* curriculum.

Student knowledge. Student knowledge was the only outcome variable that resulted in clinically meaningful and statistically significant between-subjects

differences. The *Think, Be, Do* curriculum taught specific concepts (e.g., what is mental health, what are internal processes that impact our mental health, what is depression, what is anxiety). Students in both treatment and control conditions were assessed on their knowledge of these concepts to determine if the *Think, Be, Do* curriculum taught specific and unique information about mental health and to assure that students in other classrooms were not receiving information about mental health through other means. The results suggest that not only did students in the treatment condition increase their knowledge about mental health (as measured by the SQ), but also students in the control condition were not gaining mental health knowledge through other curricula or concepts taught in their classrooms.

Student mental health outcomes. Between condition differences for the four main student mental health outcome variables (i.e., BADS, ATQ, CESD, and STAIC) were not clinically meaningful ($d < .30$). Examination of the means across conditions at pretest and posttest show little to no overall change after five weeks of treatment implementation. Teacher outcomes measures (i.e., TIB, TEB, and AC) resulted in similar non-clinically meaningful findings. These particular findings may be expected as effects from preventative interventions are expected to occur in the following months post-treatment (Possel, Horn, Groen, & Hautzinger, 2004; Spence & Shortt, 2007). Unexpectedly, statistically significant results were found on the ATQ, yet the effects were not in the hypothesized direction, meaning that student participants in the control condition reported a greater reduction in negative thoughts than the treatment condition at posttest.

Failure to find treatment effects does not suggest that the intervention is not worthwhile. Multiple factors could have impacted intervention outcomes. The *Think, Be, Do* curriculum was based on the Adolescent Coping with Depression Course, an effective intervention that has been shown to reduce depression and depression symptomatology in adolescents (Rohde et al., 2004). One explanation for the lack of treatment effects could be due to an adaptation failure in which key components that facilitate treatment of depression were not included in the *Think, Be, Do* curriculum. Another explanation for the lack of treatment effects could also be due to the reduced number of sessions in the *Think, Be, Do* curriculum. Even though one teacher indicated, "the students are ready to move on" by session eight, a reduction in sessions could have had an unintended impact on overall treatment dosage, which could have reduced the likelihood of finding an effect. Associated with a reduced number of sessions, is reduced exposure to therapeutic principles (e.g., emotional awareness), skill practice, and corrective experiences that could be facilitated by the teacher and environment (school or clinic) that the curriculum is implemented.

Another component that could have an impact on treatment outcomes, are issues regarding the goal setting activity. As noted before, the theoretical framework for this particular curriculum is focused on increasing students positively reinforcing activities, which would lead to a positive change in feelings and thoughts. The failure to implement of this particularly important active ingredient could have impacted treatment outcomes.

Association between Fidelity, Acceptability, and Outcomes

For this study, it was hypothesized that increased fidelity of implementation would also be associated with positive student outcomes. Although fidelity of

implementation the intervention was high, there was no association with treatment effects, resulting in no statistically significant correlations between the fidelity of implementation and student outcomes. These findings are inconsistent with research that has evaluated the relationship between the two variables. Durlak and DuPre (2008) found in their review of the literature that fidelity of implementation was strongly associated with positive student outcomes. They reported that higher fidelity of implementation resulted in mean effect sizes two to three times higher than lower fidelity of implementation (Durlak & DuPre, 2008).

Social validity is an important measure to determine the prospect of treatment program survival (Schwartz & Baer, 1991). In addition, social validity measures the consumer's belief that the treatment is relevant to addressing the problem at hand (Carter, 2010). Overall, findings indicate that teachers had higher social validity scores than student participants and teacher and student rated social validity were statistically significantly correlated ($r = .30$). There were findings that suggested an association between student rated social validity and outcomes including students who had higher social validity scores also had higher behavior activation, and students who had higher social validity scores were rated to have less externalizing behaviors by teachers. Because the *Think, Be, Do* curriculum had never been implemented in special education classrooms before this study, social validity was an important measure to consider when evaluating the likelihood that special educators would implement the curriculum again.

Limitations

This study faced a number of limitations. First, this study utilized a randomized controlled trial design, in which classrooms were randomly assigned to either a treatment

92

or control condition, yet outcome measures were analyzed on the student level. This design and analysis creates a number of complications that need to be addressed. Most formidably as a feasibility trial, this study lacked the necessary power to conduct multilevel modeling to account for the nested design. Given that the study was underpowered, effect sizes were used instead of statistical significance (typically associated with hypothesis testing to determine meaningful results; Ogles, Lunnen, & Bonesteel, 2001).

Measurement of mental health outcomes, especially student self-reported mental health, is another limitation of this study. Students with disabilities may have had issues with completing a variety of questions on the student survey as exemplified by the need to drop reverse coded items on the BADS to create a more reliable measure for behavior activation. The particular issues with reverse coded items on the BADS could be due acquiescence bias (McGilvery & Sweetland, 2011). In other words, individuals with disabilities may answer questions in more affirmative ways, without comprehending the nuanced change in the stem question often found on reverse coded items.

Another limitation of this study could be attributed to the heterogeneity of the student participants. Students with disabilities are a diverse group of individuals and the lack of homogeneity of student participants may have made it difficult to make comparisons and find between condition effects. One expectation prior to implementation was there would be a higher concentration of students in the study classrooms with Emotional Behavioral Disorder (EBD) or Other Health Impairment (OHI), who might benefit most from the treatment. Students also self-reported their disability and students who reported more than one disability were categorized into the multiple disability

category, which could have impacted the accuracy of demographic results on disability. There was also heterogeneity among student level of symptomatology, and the decision to include all students rather than students with elevated symptomatology could be a limitation. Approximately one third of the treatment condition and one half of the control condition did not meet the minimum criteria for elevated depression (as measured by an eight or higher on the CESD). Because a large proportion of students were considered in the "normal" range, treatment effects could be diluted due to those students' lack of treatment response, which could also be explained by the minimal time between curriculum completion and posttest and limited opportunities for skill practice.

An additional limitation was the unobserved control condition classroom. Teachers in the control condition were instructed to keep their classroom "business as usual" and were not trained or informed about the components of the *Think, Be, Do* curriculum until after the study was completed. Because of this particular instruction, no observations occurred in control classrooms during the time of curriculum implementation to observe for naturally occurring social emotional instruction. Although the assumption that social emotional instruction was occurring is speculative, this may be one explanation for the reduction in ATQ scores found in control classrooms.

Lessons Learned

The *Think, Be, Do* curriculum is an innovative approach to teach and help students about common mental health concerns that they might face. Multiple lessons have been learned through the process of establishing an intervention that fills a multitude of gaps (e.g., teacher versus clinician led, a curriculum for students with disabilities) and implementing the intervention in special education classrooms.

94

Reflecting on the QIF, a few implementation steps are consistent with some of the lessons learned during the entirety of the study (e.g., step five – obtaining explicit buy-in from critical stakeholders and fostering a supportive community/organizational climate; and step 11 – technical assistance/coaching/supervision). These lessons include (a) the importance of educator input buy-in during development of the curriculum, (b) the need for thorough training and coaching, and (c) the need for more refined adaptation.

Educator input and buy-in during development. It was imperative that special educators were able to be part of the iterative development of the *Think, Be, Do* curriculum. Educator feedback provided opportunities to ensure the curriculum content would be applicable to transition age students. In addition, educators were able to provide feedback regarding the structure of each session and the instructional processes requested of them during curriculum implementation. Yet, even with the opportunities for educator input, a rather constricted formative development cycle was employed; the curriculum could benefit from more input and vetting sessions from additional stakeholders.

Having special educators be part of the development process was also essential for recruitment of special education classrooms. Indicating to potential teachers that the curriculum had been through an iterative development process with special educators reduced anxiety about curriculum implementation. Special educators as developers and stakeholders could also potentially help build trust and a strong rapport when meeting new teachers because similar individuals to themselves and not only a researcher from the "outside" vetted the curriculum.

Training and coaching. The National Professional Development Center on Inclusion (NPDCI) suggests professional development (i.e., training and coaching)

95

should be transactional and designed to support knowledge and skill acquisition (NPDCI, 2008). Training and coaching are important drivers to help increase competence in implementing different classroom practices (Snyder, Hemmeter, & Fox, 2015). Teachers were provided a two-hour training on the scripted *Think, Be, Do* curriculum. The training reviewed the overall purpose of the curriculum, theoretical rationales, curriculum expectations, and content covered in each session. Discussions with teachers after the completion of the study indicated that they felt the training was more than adequate and they would not add or change anything. The responses from teachers imply the training they received was sufficient to implement the curriculum, although it could also be argued that there is room for improvement. For example, increased training on how to check-in and monitor student goals as part of the curriculum or outside of classroom instruction.

Due to the response delay between an observation and review of fidelity of implementation it was difficult to be proactive when an teacher required coaching. More specific procedures that include ongoing technical assistance during implementation that reviews fidelity data could produce a more immediate coaching response. Furthermore, structured reminders throughout implementation of the curriculum on the purpose of sessions and critical elements to deliver may also bolster and increase fidelity of implementation.

Refined adaptation. The Coping with Depression Course (Lewinsohn, 1984) has been through numerous adaptations and has been tested in a variety of context with a variety of populations (Cuijpers et al., 2009). Due to the overall success of the Coping with Depression Course, Adolescent Coping with Depression course and subsequent

96

adaptations at reducing depression and depressive symptomatology, the current adaptation (i.e., the *Think, Be, Do* curriculum implemented with transition age students in special education classrooms) was a logical next step. Although the feasibility and acceptability results were positive, the lack of clinically meaningful effects suggests intervention failure at some level. Another explanation for this could be the adaptations made to the Adolescent Coping with Depression course were too extreme and a more traditional approach to intervention development (e.g., additional development iterations, individual component and session testing) may have produced alternative findings. Extended formative development, iterative testing of sessions, and pilot testing would be beneficial for future editions of the *Think, Be, Do* curriculum.

Implications for Research

      Theory. A few key findings from this study suggest that the behavioral activation theoretical framework woven throughout the curriculum is a sound and plausible theoretical framework to continue developing the *Think, Be, Do* curriculum. The strong association between mood and activity, as seen with the MAC chart, suggest that being more active is associated with having better moods. Further theoretical testing focused on the connection between goal setting and behavior change would be beneficial for students with disabilities. Because sessions and parts of the curriculum focused on goal setting were difficult teachers, it is important to ask, would an increase in the fidelity of implementation around goal setting or having goals that were developed through person-centered planning in the *Think, Be, Do* curriculum increase the likelihood of greater change on mental health outcomes?

Measurement. Although the measures used in this study were found to be reliable for students with disabilities considerable work is necessary to ensure mental health measures are valid for this population. Two main concerns arise when working with students with disabilities (a) the cognitive capacities to complete a variety of questions that require introspection and an understanding of time, and (b) finding measures that are sensitive to the complex way mental health reveals itself within a variety of disabilities.

Feedback from teachers indicated that students had difficulties with completing the mental health measures without support on measure wording and scaling. For example, students were confused why each measure (BADS, ATQ, CESD, STAIC) had different scales. Furthermore, some students were unable to interpret the BADS reverse coded items, which were dropped to obtain a more reliable measure. The creation of measures that are reliable and valid for students with disabilities is critical to the study of mental health concerns and disorders for this population.

In addition, typical mental health diagnoses come from understanding the complex nature of the mental illness and how it impacts individual's daily capacities and for how long those capacities have been impacted. For students with disabilities, the ability to understand the complex interaction between moods and time can be challenging, and even more so when being asked to evaluate moods over a two week period (as the CESD requires) because of issues with recall. Gaining a better understanding on how mental health impacts students with disabilities would be beneficial for both special education and mental health fields. The complex interaction between disability and mental health was recently highlighted in 2015 when the National

98

Institute of Mental Health called for additional research and development of valid diagnostic tools for this population.

Implementation. Results from the fidelity of implementation measures indicate overall high fidelity. Yet, feedback from teachers suggest that there are opportunities for the *Think, Be, Do* curriculum to be more beneficial for students through changes in the implementation and curriculum. One common finding was teachers found it difficult to complete sessions within a typical class period. Changes to implementation procedures and timelines may be beneficial. For example, extending the implementation time period to covering one session a week for ten-weeks would allow for a longer dosage period as well as more flexibility for teachers to cover all of the content in a session over one or multiple days. More flexibility in scheduling might allow for additional student practice of session skills because content would be spread over a longer time period.

Adaptations. Additional adaptations could also be beneficial, such as (a) having scales and activities that are aligned with tools that are already familiar to students with disabilities, (b) adding more visuals, and (c) providing more differentiation to the curriculum. A common comment made by teachers was that the MAC chart has a larger ranged scale and was reversed from a more familiar five-point mood scale (e.g., the Incredible Five-point Scale; Buron, 2015) that students previously used. Teachers also mentioned that some of the activities were too complex for their students and so they took the liberty to make changes to simplify the activities. Future adaptations of the *Think, Be, Do* curriculum would also benefit from adding more visuals throughout the sessions. Teacher feedback suggested they liked the Actions, Thoughts, and Feelings triangle as well as the mood spirals and would like similar visuals to parallel other

concepts taught in the curriculum. Furthermore, future research utilizing the *Think, Be, Do* curriculum should include tips for further differentiation of instruction. Self-contained classrooms can have students with a variety of disabilities, which impact a variety of cognitive processes. Having options for differentiation at the beginning of each session could help teachers convey content to a variety of students in their classroom.

More significant adaptations could help to ensure the inclusion of additional effective social emotional learning strategies, positive behavior strategies, and mental health coping strategies. "Integrative models consist of merging different independent universal programs or practices which target various risk and protective factors into a single program that has the potential to produce better outcomes than could either program implemented alone" (Cook et al., 2015, p. 3). These integrative approaches to school-based mental health interventions have shown to be effective in reducing teacher and student rated internalizing and externalizing behaviors (Cook et al., 2015).

The inclusion of caregivers (e.g., parents) during curriculum implementation would be another significant adaptation for future studies. Caregiver involvement in school-based interventions, such as the Family Check Up has resulted in positive student emotional and behavioral outcomes (Stormshak et al., 2011). Caregiver involvement has also been integrated in non-cognitive skill development for students with disabilities (e.g., Steps to Self-determination; Field & Hoffman, 1996). For future implementation, including caregiver participation throughout the *Think, Be, Do* curriculum could potentially have positive impact on student outcomes due to additional practice of coping strategies at home or in other settings outside of the classroom.

Future research considerations. The current study is considered a pragmatic trial. Pragmatic research has returned the focus of research towards real-world implementation, where control of extraneous variables is minimal (Glasgow, 2013). For example, inclusionary criteria for this study were minimal (e.g., students must be receiving special education services and must be able to comprehend student survey measures) and implementation was through the use of teachers (i.e., special educators and transition specialists - not clinicians or researchers). Future research designs could lend themselves to be more explanatory (Glasgow, 2013), or more controlled, by setting more rigorous inclusion criteria for students (e.g., students who have been screened and found to have elevated depression or anxiety, or inclusion of specific disability categories).

In addition, the *Think, Be, Do* curriculum would benefit from a thorough evaluation utilizing implementation frameworks such as the QIF (Meyers et al., 2012), which was utilized in the design and development of the study, the Reach, Efficacy, Adoption, Implementation, and Maintenance (RE-AIM) model (Glasgow, Vogt, & Boles, 1999), or the Practical, Robust Implementation and Sustainability (PRISM) Model (Feldstein & Glasgow, 2008). Each model reports on a myriad of considerations to critically analyze intervention implementation and how to translate research to practice. Such critical analysis of the development and implementation process is necessary prior to future application of the *Think, Be, Do* curriculum to increase the probability of continued feasibility, acceptability, and potentially efficacy.

Furthermore, creating guidelines to utilize the curriculum on a selected and indicated level rather than universal may be beneficial. As the study stands now, the *Think, Be, Do* curriculum is considered a selected intervention for students at-risk (i.e.,

students with disabilities), yet the implementation is considered a universal intervention (i.e., whole class instruction). Aligning implementation of the curriculum within mental health Multi-tiered Systems of Support (MTSS) such as the Interconnected Systems Framework (Barrett, Eber, & Weist, 2014) or other school wide MTSS models such as School Wide Positive Behavioral Interventions and Supports (McIntosh, Ty, & Miller, 2014) could also potentially increase the likelihood of positive student mental health and academic outcomes. For example, MTSS models such as the Interconnected Systems Framework have self-assessment questions (i.e., Implementation Framework Self-Assessment; Barrett et al., 2014, p. 30) that can be used to target areas of implementation strengths and weaknesses to maximize intervention implementation effectiveness.

Implications for Practice

Social and emotional learning is a "process in which individuals are able to apply the knowledge, attitudes, or skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy or others, establish and maintain positive relationships, and make responsible decisions" (CASEL, 2015, p. 1). The development of social emotional and non-cognitive skills (e.g., self-awareness, emotional health) continues to produce positive student outcomes for students across the age span (e.g., engagement, long term academic achievement, Durlak et al., 2011). The *Think, Be, Do* curriculum offers a chance for students to gain social emotional skills while learning about common mental health concerns. Future implementation may benefit from smaller class sizes or grouping students with particular characteristics (i.e., students with more internalizing concerns such as students with EBD or OHI) so that discussions throughout the curriculum could be more targeted and relevant to the student participants.

In addition, it may be beneficial to focus attention on students with elevated levels (tier 2/3) of depression and anxiety prior to curriculum implementation. Research has indicated that cognitive behavioral interventions do work for populations with subclinical depression (Spence & Shortt, 2007). Students who have experienced depression or anxiety may respond differently to the curriculum than students who have not experienced depression or anxiety. Potentially, students who have experienced depression or anxiety may find the information more pertinent to their life and be more receptive to analyzing how depression and anxiety are impacting their education, employment, or personal relationships. Screening students before they participate would also make this a more traditional targeted intervention approach.

Furthermore, positive student teacher relationships are critical when discussing topics such as depression and anxiety. Building a positive rapport with students is an important first step when teaching a social emotional curriculum like *Think, Be, Do*. In addition it would benefit future teachers to have a reserve of therapeutic techniques (e.g., empathizing, active listening, conversing with transparency, and empowering students) to apply during classroom instruction. Therapeutic skill development can be done through professional development or training through curricula like *Think, Be, Do.*

Conclusion

There is a critical need for additional school-based mental health research that is inclusive of students with disabilities. Students with disabilities who also have mental health concerns face considerable challenges for success in and after high school. It is critical to ensure students with disabilities have access to care that takes into account the unique way mental health presents itself across disabilities types. The *Think, Be, Do*

curriculum is the first known curriculum that was developed and implemented in transition age classrooms by special educators to address depression and anxiety. Although the intervention did not result in clinically meaningful treatment effects, it was successful in teaching students about mental health, was feasible to implement by teachers in transition age classrooms, and was an acceptable intervention. By addressing the needs of students with disabilities and mental health concerns in high school, the long-term impact of depression and anxiety on individual outcomes, such as vocational and educational attainment may be reduced. The strategies and content students learn in the *Think, Be, Do,* curriculum is essential to begin making a lasting positive impact on student lives.

SUMMARY OF UNIQUE COGNITIVE BEHAVIORAL INTERVENTIONS

INCLUDED IN SCHOOL-BASED MENTAL HEALTH REVIEWS

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
Calear & Christensen (2010)					
Barrett & Turner (2001)	Universal	Child	CBT	Small	1
Barrett et al. (2005)	Universal	Adolescent & Child	CBT	N/A	1
Barrett et al. (2006)	Universal	Adolescent & Child	CBT	Small	1
Bonhauser et al. (2005)	Universal	Adolescent	Exercise (SBMHP)	N/A	1
Cardemil et al. (2002)	Selective	Child	CBT	Large	3
Cardemil et al. (2007)	Selective	Child	CBT	Small	1
Castellano & Conrad (2006)	Selective	Child	CBT & Psycho-educational	Small	2
Chaplin et al. (2006)	Universal	Adolescent & Child	CBT	Medium	1
Clarke et al. (1993) Study 1	Universal	Adolescent	Psycho-educational	Small	2
Clarke et al. (1993) Study 2	Universal	Adolescent	Behavior Therapy & Psycho-educational	Small	2
Clarke et al. (1995)	Indicated	Adolescent	Cognitive Therapy	Medium	1
Cutuli et al. (2006)	Indicated	Child	CBT	N/A	0
Gillham et al. (2006)	Indicated	Adolescent & Child	CBT	Small	3
Gillham et al. (2007)	Universal	Adolescent & Child	CBT	Small	2
Hains (1992)	Universal	Adolescent	Relaxation & CBT	Large	1
Hains & Ellmann (1994)	Universal	Adolescent	CBT	Large	0
Hains & Szyjakowski (1990)	Universal	Adolescent	CBT	N/A	1
Horowitz et al. (2007)	Universal	Adolescent	CBT & Psychotherapy	Medium	0
King & Kirschenbaum	Indicated	Child	Social Skills	Medium	0

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
(1990)					
Lamb et al. (1998)	Indicated	Adolescent	CBT	N/A	1
Lock and Barrett (2003)	Universal	Adolescent & Child	CBT	Small	0
Lowry-Webster et al. (2001)	Universal	Adolescent & Child	CBT	Small	1
Lowry-Webster et al. (2003)	Universal	Adolescent & Child	CBT	Small	1
Pattison & Lynd-Stevenson (2001)	Universal	Child	CBT	Small	2
Petersen et al. (1997)	Universal	Child	Psycho-education	N/A	0
Possel et al. (2004)	Universal	Adolescent	CBT	Small	1
Possel et al. (2008)	Universal	Adolescent	Interpersonal Psychotherapy & Psycho-education	Medium	1
Puskar et al. (2003)	Indicated	Adolescent	CBT	Medium	1
Quayle et al. (2001)	Universal	Child	CBT	Negative	1
Rooney et al. (2006)	Universal	Child	CBT	Medium	1
Ruini et al. (2006)	Universal	Adolescent	CBT	Negative	1
Sheffield et al. (2006)	Indicated	Adolescent	CBT	Small	1
Shochet & Ham (2004)	Universal	Adolescent	CBT & Interpersonal Psychotherapy	Small	0
Spence et al. (2003)	Universal	Adolescent	CBT	Medium	1
Spence et al. (2005)	Universal	Adolescent	CBT	Medium	2
Stice et al. (2006)	Indicated	Adolescent	CBT	Large	0
Stolberg & Mahler (1994)	Selective	Child	CBT	N/A	0
Weisz et al. (1997)	Indicated	Child	CBT	Medium	0
Young et al. (2006)	Indicated	Adolescent	Interpersonal Psychotherapy & Psycho-education	Large	2
Yu & Seligman	Indicated	Adolescent	CBT	Small	2

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
(2002)		& Child			
Cobb et a. (2006)					
Barkley et al. (2001)	Not reported	Adolescent	Problem Solving & Behavior Management (SBMHP)	N/A	0
Bodtker (2001)	Not reported	Adolescent	Conflict Education (SBMHP)	N/A	0
Clarke et al. (1995)	Indicated	Adolescent	Cognitive Therapy	Medium	1
Coleman et al. (1992)	Not reported	Adolescent	Aggression replacement training (SBMHP)	N/A	0
Dangel et al. (1989)	Not reported	Adolescent	Cognitive Therapy	N/A	0
Etscheidt (1991)	Not reported	Not reported	CBT	N/A	0
Freeman & Hutchinson (1994)	Not reported	Adolescent	N/A	N/A	0
Knapczyk (1988)	Not reported	Adolescent	Social Skills	N/A	0
Knapczyk (1992)	Not reported	Adolescent	Behavior Management (SBMHP)	N/A	0
Larson & Gerber (1987)	Not reported	Adolescent	Cognitive Therapy	N/A	0
LeCroy (1988)	Not reported	Adolescent & Child	CBT	N/A	0
Ninness et al. (1995)	Not reported	Adolescent	Social Skills	N/A	0
Presley & Hughes (2000)	Not reported	Adolescent	Cognitive Therapy	N/A	0
Robinson et al. (2002)	Indicated	Adolescent	CBT	Medium	1
Sinclair et al. (1998)	Not reported	Adolescent	Behavior Management (SBMHP)	N/A	0
Smith (1992)	Not reported	Adolescent	Cognitive Therapy	N/A	0
Cuijpers (1998)					
Antonuccio et al. (1984)	Not reported	Adults	CWD Course	Large	0
Breckenridge et al. (1987)	Not reported	Elderly	CWD Course	Medium	0
Brown &	Not	Adults	CWD Course	Large	0

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
Lewinsohn (1984)	reported				
Clarke (1985)	Not reported	Adolescents	CWD Course	Large	0
Cuijpers (1998)	Not reported	Adults	CWD Course	Large	0
Cuijpers et al. (1995)	Not reported	Adults	CWD Course	Large	0
Cuijpers et al. (1997)	Not reported	Adults	CWD Course	Large	0
Gonzalez et al. (1993)	Not reported	Adults	CWD Course	Large	0
Hoberman et al. (1988)	Not reported	Adults	CWD Course	Large	0
Lewinsohn et al. (1990)	Not reported	Adolescent	CWD Course	Large	0
Lewinsohn et al. (1996)	Not reported	Adolescent	CWD Course	Large	1
Lovett & Gallagher (1988)	Not reported	Adults	CWD Course	Medium	0
Manson & Brenneman (1995)	Not reported	Elderly	CWD Course	Large	0
Munoz et al. (1982)	Not reported	Adults	CWD Course	Large	0
Organista et al. (1994)	Not reported	Adults	CWD Course	Large	0
Scogin et al. (1989)	Not reported	Elderly	CWD Course	Large	0
Steinmetz et al. (1983)	Not reported	Adults	CWD Course	Large	0
Teri & Lewinsohn (1986)	Not reported	Adults	CWD Course	Large	0
Thompson et al. (1983)	Not reported	Elderly	CWD Course	Small	0
Van der Meeren (1996)	Not reported	Adults	CWD Course	Large	0
David-Ferdon & Kaslow (2008)					
Ackerson et al. (1998)	Not reported	Adolescent	CBT	Large	0
Asarnow et al. (2002)	Indicated	Child	CBT	Large	1
Asarnow et al. (2005)	Not reported	Adolescent	CBT	Small	0

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
Clarke et al. (1999)	Not reported	Adolescent	CBT	Large	0
Clarke et al. (2001)	Not reported	Adolescent	CWD Course	Medium	0
Clarke et al. (2002)	Not reported	Adolescent	CWD Course	N/A	0
Clarke et al. (2005)	Not reported	Adolescent	CBT	N/A	0
De Cuyper et al. (2004)	Not reported	Child	Taking action	N/A	0
Diamond et al. (2002)	Not reported	Adolescent	Attachment Based Family Therapy	Large	0
Gillham et al. (2006)	Indicated	Adolescent & Child	CBT	Small	3
Goodyer et al. (2007)	Not reported	Adolescent	CBT	N/A	0
Kaufman et al. (2005)	Not reported	Adolescent	CWD Course	Small	0
Kowalenko et al. (2005)	Not reported	Adolescent	CBT	Medium	0
Lewinsohn et al. (1996)	Not reported	Adolescent	CWD Course	Large	1
Melvin et al. (2006)	Not reported	Adolescent	CBT	N/A	0
Mufson et al. (1999)	Not reported	Adolescent	Interpersonal Psychotherapy	Large	0
Muratori et al. (2003)	Not reported	Child	Psychodynamic Psychotherapy	Large	0
Nelson et al. (2003)	Not reported	Child	CBT	Large	0
Pfeffer et al. (2002)	Not reported	Child	Bereavement Group Intervention	Large	0
Roberts et al. (2003)	Indicated	Adolescent	CBT	Small	2
Rohde et al. (2004)	Not reported	Adolescent	CWD Course	Small	0
Rossello & Bernal (1999)	Not reported	Adolescent	CBT	Large	0
Sanford et al. (2006)	Not reported	Adolescent	Family Psycho-education	Large	0
Sheffield et al. (2006)	Universal	Adolescent	CBT	Medium	3
TADS team (2004)	Not reported	Adolescent	CBT	Medium	0
Trowell et al. (2007)	Not reported	Child	Systems Integrative Family Therapy	Medium	0

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
Young et al. (2006)	Indicated	Adolescent	Interpersonal Psychotherapy & Psycho-education	Large	2
Yu & Seligman (2002)	Indicated	Adolescent & Child	CBT	Small	2
Farahmand et al. (2011)					
Cardemil et al. (2002)	Selective	Child	CBT	Large	3
Cardemil et al. (2007)	Selective	Child	CBT	Small	1
Henderson et al. (1992)	Not reported	Child	Stress Control Program	Large	0
Jagers et al. (2007)	Not reported	Child	Aban Aya Youth Project (SBMHP)	Small	0
McClowry et al. (2005)	Not reported	Child	INSIGHTS into child's temperament (SBMHP)	Large	0
McDonald et al. (2006)	Not reported	Child	Families and Schools Together (SBMHP)	Large	0
Mufson et al. (2004)	Not reported	Adolescent	Interpersonal Psychotherapy	Medium	2
Sinclair et al. (2005)	Not reported	Adolescent	Check and Connect (SBMHP)	Medium	0
Weiss et al. (2003)	Selective	Child	Reaching Educators, Children & Parents - Psychosocial intervention (SBMHP)	Small	2
Franklin et al. (2012)					
Armruster & Lichtman (1999)	Indicated	N/A	SBMH Program	Small	0
Asarnow et al. (2002)	Indicated	Child	CBT	Large	1
Bauer et al. (2007)	Universal	N/A	Anti-bullying prevention program (SBMHP)	Small	0
Bohman et al. (2004)	Universal	N/A	Protecting me/protecting you curriculum (SBMHP)	Small	0
Cardemil et al. (2002)	Selective	Child	CBT	Large	3
DeRosier (2004)	Selective	N/A	Social Skills	Small	0

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
Frey (2002)	Universal	N/A	Social Skills	Medium	0
Gillham et al. (2007)	Universal	Adolescent & Child	CBT	Small	2
Gingsburg & Drake (2002)	Indicated	N/A	CBT	Medium	2
Gottfredson & Gore (2002)	Universal	N/A	CBT	Small	0
Harris & Franklin (2003)	Indicated	N/A	CBT	Large	0
Kataoka et al. (2003)	Indicated	N/A	CBT	Small	0
Larkin & Thyer (1999)	Indicated	N/A	CBT	Large	0
Melnyk et al. (2009)	Universal	N/A	SBMH program	Small	0
Mufson et al. (2004)	Not reported	Adolescent	Interpersonal Psychotherapy	Medium	2
Murray & Malmgren (2005)	Not reported	Adolescent	N/A	Small	1
Robinson et al. (2002)	Indicated	Adolescent	CBT	Medium	1
Stein et al. (2003)	Indicated	N/A	CBT	Small	1
Huey & Polo (2008)					
Gingsburg & Drake (2002)	Indicated	N/A	CBT	Medium	2
Lochman & Wells (2004)	Not reported	Child	Coping power (SBMHP)	Small	0
Stein et al. (2004)	Not reported	Child	CBT	N/A	0
Weiss et al. (2003)	Selective	Child	Reaching Educators, Children & Parents - Psychosocial intervention (SBMHP)	Small	2
Wilson & Rotter (1986)	Not reported	Child	Anxiety Management Treatment	Large	0
Kavanagh et al. (2009)					
Castellano & Conrad (2006)	Selective	Child	CBT & Psycho-educational	Small	2
Chaplin et al. (2006)	Universal	Adolescent & Child	CBT	Medium	1
Gillham et al.	Indicated	Adolescent	CBT	Small	3

111

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
(2006)		& Child			
Gillham et al. (2007)	Universal	Adolescent & Child	CBT	Small	2
Lamb et al. (1998)	Indicated	Adolescent	CBT	N/A	1
Listug-Lunde (2005)	Indicated	Adolescent	CWD Course	Small	0
Lock and Barrett (2003)	Universal	Adolescent & Child	CBT	Small	0
Masia-Warner et al. (2005)	Indicated	N/A	Skills for Academic and Social success (SBMHP)	Small	1
Merry et al. (2004)	Universal	Adolescent	CBT & Interpersonal Psychotherapy	Small	2
Puskar et al. (2003)	Indicated	Adolescent	CBT	Medium	1
Ruini et al. (2006)	Universal	Adolescent	CBT	Negative	1
Sheffield et al. (2006)	Universal	Adolescent	CBT	Medium	3
Spence et al. (2005)	Universal	Adolescent	CBT	Medium	2
Stein et al. (2003)	Indicated	N/A	CBT	Small	1
Yu & Seligman (2002)	Indicated	Adolescent & Child	CBT	Small	2
Maag & Swearer (2005)					
Clarke et al. (1995)	Indicated	Adolescent	Cognitive Therapy	Medium	1
Kahn et al. (1990)	Not reported	Adolescent	CBI	N/A	0
Reynolds & Coats (1986)	Not reported	Adolescent	CBI	N/A	1
Neil & Christensen (2009)					
Barrett & Turner (2001)	Universal	Child	CBT	Small	1
Barrett et al. (2005)	Universal	Adolescent & Child	CBT	N/A	1
Barrett et al. (2006)	Universal	Adolescent & Child	CBT	Small	1
Berger et al. (2007)	Universal	Child	CBT	Large	0
Bonhauser et al. (2005)	Universal	Adolescent	Exercise (SBMHP)	N/A	1

112

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
Castellano & Conrad (2006)	Selective	Child	CBT & Psycho-educational	Small	2
Dadds et al. (1997)	Indicated	Adolescent & Child	CBT	N/A	0
Dadds et al. (1999)	Indicated	Adolescent & Child	CBT	N/A	0
Garaigordobil (2004)	Universal	Adolescent	Relaxation	Large	0
Gillham et al. (2006)	Indicated	Adolescent & Child	CBT	Small	3
Gingsburg & Drake (2002)	Indicated	N/A	CBT	Medium	2
Hains (1992)	Universal	Adolescent	Relaxation & CBT	Large	1
Hains & Ellmann (1994)	Universal	Adolescent	CBT	Large	0
Hains & Szyjakowski (1990)	Universal	Adolescent	CBT	N/A	1
Hiebert et al. (1989)	Universal	Adolescent	Relaxation	Medium	0
Keogh et al. (2006)	Universal	Adolescent	CBT	Small	0
Kiselica et al. (1994)	Indicated	Adolescent	CBT	Large	0
Lock and Barrett (2003)	Universal	Adolescent & Child	CBT	Small	0
Lowry-Webster et al. (2001)	Universal	Adolescent & Child	CBT	Small	1
Lowry-Webster et al. (2003)	Universal	Adolescent & Child	CBT	Small	1
Masia Warner et al. (2005)	Indicated	N/A	Skills for Academic and Social success (SBMHP)	Small	1
Misfud & Rapee (2005)	Indicated	Child	CBT	Small	0
Pattison & Lynd-Stevenson (2001)	Universal	Child	CBT	Small	2
Roberts et al. (2003)	Indicated	Adolescent	CBT	Small	2
Roberts et al. (2004)	Indicated	Adolescent	CBT	Small	1
Rooney et al. (2006)	Universal	Child	CBT	Medium	1
Sheffield et al.	Universal	Adolescent	CBT	Medium	3

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
(2006)					
Sheffield et al. (2006)	Universal	Adolescent	CBT	Medium	3
Stolberg & Mahler (1994)	Selective	Child	CBT	N/A	0
Rones & Hoagwood (2000)					
Clarke et al. (1993) Study 1	Universal	Adolescent	Psycho-educational	Small	2
Clarke et al. (1993) Study 2	Universal	Adolescent	Behavior Therapy & Psycho-educational	Small	2
Clarke et al. (1995)	Indicated	Adolescent	Cognitive Therapy	Medium	1
Gillham et al. (1995)	Indicated	Child	CBI	N/A	0
Klingman & Hochdorf (1993)	Universal	Adolescent	CBI	N/A	0
Reynolds & Coats (1986)	Not reported	Adolescent	CBI	N/A	1
Spence & Shortt (2007)					
Clarke et al. (1993) Study 1	Universal	Adolescent	Psycho-educational	Small	2
Clarke et al. (1993) Study 2	Universal	Adolescent	Behavior Therapy & Psycho-educational	Small	2
Pattison & Lynd-Stevenson (2001)	Universal	Child	CBT	Small	2
Quayle et al. (2001)	Universal	Child	CBT	Negative	1
Shochet et al. (2001)	Universal	Adolescent	CBT	Medium	0
Cardemil et al. (2002)	Selective	Child	CBT	Large	3
Cardemil et al. (2007)	Selective	Child	CBT	Small	1
Spence et al. (2003)	Universal	Adolescent	CBT	Medium	1
Spence et al. (2005)	Universal	Adolescent	CBT	Medium	2
Merry et al. (2004)	Universal	Adolescent	CBT & Interpersonal Psychotherapy	Small	2
Harnett & Dadds (2004)	Universal	Adolescent	Resourceful Adolescent Program	Small	0

Citation	Prevention Type	Age Focus	Primary Intervention Type	Overall Post-Treatment Effect	# Of Repeats
			(SBMHP)		
Possel et al. (2004)	Universal	Adolescent	CBT	Small	1
Possel et al. (2005)	Universal	Adolescent	Cognitive Therapy	Medium	0
Sheffield et al. (2006)	Indicated	Adolescent	CBT	Small	1

Note. CBT = Cognitive behavioral therapy, CWD course = Coping with Depression Course, SBMHP = School Based Mental Health Program

THINK, BE, DO CURRICULUM

Think, Be, Do

Developed by:
James Sinclair

A curriculum designed for degree of PhD in the Department of Special
Education and Clinical Sciences, at the University of Oregon, College of
Education

An Adaptation of The Adolescent Coping with Depression Course
Clarke, G. Lewinsohn, P., Hops, H., Grossen, B. (1990). *Adolescent Coping with
Depression Course.* Kaiser Permanente: Portland, OR.

Table of Contents

Introduction

The Think, Be, Do (TBD) curriculum is a mental health curriculum developed to be implemented by teachers for students with disabilities. Students with disabilities experience mental health problems at higher rates than their typically developing peers. The most prevalent mental health problems that students experience in high school are depression and anxiety. Teacher's are in a critical position to help students in need and often are first to identify when a student's typical behavior has changed. In addition, due to the lack of mental health resources on many school campuses, teachers often are left with becoming counselors for students during crises and times of need.

This curriculum is designed to help teachers and students address common mental health problems. Using a Cognitive-Behavioral Theoretical (CBT) framework, and an ecological approach to understanding mental health, the TBD curriculum provides a structured opportunity to discuss what mental health is and how it can impact students' lives. The curriculum is designed to teach students what mental health is and how they can become agents to make positive changes in their lives.

Within each session you will find:
1. An introduction and purpose to the lesson.
2. Teaching strategies and materials necessary for the lesson.
3. Teaching instructions and scripts.
4. Review of the lesson and plan for the next lesson.
5. Strategy to use.

The following are a few suggestions for classroom implementation.

1. **Please follow the sessions as outlined in the curriculum:** The following curriculum has been designed to take place in a 50-60 minute classroom time period. While, the art of teaching is left to the discretion of each teacher, it is essential that all of the content in each class be covered. This type of curriculum has been found to be effective in previous research and deviations from the curriculum could hinder its success.

2. **Create supportive classroom environments:** This curriculum may include some review for some students and may include new information

120

to others. Nonetheless, the topics covered in this curriculum could be viewed as sensitive in nature. For students to fully invest in learning and making change, a supportive classroom environment (i.e., free of stigma and judgment, as well as confidential) is needed. Teachers can utilize time within the first session to set what the expectations for a supportive classroom environment are. It is important for students to feel that they can trust you as a teacher but also the other students in the class.

3. **Utilize the curriculum:** The curriculum assumes that teachers are not mental health counselors. It will provide you with definitions, examples, and answers that will be covered in each session. Teachers can review the curriculum sessions ahead of time to orient themselves with what will be covered (e.g., definitions, and activities). In addition the italicized type is a sample script for you to use to keep the sessions on track and explain to the students what is going on.

4. **Check-in with your students:** Mood monitoring, activity tracking, and goal setting are an integral piece of the TBD curriculum. The curriculum designates time within each lesson to check with your students to have them mark their overall mood, activity, and goal accomplishments.

5. **Student workbook:** There is a student workbook for each student (to be distributed at the beginning of each class and collected at the end of each class). The student workbook will include the essential components for each lesson as well as handouts necessary to complete each session. The student workbook will also include a mood monitoring form and activity sheet to be filled out each day during the curriculum implementation.

6. **Avoid depressive talk:** When talking about mental health it is easy to focus on the negatives, if you hear students "spiraling down" (mood spirals will be discussed in session 2) at any time during the curriculum attend and acknowledge their feelings but make sure that during this time students don't use this opportunity as a sounding board for their depression. Try to have students focus on reframing the negatives into positives.

ATTENDANCE

Please indicate using the table below who in your class was present at the time of the each lesson.

Student Name	1	2	3	4	5	6	7	8	9	10

Session 1 – What is Mental Health?

Agenda for the session
_____

1. Introduce the curriculum.
2. What are the expectations for the class?
3. What is a supportive classroom environment?
4. What is mental health?
5. How can the environment and our behaviors impact our mental health?
6. Mood monitoring and activity chart.
7. Strategy to use.

_____

1. Introduce the curriculum to students.

The Think, Be, Do curriculum has a brief number of sessions that we will be completing in class to talk about our overall mental health. Sometimes we don't realize how our feelings can impact our relationships with friends and family, or impact the things we typically do at school or on the weekends. The sessions in this curriculum will help identify how our thoughts, feelings, and actions are all connected. We will also talk about strategies that you can use to help alleviate feeling depressed or anxious at school, home, or with friends. The great news is there is no homework, but I will ask you to try strategies outside of class so you can find one or more that works well for you.

_____

2. What are the expectations for the class? (SW pg. 6)

We are going to be talking about some sensitive information during our time using the TBD curriculum, so to make sure that this is a success I want to have some specific classroom expectations. [Review any classroom expectations already in place]. *To begin I have 3 expectations for us.*

i. **Take ownership of your learning:** *One thing that is extremely important to remember in all of your education, and especially when talking about mental health, is that you are the one in control. We will be talking about things that impact your life, and only you know your life. So, take what you can from these sessions and make this about you!*

ii. **Be honest:** *Throughout the sessions we will be talking about things that are general and some things that are personal. It is important to be honest with yourself and others. THIS DOES NOT MEAN YOU HAVE TO SHARE PERSONAL THINGS YOU DON'T WANT TO! But if you and the class are going to learn from each other and me, we need to be honest.*

iii. **Create a positive and supportive classroom environment:** *For most of us to be able to share things that are important and meaningful we need to make sure this classroom environment is supportive of one another!*

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3. What is a supportive classroom environment? (SW pg. 6)

In-class activity instructions:

Take this as an opportunity for your first in-class activity.

  i. Tell your students *"this will be your first opportunity to use the student workbook and to open it to session 1."*

  ii. Tell your students you want to make a list of rules that enforces a supportive classroom environment. Say to them *"there a few suggestions I have that I will write on the board and we can build upon that list."* This list is in the student workbook.

  iii. Have students generate five to ten more ways to make a supportive classroom environment. Have students write these down in the workbook to refer back to for future reference (if necessary).

Explain to students and write on the board - A supportive classroom environment is:

    i.   One that treats everyone with respect and dignity.
    ii.   A judgment and hate free zone.
    iii.   Confidential – meaning what is said in class does not leave class and shared with others.

After the students have generated and written down five to ten rules to make for a supportive classroom environment, tell them *"these will be the rules that will be enforced during these sessions. Because you made them, you all have a responsibility to make sure that these are enforced along with me. This curriculum is a partnership between you and me, and these rules will help build a strong partnership."*

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4. What is mental health? (SW pg. 8)

Now that we have discussed what makes for a supportive classroom environment, the other thing I want to accomplish today is talking about what mental health is.

> In-class activity instructions:
>
>   i.   Have your students partner with the person next to them and take three to five minutes to define <u>or</u> come up with 2-4 characteristics that describe what mental health is. Select a few students to share what they came up with and write them on the board.

Tell your students *"that you appreciate the descriptions they gave about what mental health is."* Tell them *"one definition commonly used is a state of well-being when an individual has the ability to cope with life stressors and continue to be a productive member in society."*

Then tell your students *"a mental health problem, like depression or anxiety, is considered a threat to one's mental health."*

Give your students this rationale: *"It is extremely important to be aware of our own mental health so we can understand how our feelings impact our friendships, relationships with our family, our desire to do things we enjoy, and our ability to do school work."*

---

5. Environments and behavior

Draw a large circle on the board next to the definitions of mental health that the students came up with. In the center of the circle draw a stick figure individual and tell your students *"We are now going to do a quick brainstorming activity to identify things in our lives that impact us and maybe our own mental health. The large circle represents the people, activities, and environments that we interact with daily or weekly."* For example, write "Family" on the board and then draw a two-pointed arrow toward the individual.
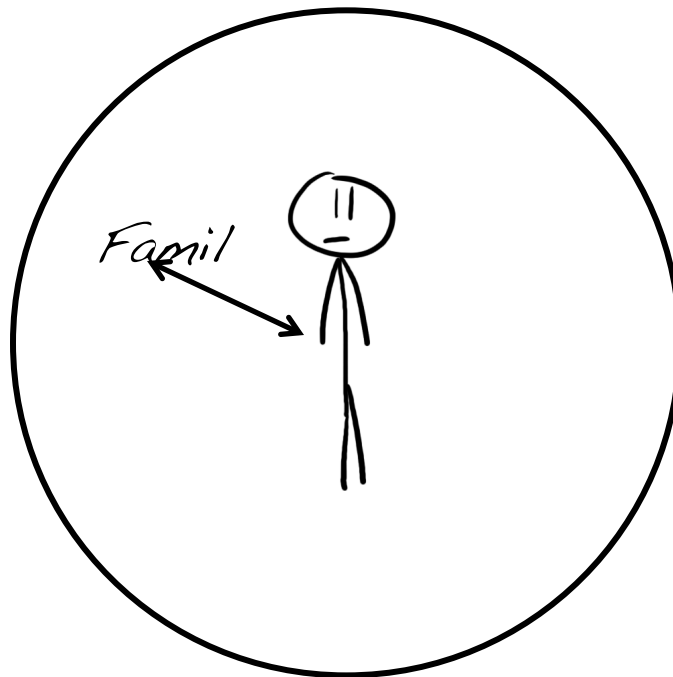
Have students come up with as many ideas as they can. If you feel comfortable, include some of your own people, activities, and environments to the circle. This might help students come up with their own ideas.

Tell students, *"Sometimes we take for granted the positives we get from participating in activities with peers and family. Sometimes we don't understand how the environment we interact with impacts our mental health. By increasing our awareness of the interaction between us and our environment, we can be more active in taking control of our lives and increasing positive interactions we have with people and the community."*

Note to teachers - By participating with the students, students may become more comfortable sharing, which will be important to build upon for later sessions. (Additional ideas could include, teachers, friends, after school sports, church, grandparents, and after school clubs).

Note to teachers - Make sure these are people, activities, and communities that students have direct contact with; not indirect contact (i.e., individuals through online video games, or online chat/topic boards). This curriculum will teach the importance of increasing positive activities, where students can have direct contact.

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6. Mood monitoring and activity chart (SW pg. 8 & 51-55)

This curriculum is not built on homework but there are a few things that will need to be thought of outside of class. One of these things will be to utilize a mood monitoring and activity chart. This can be found in the student workbook.

Tell your students *"Our goal using this curriculum is to improve the way we feel. One way to do this is to begin monitoring how we feel throughout the course by filling out the Mood Monitoring and Activity Chart or the MAC chart. The MAC chart uses a scale from one to seven to measure our feelings and activity levels."*

Have students look at the MAC chart in their student workbook so they can become familiar with the chart. Explain to them:

"It is hard to decide what number our moods should have, so think of a time in your life that YOU FELT REALLY GOOD and assign that feeling a seven."

Give your students some time to think about this and write down a couple words that resemble that feeling in the designated area provided on the MAC chart. Then ask them:

"Now think of a time when YOU FELT REALLY BAD and assign that feeling a one. Use the feelings chart as a visual representation and reminder of what the scale resembles."

Give your students some time to think about this and write down a couple words that resemble that feeling in the designated area provided on the MAC chart.

MAC - Mood Rating Scale

1. A score of one resembles feeling very depressed and/anxious

2. A score of two resembles feeling down/anxious/a feeling of being overwhelmed

3. A score of three resembles feeling a bit worse than just okay

4. A score of four resembles feeling fair/just okay/"flat"

5. A score of five resembles feeling "okay"/"pretty good" and better than feeling just okay

6. A score of six resembles feeling happy but that you could be happier

7. A score of seven resembles feeling very happy and positive

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MAC - Activity Rating Scale

1. I don't want to participate in any activities or be with friends

2. Activities that used to interest me don't really anymore

3. My energy is low and being with friends and family doesn't sound good to me

4. A score of four resembles feeling fair/just okay/"flat"

5. Friends and family interest me

6. I enjoy being with friends and family

7. I want to be with friends and family

In-class activity instructions:
  i.   Tell your students that they are going to practice using the MAC chart. Make sure that they are looking at the chart in their workbook. Have your students think about the past twenty-four hours, have them consider how they had been feeling overall. Meaning, think about more than how you are feeling right now or this morning but even last night and try to assign a score to that feeling. Have them reference their really good and really bad examples if they need help with assigning their overall feeling a score. Once they have decided a score, tell them to mark it on the corresponding day of the first week.

Instruct students that even though we might not be using the TBD curriculum every day, it is important to monitor the way you feel every day. If you can't, then time will be provided to use the MAC chart every time we use the TBD curriculum.

The activity chart uses the same monitoring scales to chart your activity over a twenty-four hour period. Tell your students *"the word "activity" might bring up the idea of PE or running, but it means so much more than that. As we discussed before, participating in things that we find pleasant is important in changing the way we feel. Pleasant activities are more than just things that bring us instant happiness, they have a long lasting impact on how we feel. For example, playing video games may make us feel good now, but going for a walk outside with friends can make us feel connected and our bodies happy from exercise."*

In-class activity instructions:

i.   *"In our next activity we are going to brainstorm a list of pleasant activities that make our mind and body feel good. This brainstorm should be individualized, as one person's pleasant activities may not match up with everyone else's. In your workbook write down as many pleasant activities as you can think of. This list can continue to grow, as you continue to think of pleasant activities you can continue to add them to the page in your workbook."*

ii.   Give students time to brainstorm and write down pleasant activities that mean something to them.

iii. Explain to your students *"Deciding a score for activities might be more difficult than assigning a score to the way you have felt in the past twenty-four hours, but it is still important to try. The scale of one to seven will be used. A score of seven indicates that in the past twenty-four hours you feel like you have accomplished and participated in activities that are necessary but also important to you and that make you feel good. A score of one indicates that in the past twenty-four hours you feel like you have not accomplished or participated in activities that are necessary or important to you."*

iv.   Have your students reference the list of pleasant activities they wrote down to help them decide if they participated in pleasant activities.

Remind your students that they will be working with the MAC chart throughout the entire time they use the curriculum. It will be important to track their mood and activities during this time.

7. Strategy to use (SW pg. 13)

The first strategy that we are going to try is using the Mood and Activity Chart over the next couple of days. Practice rating your overall mood and level of activity each day between now and the next lesson. On a separate sheet of paper or in their workbook try writing down why you chose a specific mood or activity level. This is the beginning of our practice on how to start monitoring our own moods and activities.

Session 2 – Actions, Thoughts, & Feelings

Agenda for the session

1. Review mood monitoring and activity chart (MAC chart).
2. Actions, thoughts, and feelings.
3. Mood spirals.
4. Person-environment interaction.
5. Mood monitoring and activity chart.
6. Strategy to use.

1. Review mood monitoring and activity chart (SW pg. 51-55)

Begin this lesson by reviewing the agenda with the students and by telling them *"today will be all about how our actions, thoughts, and feelings all interact with one another."*

Have your students get their student workbook out and flip to the page with the MAC chart and their own mood/activity monitoring sheet.

Explain to your students that this is an important part of the process of understanding how our moods impact our thoughts and behaviors. Having the skills to monitor your own moods can help in the future to understand why things might not be exciting anymore or why you might not want to hang out with friends and you don't know why.

Tell your students that it is important for them to use this worksheet and mark down their mood and activity score daily. Ask your students to start by marking down how they felt and their level of activity for the past 24 hours on the correct date. Then have your students review the MAC chart worksheet and see if there are any missing dates that they did not mark down their mood or activity level.

IF and ONLY IF students can clearly remember how they were feeling on those days have them mark that down. IF students cannot recollect how they were feeling or what their activity level was have them keep it blank.

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2. Actions, thoughts, and feelings (SW pg. 15)

Note to teacher: Begin this section by drawing the figure below on the board so that all students can see.

Actions
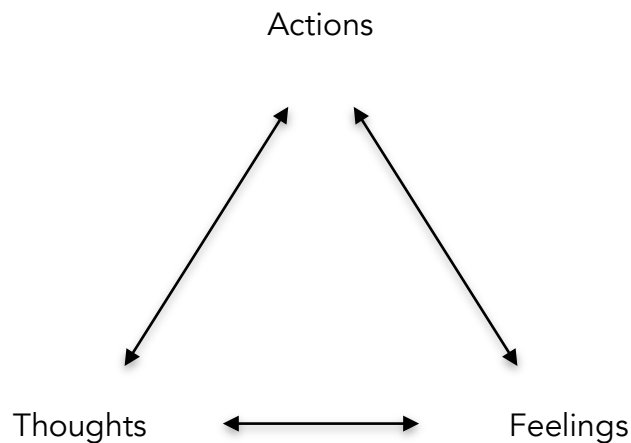
Thoughts   Feelings

Inform your students *"Actions, Thoughts, and Feelings are always connected. We might not always know that they are interacting because our reactions can be instantaneous. For example, if a teacher gives you back an assignment with a lower grade than you were expecting you might feel frustrated, you might think that all of your effort wasn't worth it, and all you want to do is leave class. Does that sound familiar? That is just one example but these things happen on a daily basis, and we need to try and figure out for ourselves how each of our actions, thoughts, and feelings interact with each other."*

Note to teacher: If you feel comfortable; give an example of how actions, thoughts, and feelings interact in your own life.

Ask your students *"what do you think impacts our mental health the most, actions, thoughts, or feelings? And Why do you think that?"*

Reminder, mental health is defined as: *a state of well-being when an individual has the ability to cope with life stressors and continue to be a productive member in society.*

Follow-up with your students by asking them, What do they think is the easiest thing to change when we are depressed or anxious?

Students may say that their feelings are easy to change, but in reality, changing our actions and thoughts might be easier! When we become aware that we are not feeling well, we can decide to take action and do something that will make us feel better, like go for a walk, get ice cream with friends, or play a game with your family.

Have students practice:

In-class activity:

i.   Have your students think about a time they were feeling sad, tell them to write down things, people, events that helped them feel better. There is space in the student workbook for this.
ii. Have students write down all the positive things that helped them through some hard times.
iii. If there is time have them share with a neighbor or partner to see if there is any strategy they can learn from each other.

3. Mood spirals (SW pg. 16)

"As we have been talking about earlier, actions, thoughts, and feelings all interact with each other. A lot of times when we start feeling down, sad, or depressed we are less likely to do things we enjoy. We also might begin to second-guess our abilities to do things. On the flip side, when we are feeling good and happy, we are more likely to enjoy activities, be with friends, and be more confident."

We can picture how this looks using mood spirals.

Note to teacher: Draw the figure below on the board so all students can see.

Downward Spiral

Feel Unhappy

Spend more time alone

Feel depressed

Become less active

Feel more depressed

Do even less

Upward Spiral

Feel great

Do well in school

Feel even better

Have fun with friends

Feel good

Do something successfully
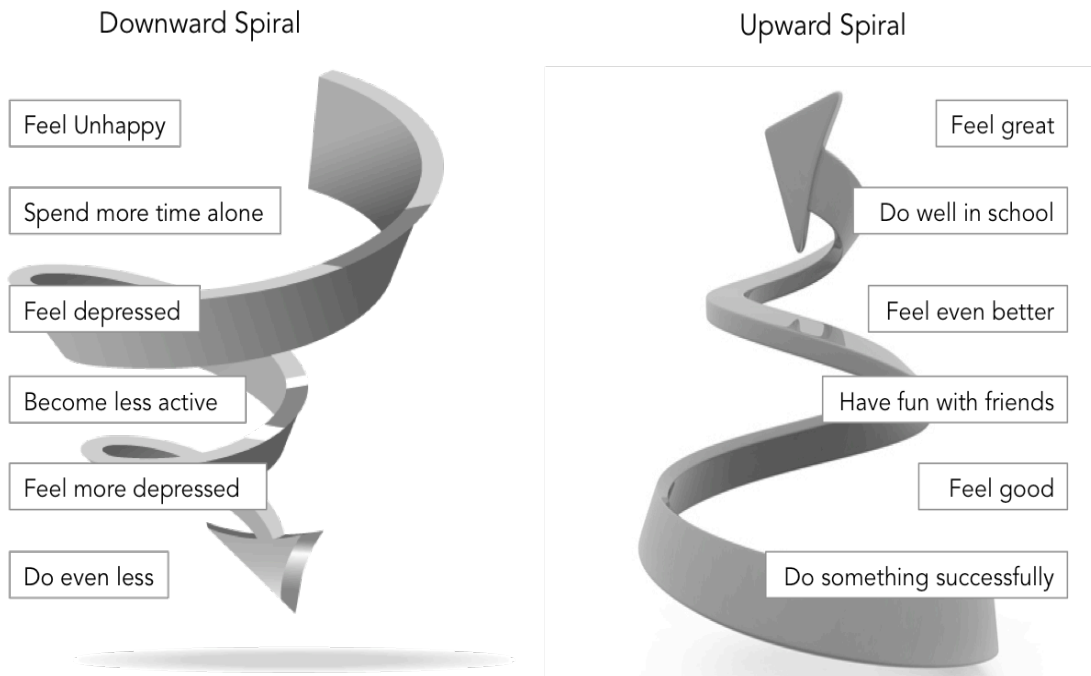
Describe to the students the downward and upward spirals. A large event does not need to occur to begin either a downward or upward spiral. It could be a little event that triggers certain emotions (e.g., getting a bad grade on an assignment), actions (e.g., a friend cancels plans with you and you spend the evening alone), or thoughts (e.g., people must not like me because they did not laugh at my joke).

Note to teacher: This is important to explain to your students - What is critical to understand about a downward spiral is at any point in time; we can do things to stop the downward spiral and turn it into an upward spiral.

In-class activity:

i.   Read the scenarios below and have students shout-out "stop" when they think they have a strategy to turn a downward spiral into an upward spiral.

SCENARIOS:

Melissa has trouble understanding multiple directions at a time. Her teacher goes over how to complete the in-class assignment but talked too fast and confused Melissa. Melissa began to withdraw from class and just looked down at her desk because she started to think she wouldn't be able to complete the in class assignment. What should she do?

Jackson's family has had a hard time being able to keep enough food in the house for every meal. Today Jackson was unable to eat breakfast and was hungry when he got to school. His hunger only got worse throughout the day and he couldn't concentrate in class. He started to withdraw from his friends because he did not want them to know he wasn't able to have breakfast. He began to think about skipping school, because he didn't think he "could learn anything anyway." Those thoughts started to transform into thoughts of inadequacy. What should he do?

Reggie and his girlfriend just broke up and he is really sad. He felt that he has lost the love of his life. He began to think that all of his self-worth was connected to his girlfriend and didn't think he could do anything. He didn't think he could do school work, he didn't think he could be with friends, and every time he thought of her he would have to stop himself from beginning to cry. What should he do?

4. Person-environment interaction (SW pg. 17)

"When we discuss how to change a downward spiral into an upward spiral we might look at what actions or thoughts we can change to make something from a negative into a positive. By changing our own actions or thoughts we are in turn actually changing our environment, whether we can see it directly or not!"

Note to teacher: Draw on the board the figure below. Have students think about how the school environment impacts them and how they make an impact on the school environment (add student responses to the circle). Sometimes these interactions can be more disruptive than something positive.
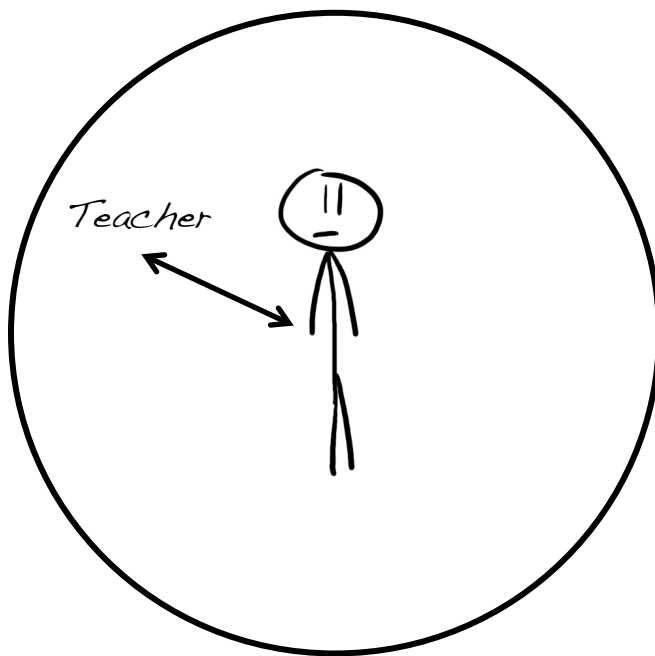
Disruptions!

When something doesn't go our way it creates a disruption in our day-to-day life. Being able to cope with these disruptions is important so we don't begin to start a downward spiral!

Many times these disruptions are from minor life or major life events. But we always have a choice in how we respond to these disruptions!

"These disruptions can put us 'in a funk' and 'throw us off' and all of a sudden things that we have found that made us feel good for some reason don't anymore, so we begin to stop doing things."

To put this in perspective follow this scenario:

Dani was walking down the hallway and accidentally was shoved to the side, the individual told Dani 'sorry' and kept walking. Dani took the shove very personally and started to think that the shove was done on purpose and that people didn't like her. Dani became sad and kept quiet for the rest of the day. Her friends didn't know what to do so they talked with her less. She also didn't participate in class, missing valuable in-class points and became more upset about it. When the teacher asked if anything was wrong, Dani said no.

Ask students: *"How was Dani interacting with her environment? How was the environment interacting with Dani?"*

Sample response - *Just like the downward spiral, Dani continues to withdraw and interactions with her friends and teachers become less appealing. If Dani is able to come up with a strategy to seek help, Dani may not have continued the downward spiral the whole day.*

Ask students to write in their student workbook two or three strategies Dani could use to make her stop the downward spiral.

Examples include: Taking the apology seriously, talking to friends to see if they thought the apology was insincere, have Dani think to herself that these things happen in busy hallways and it was probably nothing bad, talk to the teacher about what happened, ask the teacher to make up the valuable points so Dani doesn't feel bad for missing those too.

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5. Mood monitoring and activity chart (SW pg. 51-55)

Remind students that this curriculum is not built on homework but there are a few things that will need to be thought of outside of class. One of these things will be to utilize a mood monitoring and activity chart. This can be found in the student workbook.

Tell your students *"Our goal using this curriculum is to improve the way we feel. One way to do this is to begin monitoring how we feel throughout the course by*

filling out the Mood Monitoring and Activity Chart or the MAC chart. The MAC chart uses a scale from one to seven to measure our feelings and activity levels."

Have students flip to the MAC chart and fill in their mood and activity levels from the past 24 hours. Stress that it is important for them to fill this in everyday if they can.

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6. Strategy to Use (SW pg. 18)

Have your students pay attention to their favorite characters in their favorite TV shows. Have them observe two different things. First, how the character's mood changes their actions, or how their actions impact their mood?

Have your students write down an example in their student workbook.

Session 3 – Locus of Control

1. Review strategy to use.
2. Review mood monitoring and activity chart (MAC chart).
3. What is locus of control?
4. What is resilience?
5. Mood monitoring and activity chart.
6. Strategy to use.

Begin this lesson by reviewing the agenda with the students and by telling them *"today will be about how we control our own lives, and that we kind can ways to advocate for ourselves to ensure continued control."*

1. Review strategy to use.

Ask your students if they practiced the "Strategy to Use" from the previous session. In the past session your students paid attention to their favorite characters on their favorite TV shows. The observed for two different things: (1) how the character's mood changes their actions, or (2) how their actions impact their mood?

What did your students find out?

2. Review mood monitoring and activity chart (SW pg. 51-55)

Have your students get their student workbook out and flip to the page with the MAC chart and their own mood/activity monitoring sheet.

Explain to your students that this is an important part of the process of understanding how our moods impact our thoughts and behaviors. Having the skills to monitor your own moods can help in the future to understand why things might not be exciting anymore or why you might not want to hang out with friends and you don't know why.

Tell your students that it is important for them to use this worksheet and mark down their mood and activity score daily. Ask your students to start by marking down how they felt and their level of activity for the past 24 hours on the correct date. Then have your students review the MAC chart worksheet and see if there are any missing dates that they did not mark down their mood or activity level. IF and ONLY IF students can clearly remember how they were feeling on those days have them mark that down. IF students cannot recollect how they were feeling or what their activity level was have them keep it blank.

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3. What is locus of control? (SW pg. 19)

Note to teacher: One of the purposes of this curriculum is to empower students to feel that they have control of their life. Whether it is control over their behaviors or thoughts, this is a critical component of the curriculum. This session highlights this concept, but the concept should be discussed throughout all the sessions.

In-class activity:

Ask students to write a list of people who they feel have control over their lives in the student workbook.

   i.   Once students have had time to write down people who have control, ask them to shout out people who they wrote down. Quickly, write their answers down on the board. Analyze their responses to see if there are any themes through out their responses.

   ii.   Look to see if anyone said "me" or that they were in control of their lives. If no one mentioned that they were in control of their life, ask the student why they didn't write themselves down.

iii.   Share a story with your students about how there are times you feel more in control of your life than other times. But, that it is always important to understand as we grow older we get more and more responsibilities and we have the ability to gain more control of our life.

iv.   Relate this to how students gain more responsibility and control over their own education in high school than they did in middle school, and that this trend will continue as they transition from high school into adult life. So it is important to recognize that although sometimes it feels that a parent or teacher may have control of our lives, we have the most control of our lives, and daily decisions are up to us.

Locus of control defined:

There are two types of locus of control; External and Internal.

People who have higher external locus of control perceive their actions as having little or no influence on the outcomes they experience…meaning the experienced outcomes are typically due to someone or something outside of the individual's control.

People who have higher internal locus of control perceive that their actions influence the outcomes they experience.

> *Note to teacher:* Draw a horizontal line with two arrows on each side and write external control beneath one arrow and internal control beneath the other arrow. Tell your students that this sense of control is along a continuum.

Tell your students *"students who recognize that they have control of their life, and take responsibility for their actions, typically will be more successful than students who don't"* and ask them *"why do you think this is?"*

Tell your students *"as we become adults, people begin to rely on our abilities to do what we said we are going to do. We begin to become more confident in our abilities as we start taking control of our lives and when our decision for action is reflected in a positive outcome."*

"Similar to having to take responsibility for our actions in school or outside of school with friends and family, we also become the keeper of our own feelings. As you grow older people rely more on you to tell them how you are feeling. When we feel sad, depressed, worried, or upset, as adults we must begin to start recognizing these symptoms and do something about them."

"What is great is that we CAN do something about them!"

Remind your students that in the last session we talked about mood spirals and how sometimes our moods can be in a downward or upward spiral. What we want to understand is when we are in a downward spiral we have the ability to stop the spiral and begin to change, because we have control of how we are feeling.

By changing the direction of a downward spiral into an upward spiral we <u>take control of our lives and our actions and our feelings.</u>

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4. What is resilience? (SW pg. 19)

Resilience is the ability to prevent, deal with, and overcome hardships and adversity in our lives.

"The great thing about resilience is that we have it in us to be resilient."

To demonstrate this we are going to do another in-class activity:

In-Class Activity:

i. Think back to a time when you were doing a school project and you didn't think you could do it because it was too hard.

ii. In the student workbook write this project down in the space provided.

143

Resilience strategies **in student workbook**:
- I told myself that my effort on this project will pay off.
- I told myself that I am smart and have the ability to complete this project.
- I worked on the project one question at a time. Knowing that I can do a little at a time helps me complete the project.
- I worked for twenty minutes at a time, and then gave myself a break.
- I planned my week to complete the project day by day.

People who have helped you **in student workbook**:

- Caregiver (Parent, grandparent) _____
- Sibling _____
- Friend _____
- Teacher _____
- Coach _____
- Tutor _____

"By reflecting back on our experience of overcoming something that was hard for us and seeing what strategies we used and the people who helped us, we can say that each one of us is already resilient!"

"Resilience is also important when we think about our own feelings. Maybe in the project you came up with 'you didn't want to do it because it was hard,' or you started to think you could not do it for some reason. These negative thoughts can start that downward spiral we have been talking about."

"Sometimes when we are feeling down we can't see the light at the end of the tunnel, everything seems dark and even the littlest of tasks can be very difficult to do. Yet, even in the most difficult of times we can say we survived and that we are all here. Getting through those dark times is also resilience."

Ask your students why they might think that getting through a difficult emotional time is resilience?

Tell your students *"resilience comes and goes depending on the situation we are in, whether it be having a problem at school, at home, or with friends. Sometimes we might feel resilient and sometimes we might not feel resilient, but what is important to know is that we all have the ability to be resilient even if we don't think we are."*

Note to teacher: If you feel comfortable, share an experience with your students about being resilient, (e.g., a time when you second guessed your abilities but kept moving forward). By sharing a personal story, students can see that someone they trust has been through hardships and are still successful.

Have your students look back at the list of strategies they used to get through tough times in school. Ask them *"what strategies could you use to help get yourself out of a funk and feeling down?"*

Students should answer with all of the options. Have students write down in the space provided in their student workbook which strategies they are most likely to use when they face a difficult situation in the future.

Ask your students to share with you what is their top strategy and why it is their top strategy?

- FOLLOW UP – Can your students give an example of a difficult situation they might face in the future (e.g., school, or personal life) and how they would use that strategy?

145

In-Class activity:

Have your students wrap up the session with coming up with one reason why they are resilient. Have them write it down and share it with a neighbor. IF there is time, have the neighbor share out loud to the class why their partner is resilient.

Tell your students that we are going to learn more about a few of these strategies later on using this curriculum.

5. Mood monitoring and activity chart (SW pg. 51-55)

Remind students that this curriculum is not built on homework but there are a few things that will need to be thought of outside of class. One of these things will be to utilize a mood monitoring and activity chart. This can be found in the student workbook.

Tell your students *"Our goal using this curriculum is to improve the way we feel. One way to do this is to begin monitoring how we feel throughout the course by filling out the Mood Monitoring and Activity Chart or the MAC chart. The MAC chart uses a scale from one to seven to measure our feelings and activity levels."*

Have students flip to the MAC chart and fill in their mood and activity levels from the past 24 hours. Stress that it is important for them to fill this in everyday if they can.

6. Strategy to use (SW pg. 21)

Have your students find an inspirational quote in a book, poem, or online by their favorite author or person. Have them find a quote that is inspirational and something that will give them a friendly reminder that they can achieve anything they put their mind to. This quote can be used as their own personal motto from now on. Have them write down the quote in their workbook!

Session 4 – Pleasant Activities – Part 1

Agenda for the session

1. Review Strategy to Use
2. Review mood monitoring and activity chart (MAC chart).
3. Review actions, thoughts, and feelings.
4. What are activity domains?
5. Setting activity goals.
6. Mood monitoring and activity chart.

Begin this lesson by reviewing the agenda with the students and by telling them *"today will be about identifying activities that are positive and reinforcing across the different environments we interact with."*

1. Review strategy to use

Ask your students if they practiced the "Strategy to Use" from the previous session. In the past session your students found an inspirational quote in a book, poem, or online by their favorite author or person. They found a quote that was inspirational and something that would give them a friendly reminder that they can achieve anything they put their mind to. This quote can be used as their own personal motto from now on.

Ask your students what motto/quote they chose for themselves?

2. Review mood monitoring and activity chart (SW pg. 51-55)

Have your students get their student workbook out and flip to the page with the MAC chart and their own mood/activity monitoring sheet.

Explain to your students that this is an important part of the process of understanding how our moods impact our thoughts and behaviors. Having the skills to monitor your own moods can help in the future to understand why things might not be exciting anymore or why you might not want to hang out with friends and you don't know why.

Tell your students that it is important for them to use this worksheet and mark down their mood and activity score daily. Ask your students to start by marking down how they felt and their level of activity for the past 24 hours on the correct date. Then have your students review the MAC chart worksheet and see if there are any missing dates that they did not mark down their mood or activity level. IF and ONLY IF students can clearly remember how they were feeling on those days have them mark that down. IF students cannot recollect how they were feeling or what their activity level was have them keep it blank.

3. Review actions, thoughts, and feelings.

Note to teacher: Draw on the board the actions, thoughts, and feelings triangle.
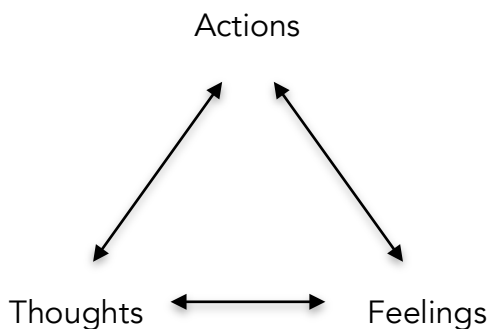
Actions

Thoughts ⟷ Feelings

REVIEW: Ask students if they remember the actions, thoughts, and feelings triangle. Ask the students if they remember what the triangle means for them? What is it supposed to remind them of?

Answer: all three interact within us and each one can influence the other. Remind students that even if we don't think all three are present at one time, they are, and sometimes we can identify one (e.g., actions) over the other two (e.g., thoughts, actions).

REVIEW: Ask students if they can share an example of when they realized that each of these was interacting within them?

Note to teacher: If you feel comfortable share with your students a recent experience where you felt that your actions, thoughts, and feelings were all interacting and see if this helps students come up with their own experiences to share.

Read or create a similar scenario:
"Sometimes our thoughts can get in the way of us doing things we actually might want to do. I'll give you an example, my friend invited me to a (e.g., concert, football game, comic convention) and I was really hesitant to go because sometimes I don't like big crowds. But I realized, that if I let my thoughts about how bad the crowds could be control my decisions, I would miss out on a really fun opportunity to see the (e.g., concert, football game, comic convention). I decided that I should not let my fear of a crowd stop me from doing something I wanted to do, and you know what? Afterwards, I was so happy that I went."

"What that experience showed me is that by going to the (e.g., concert, football game, comic convention) I was happier, I had fun with my friend, and it got me out of my house. I realized by doing something enjoyable, it changed my thoughts and feelings for the better, which put me in an upward mood spiral. It made me want to do more fun things."

Note to teachers: Talking about pleasant activities will be the focus on the next two lessons.

4. What are activity domains? (SW pg. 22)

There are two main pleasant activity domains. The two are SOCIAL and SUCCESS activities.

SOCIAL Activities are time spent with other people (friends and family) that are positive, pleasurable, and fun.

Tell your students *"even though I am sure that some of you will have the same social activities, I want you to take a moment and think about social activities that YOU enjoy, and write them down in your student workbook. Begin a list of activities that YOU know and YOU enjoy. This is important so that we can begin to rely on ourselves to take action on things we enjoy."*

Have students try to come up with 8-10 pleasant social activities.

Note to teacher: Walk around the room and help students. If students are having a hard time coming up with activities, use what you know about the student and ask them *"What about _____ activity, would you consider that a pleasant social activity?"* and let them decide if they want to add it to their list.

Once they have completed a list of 8-10 social activities, tell your students we are going to do the same thing with success activities, which are:

SUCCESS Activities are experiences that make us feel skillful or competent (the way we feel when we have done a good job on a project at home or a homework assignment).

Explain again that students should work on their own to find success activities that are personal to them, and that these should be meaningful to them. Success activities may be more difficult to come up with for some students. Tell your students *"another way to think about this is, come up with a list of things that you feel you are good at doing. Something that you feel gives you a sense of accomplishment after you do it."*

Have students try to come up with 8-10 pleasant success activities.

Note to teacher: Walk around the room and help students. If students are having a hard time coming up with activities, use what you know about the student and ask them *"What about _____ activity, would you consider that a pleasant success activity?"* and let them decide if they want to add it to their list.

Once these two lists are completed, you can have students share some of their activities if they would like. Otherwise, tell your students that we are going to take this activity one step further.

In-class activity:

i.   Ask students if they remember what the difference between internal and external locus of control is?

     a.   People who have higher <u>external locus of control</u> perceive their actions as having little or no influence on the outcomes they experience…meaning the experienced outcomes are typically due to someone or something outside of the individual's control.

     b.   People who have higher <u>internal locus of control</u> perceive that their actions influence the outcomes they experience.

ii.   Tell your students *"I want you to review both the SOCIAL and SUCCESS activities and write a number between 1 and 10 (1 being total external locus of control and 10 being total internal locus of control) rating next to them that corresponds with the level of external or internal locus of control"*

iii. Tell your students *"Take a look at your activities, find two or three activities you feel that you have complete control over (i.e., total internal locus of control).*

iv.   Have your students write down those two or three activities in the space provided on their worksheet, or indicate the two or three activities with a star next to it.

v.   Tell your students we will use these in future sessions.

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5. Setting activity goals. (SW pg. 24)

"Through out our time with the TBD curriculum, we have talked about how our behaviors can impact our thoughts and feelings. With the previous activity we found some activities or actions that we enjoy and activities or actions that we have complete control of."

"As I have mentioned before, sometimes when our mood starts going down the downward spiral and we start feeling bad, we begin to stop doing things that we enjoy, and sometimes that makes it even harder to turn a downward spiral into an upward spiral."

"Being aware of pleasant activities that make us feel good at ALL times is important. This is because if we are feeling down, doing a pleasant activity can change the direction of our downward spiral to up. And if we are feeling good, it makes the upward spiral even stronger!"

"In any case, we need to be prepared and set goals to make sure that we keep ourselves feeling good, thinking good things, and doing things we find enjoyable!"

"When we think about setting goals, we should make sure that they are SMART goals. SMART is actually an acronym to help us set goals that we will be successful in accomplishing."

SMART stands for:

S<u>pecific</u> –State what you want to accomplish (include who, what, where, why)

M<u>easurable</u> – State how you will observe your goal being met. Make sure you can measure your progress.

A<u>chievable</u> – What are the actions you need to take? Do you have control of your ability to do these actions?

R<u>elevant</u> – Make sure your goal connects with your broader long-term goals.

T<u>imely</u> – Can your goal be accomplished within the timeline you want?

"Let me give you an example of a SMART goal"

In-class activity:

i.   Take this opportunity to write a SMART goal on board; it could be a personal goal for yourself or an example of a SUCCESS activity for the students.

ii. Once the SMART goal is on the board, walk through with your students why your goal meets all the SMART requirements by underlining the section of the goal that corresponds with each letter of the acronym. Check to make sure your students can see all the requirements.

iii. Once this is completed, write another SMART goal on the board that meets all the SMART requirements.

iv. Ask students to then look over the goal and ask them what parts of the goal are *specific, measurable, achievable, relevant, and timely.* Underline the parts they identify.

v.   Once completed, have students take a moment to think about a SMART goal for themselves. Make sure that the goal is focused on or around a SUCCESS activity.

vi. Have students practice writing a SMART SUCCESS activity goal in their student workbook.

vii. Have students share a SMART SUCCESS goal and provide feedback individually, or have students partner up and give each other feedback.

Tell your students *"we will practice more SMART goals in the next session."*

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6. Mood monitoring and activity chart (SW pg. 51-55)

Remind students that this curriculum is not built on homework but there are a few things that will need to be thought of outside of class. One of these things will be to utilize a mood monitoring and activity chart. This can be found in the student workbook.

Tell your students *"Our goal using this curriculum is to improve the way we feel. One way to do this is to begin monitoring how we feel throughout the course by filling out the Mood Monitoring and Activity Chart or the MAC chart. The MAC chart uses a scale from one to seven to measure our feelings and activity levels."*

Have students flip to the MAC chart and fill in their mood and activity levels from the past 24 hours. Stress that it is important for them to fill this in everyday if they can.

Session 5 – Pleasant Activities – Part 2

Agenda for the session

1. Review mood monitoring and activity chart (MAC chart).
2. Review actions, thoughts, and feelings and mood spirals.
3. Goal setting and action plans.
4. Mood monitoring and activity chart.
5. Strategy to use.

Begin this lesson by reviewing the agenda with the students and by telling them *"today we will learn about setting goals, to make sure we participate in activities that are reinforcing to us and make plans to continue to engaging in activities that are positive and pleasant to us!"*

1. Review mood monitoring and activity chart (SW pg. 51-55)

Have your students get their student workbook out and flip to the page with the MAC chart and their own mood/activity monitoring sheet.

Explain to your students that this is an important part of the process of understanding how our moods impact our thoughts and behaviors. Having the skills to monitor your own moods can help in the future to understand why things might not be exciting anymore or why you might not want to hang out with friends and you don't know why.

Tell your students that it is important for them to use this worksheet and mark down their mood and activity score daily. Ask your students to start by marking down how they felt and their level of activity for the past 24 hours on the correct date. Then have your students review the MAC chart worksheet and see if there are any missing dates that they did not mark down their mood or activity level.

IF and ONLY IF students can clearly remember how they were feeling on those days have them mark that down. IF students cannot recollect how they were feeling or what their activity level was have them keep it blank.

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2. Review actions, thoughts, and feelings and mood spirals.

Note to teacher: Draw on the board the actions, thoughts, and feelings triangle.
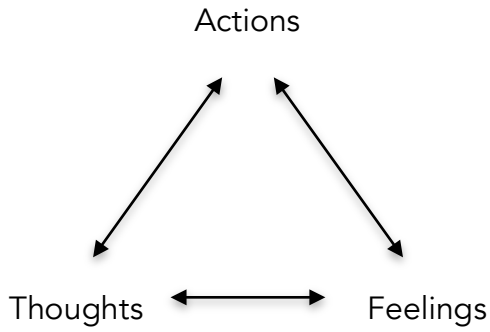
Actions

Thoughts ⟷ Feelings

REVIEW: Ask students if they remember the actions, thoughts, and feelings triangle. Ask the students if they remember what the triangle means for them? What is it supposed to remind them of?

Answer: All of three interact within us and each one can influence the other. Remind students that even if we don't think all three are present at one time, they are, and sometimes we can identify one (e.g., actions) over the other two (e.g., thoughts, actions).

NEXT: Draw an upward and downward spiral on the board.
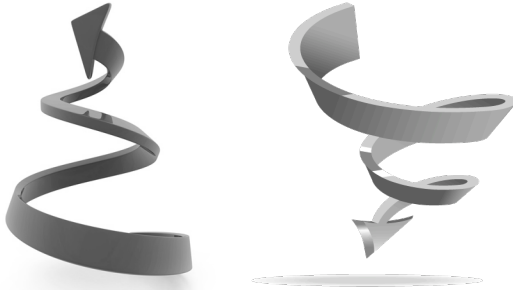
Ask students to look at their MAC chart scores since they began writing them down.

Ask your students if they can identify what actions, thoughts, and feelings contributed to having a really good day?

Ask your students if they can identify what actions thoughts or feelings contributed to them having a really bad day?

Ask your students if anyone can share a time when they felt that they were on a downward spiral and used a strategy to turn the downward spiral into an upward spiral?

IF your students can't come up with an example, tell them that is okay, tell them that the rest of the class is going to be focusing on making goals and plans so that we can all be ready to take action when we are feeling down.

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3. Goal setting and action plans. (SW pg. 25)

Start this session with reviewing what SMART goals are. **SMART** stands for:

Specific –State what you want to accomplish (include who, what, where, why)

Measurable – State how you will observe your goal being met. Make sure you can measure your progress.

A<u>chievable</u> – What are the actions you need to take? Do you have control of your ability to do these actions?

R<u>elevant</u> – Make sure your goal connects with your broader long-term goals.

T<u>imely</u> – Can your goal be accomplished within the timeline you want?

Tell your students *"last session we reviewed what SMART goals were and practiced creating a SMART goal with one SUCCESS activity. In this lesson we are going to try to go into more depth and write more goals that are specific to two things, (1) being more socially and successfully active, (2) setting plans to turn downward spirals into upward spirals."*

PART 1 – *Being more social and successfully active*

Have your students refer back to their student workbook from the previous lesson where they identified SOCIAL and SUCCESS activities.

Note to teacher: Have your students review the SOCIAL and SUCCESS activities and rank each list by what they would like to set goals, most to least. Tell them to consider each activity individually and also have them consider the amount of internal locus of control they have over each activity.

Tell your students to select the top two SOCIAL and SUCCESS activities and write them down in their student workbook for this session.

Tell your students *"These activity goals should be goals that you want to accomplish before the term ends. I want you to feel like you have been able to accomplish these goals and have taken part in some activities that are really meaningful to you!"*

Note to teacher: Walk your students through writing a goal starting with your own on the board (you can use the same example from the previous lesson or come up with a new one, for example wanting to go to more concerts with friends as a SOCIAL activity or working with your Co-teacher to create an awesome activity for your students, even if it takes a lot of work to do it as a SUCCESS activity).

Students will follow this formula in their workbook.

1. Write two SOCIAL and SUCCESS activities.
2. Write a SMART goal (with the timeline for it to be completed by the end of the term).
3. Have their partner review each goal to make sure that it is a SMART goal and to give feedback on each goal if it is not a SMART goal.

PART 2 – *Setting plans to turn downward spirals into upward spirals*

"Whenever we work with the TBD curriculum we are always talking about how our actions, thoughts, and feelings interact with each other. We have also been focusing on how our actions are extremely important as they can impact what we do, who we see, and can either start a downward or upward spiral."

"What we want to do now is really combat downward spirals with finding little actions that can be used at a choice point to change the downward spiral into an upward spiral."

"Little actions are things we can do instantaneously! They should take only a second to do, and should be something you always find enjoyable that is healthy and fun."

Give your students some Little Action Examples
- Have a fun conversation with a friend in the hallway
- Saying something positive to yourself like "I am going to conquer today"
- Stopping by a teacher's class to say hello
- Going outside and taking three big deep breaths on your own
- Listening to your favorite song at lunch

Have your students look at these examples in their workbook and think if any of these would work for them. Give them a few minutes to come up with their own "little actions" that they could use and have them write them down in the space provided.

Have your students come up with little actions that would be appropriate for school, home, and work.

5. Mood monitoring and activity chart (SW pg. 51-55)

Remind students that this curriculum is not built on homework but there are a few things that will need to be thought of outside of class. One of these things will be to utilize a mood monitoring and activity chart. This can be found in the student workbook.

Tell your students *"Our goal using this curriculum is to improve the way we feel. One way to do this is to begin monitoring how we feel throughout the course by filling out the Mood Monitoring and Activity Chart or the MAC chart. The MAC chart uses a scale from one to seven to measure our feelings and activity levels."*

Have students flip to the MAC chart and fill in their mood and activity levels from the past 24 hours. Stress that it is important for them to fill this in every day if they can.

6. Strategy to use (SW pg. 28)

The strategy for this lesson is for you to practice using little actions at home. We have talked about using little actions at school, but try using them somewhere else.

Keep a log in your student workbook what little actions you used and how it changed the way you were feeling and the situation you were in.

Session 6 – Negative and Wise Thoughts

Agenda for the session

1. Review Strategy to Use
2. Review mood monitoring and activity chart (MAC chart).
3. What are automatic thoughts?
4. What are wise thoughts?
5. Mood monitoring and activity chart.
6. Strategy to use.

Begin this lesson by reviewing the agenda with the students and by telling them *"today will be focused on transforming negative thoughts that we might have into positive WISE thoughts."*

1. Review strategy to use

Ask your students if they practice the "Strategy to Use" from the previous lesson. In the past lesson your students practiced using little actions at home. Ask your students "What little actions did you use and how did it change the way you were feeling and the situation you were in?"

2. Review mood monitoring and activity chart (SW pg. 51-55)

Have your students get their student workbook out and flip to the page with the MAC chart and their own mood/activity monitoring sheet.

Explain to your students that this is an important part of the process of understanding how our moods impact our thoughts and behaviors. Having the skills to monitor your own moods can help in the future to understand why things might not be exciting anymore or why you might not want to hang out with friends and you don't know why.

Tell your students that it is important for them to use this worksheet and mark down their mood and activity score daily. Ask your students to start by marking down how they felt and their level of activity for the past 24 hours on the correct date. Then have your students review the MAC chart worksheet and see if there are any missing dates that they did not mark down their mood or activity level. IF and ONLY IF students can clearly remember how they were feeling on those days have them mark that down. IF students cannot recollect how they were feeling or what their activity level was have them keep it blank.

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3. What are automatic thoughts?

"Automatic thoughts are thoughts that go through our brain in an instant. These thoughts typically happen after something happens to us, like, being called a name, running into an ex-boyfriend or ex-girlfriend, or driving in a car. They happen anywhere and at anytime!"

"Like the actions, thoughts, feelings triangle shows, our automatic thoughts are also connected to a lot of feelings and emotions. Many times we don't even notice that a thought occurred, we just feel good or bad."

"What is important to know is that these thoughts can contribute to us staying in a downward or upward spiral."

"Feeling good and having positive automatic thoughts is great. It is when we start feeling bad and we start having negative automatic thoughts that contribute to feeling bad."

"Sometimes these negative automatic thoughts become value judgments about ourselves. Many times these judgments we place on ourselves, without even knowing it, are completely false."

Note to teacher: Can you give an example of a negative automatic thought that you had that was not true? If you can explain to them how fast the thought came into your head and how you recognized why that thought was not true.

A student example may be: *The student received a lower grade on an assignment for class than they were expecting, and a negative automatic thought would be "I must be stupid" but this is masked with feeling sadness because they needed the better grade to go on the class fieldtrip.*

Tell your students *"the hard part with identifying an automatic thought is that it happens so fast and because we tend to feel things at the same time, we don't know that they are there. So we must be able to combat negative automatic thoughts by first being able to identify negative automatic thoughts when they happen."*

In-class Activity:

i.   Have your students take out a piece of paper and tear it into three strips (you can cut paper strips out before the activity as well and pass them out).

ii. Have your students write down on each piece of paper one event that makes them upset, angry, frustrated, sad, or happy. (Keep these events simple). Tell your students not to write their names anywhere on the strips and that they should keep them anonymous.

iii. Have your students write a number next to the event from 1 to 10 on how upset, angry, frustrated, or sad it makes them. 1 being the least and 10 being the most upset etc.

iv. Take what your students wrote down and put them in a hat/bucket/basket and shuffle them around.

v.   As you do this tell your students "we are going to do an activity about automatic thoughts. To do this activity we need to be respectful to everyone's events and not judge what anyone wrote down."

vi.   Tell your students "I am going to ask for volunteers (or identify a student to participate first) to help me. When I pull an event out of this hat, I want you to tell me how you would feel or what you would think if this event happened to you."

vii. Read the event and have the student respond to the questions.

viii. Once the student has responded to the question, tell the student what level this was marked, ask them if the event would put them on the same level (1 to 10) or not, and what level they would identify for themselves for this event.

ix.   Repeat this activity by pulling out more events and choosing different students to participate.

x.   *Note to teacher:* The end message of this activity is for students to identify different automatic thoughts and feelings, but also realize that different people react differently to different events and that our automatic thoughts can be different from person to person, but that we all have them.

"Once we are able to identify what our negative automatic thoughts are, then the next step is to change them into the wise thoughts!"

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4. What are wise thoughts?

Wise thoughts are accurate, logical, and true thoughts that are <u>not</u> exaggerated, filled with emotions, untrue or irrational.

If our automatic thoughts can be negative, exaggerated, and untrue, then we want to correct those thoughts to be wise thoughts!

Give your students this example:

Leslie was texting her friend a couple hours after school got out. They were talking about someone Leslie really liked in her class. This conversation was really important to Leslie because she had been waiting to tell her friend about it for a long time.

Mid-way through their conversation, Leslie's friend stops responding to her text messages. Leslie gets upset and text back "Why are you ignoring me? This is really important! I thought you were my friend!"

Leslie's negative automatic thoughts tell her, that she is being ignored, and that her friend might say something to someone else about her secret.

What Leslie can do is identify the negative automatic thought and change it to a wise thought. Leslie can consider what could be an alternative reason for WHY her friend hasn't responded yet.

What Leslie concludes is that her friend was probably called to have dinner and that her friend did not have her phone with her, and that she should just wait patiently for her friend to respond in a little bit.

Ask your students *"can any of you relate to this example?"* Ask students to share what an example of their automatic negative thought was and how they turned it into a wise thought.

After your students share any similar experiences, tell them you are going to practice as a group.

In-class Activity:

    i.   Split your class into two sides. Label one group the "Negative Thoughts" and label the other group "Wise Thoughts."

    ii.   Tell your students "I am going to read a scenario/event. I am going to give the Negative thought group to come up with their best automatic negative thought. Remind your students that they can exaggerate and

their thoughts can be untrue.

iii. Then I will allow time for students in the Wise Thought group to come up with the BEST alternative Wise thought that could provide a rationale explanation for the event.

iv. Practice two or three times and then switch the groups.
    a. You just got a D on an assignment.
        i. Negative example: I'm stupid and how can I do well in this class if I can't do well on this assignment.
        ii. Wise example: I didn't put my best work into the assignment, next time I need to put in more effort.
    b. Your teacher just told you to be quiet in front of the whole class.
        i. Negative example: The teacher is out to get me; I was only talking a little bit.
        ii. Wise example: I should of waited until it is an okay time to talk.
    c. Your friend did not show up for lunch when they said they would.
        i. Negative example: I bet they forgot about me, I am probably not that good of a friend.
        ii. Wise example: I should probably check in with them in case something happened and they need help.
    d. Your teacher confronted you and said he thought you cheated on an assignment.
        i. Negative example: It sucks that the teacher doesn't think I can do quality work on my own.
        ii. Wise example: I can explain to the teacher in a professional manner that I did not cheat and ask why they believe that so I can explain any misunderstandings.
    e. You thought you heard someone call you a name in the hallway.
        i. Negative example: People at this school really don't like me.
        ii. Wise example: I don't really know that person, they probably were not talking to me, and I probably heard that wrong. I shouldn't get upset.

    f. Your boyfriend or girlfriend wouldn't let you hold their hand in the hallway.
        i. Negative example: I bet he/she is going to break up with

      ii. Wise example: It is really crowded in the hallway and it is easier to get through without holding hands.

  g. You thought you saw people talking about you when you walked into class.

      i. Negative example: I bet people think what I am wearing is ugly.

      ii. Wise example: I bet they weren't talking about me, and it doesn't matter because I am having a great day.

v.   After you have practiced and both groups have had a chance to be a Negative Thought and Wise Thought group. Ask them *"What type of thinking makes you feel better and more assured?"*

vi.   Reinforce that Wise thoughts are accurate, logical, and true, and from there we can feel better about ourselves and our interactions with our environment and the people around us.

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5. Mood monitoring and activity chart (SW pg. 51-55)

Remind students that this curriculum is not built on homework but there are a few things that will need to be thought of outside of class. One of these things will be to utilize a mood monitoring and activity chart. This can be found in the student workbook.

Tell your students *"Our goal using this curriculum is to improve the way we feel. One way to do this is to begin monitoring how we feel throughout the course by filling out the Mood Monitoring and Activity Chart or the MAC chart. The MAC chart uses a scale from one to seven to measure our feelings and activity levels."*

Have students flip to the MAC chart and fill in their mood and activity levels from the past 24 hours. Stress that it is important for them to fill this in every day if they can.

6. Strategy to use (SW pg. 30)

Over the next couple of days, I want you to start monitoring any negative thoughts that come through your head. Write down in your student workbook any negative thoughts that come up multiple times during the day and try writing down a wise thought in its place. Then practice changing the thought from negative to wise the next time a negative thought enters your mind.

Session 7 – Depression

1. Review strategy to use.
2. Review mood monitoring and activity chart (MAC chart).
3. What is depression?
4. Depression and our environment.
5. Depression and school.
6. Check-in on goals.
7. Mood monitoring and activity chart.
8. Strategy to use.

Begin this lesson by reviewing the agenda with the students and by telling them *"today we will be learning about what depression is and how depression can impact our schooling and other aspects of our life."*

1. Review strategy to use

Ask your students if they practiced the "Strategy to Use" from the previous lesson. In the past session your students were monitoring negative thoughts that would come to them. They were supposed to write down any negative thought that came up multiple times and then turned those negative thoughts into WISE thoughts. Did anyone do this? If so, how did it work for you? Could you give an example?

2. Review mood monitoring and activity chart (SW pg. 51-55)

Have your students get their student workbook out and flip to the page with the MAC chart and their own mood/activity monitoring sheet.

Explain to your students that this is an important part of the process of understanding how our moods impact our thoughts and behaviors. Having the skills to monitor your own moods can help in the future to understand why things might not be exciting anymore or why you might not want to hang out with friends and you don't know why.

Tell your students that it is important for them to use this worksheet and mark down their mood and activity score daily. Ask your students to start by marking down how they felt and their level of activity for the past 24 hours on the correct date. Then have your students review the MAC chart worksheet and see if there are any missing dates that they did not mark down their mood or activity level. IF and ONLY IF students can clearly remember how they were feeling on those days have them mark that down. IF students cannot recollect how they were feeling or what their activity level was have them keep it blank.

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3. What is depression?

Your students have probably heard of the word depression before, start this section by asking your students *"What is depression?"*

DEFINITION: Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. (Depression can be caused by an event or could be more of a chronic illness).

Write a synopsis on the board of the words your students use. Most likely students will identify what the symptoms of depression are, not what depression is.

- Examples of depressive symptoms include: anger, withdrawal, hypersensitivity to criticism, sadness, worry, loss of interest in pleasant activities, tiredness, significant weight loss or weight gain, abuse alcohol or drugs.

Note to teacher: Be aware of students sharing things that are too personal. Remind the classroom that what is shared in this class remains in the class, and

that we should all have mutual trust with one another. Please follow any mandatory reporting procedures if they are necessary.

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4. Depression and our environment.

Keep the list of depressive symptoms that the students came up with on the board. Add any symptoms that were given as examples that students did not come up with.

Tell your students *"sometimes we don't realize that we are feeling depressed. Our actions might change without knowing why and our moods might change without understanding why."*

"What is even more difficult to understand is how depression impacts our environment when we don't really know how it impacts us. To help us understand lets use a visual."

In-class activity:

i.   Draw on the board next to the list, a large square and tell your students it is a box full of water.

ii.   Then draw a dot in the middle of the square. Tell your students that you just dropped a rock in this box of water. Ask them "*what will happen to the water?* "

iii. Your students should answer: "There will be a ripple effect."

iv.   Draw the ripples going out towards the edge of the box with an arrow pointing out.

v.   Then ask your students, *"What is going to happen when the ripples hit the edge of the box?"*

vi.   Your students should answer: "The ripples will bounce back."

vii. Then draw another arrow back towards the center point.
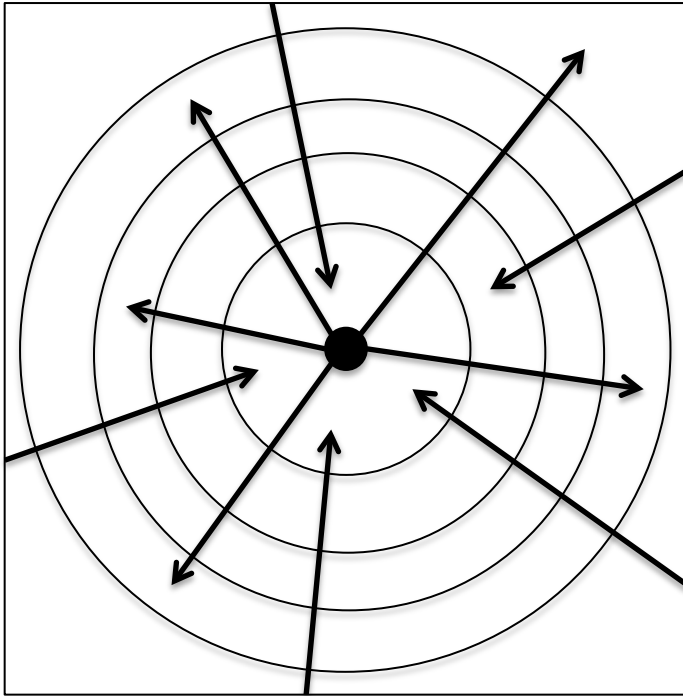
Tell your students *"this is similar to how depression can impact us and our environment. When we become depressed, whether we know it is happening or not, we are impacting our environment. Like the rock being dropped into the water, our environment changes and we start to perceive our environment differently because we are on the receiving end of other peoples reaction to us."*

"Just as depression impacts us because we are feeling sad or upset, it also impacts the people around us."

Ask your students: *"Give me an example of how one of these symptoms of depression we might feel impact our friends or our family."* Ask students to identify how the other symptoms can impact their peers and family.

5. Depression and school. (SW pg. 31)

"Just like depression impacting our relationships and environments outside of school, depression can have a BIG impact on our relationships with peers, teachers, and even school work."

Ask your students *"how do you think depression can impact our school work?"*

Remind them to review the list of symptoms if they are having a difficult time coming up with ideas.

- Examples: We are late to class, we don't pay attention in class because we are thinking of other things, we don't want to see our friends in the hallways, we don't do our homework or we don't do assignments to the best of our abilities, we stop caring about getting bad grades.

Note to teachers: IF you feel comfortable you can share your own experience about how you think "feeling down" impacts your ability to teach that day or your interactions with students.

Empathize with your students about how being depressed is something difficult to go through, and a lot of students their age experience some form of depression.

Normalize the idea that a student may face an episode of depression due to a specific event (loss of a pet, break up with a boyfriend or girlfriend, families splitting up) and that no one should go through something that is this difficult alone.

Tell your students *"there are places and people to go to if you need help."* Tell them *"first, that as a teacher I am here and will have an open ear to make sure you (the students) get the help they need. Also, if you don't feel comfortable talking to me I can connect you with someone at our school that helps students going through difficult times."*

Another thing that is also difficult, in addition to feeling depressed is asking for help! Sometimes when we need it the most, it is hardest to ask. But this is critical so that we can make sure we can get the help we need.

In-class activity (questions are in student workbook):

   i.   Tell your students to partner up. For this activity they are going to come up with ways to ask for help.

   ii. Ask your students to think of the best way to talk to their teacher or counselor about how depression is impacting their schooling.

   iii. Then ask them, what they think the teacher our counselor would say to the student after they came to them with the problem.

   iv. IF you feel comfortable, tell your students if you agree or not, how the teacher/counselor would respond and give an example of what you'd say if it actually happened.

Wrap-up: Tell your students: "by asking for help you are changing the environment. This happens because when you feel depressed it feels like you don't have control, but by taking ACTION you are beginning to have more control over your environment. And by taking ACTION that impacts our thoughts and our feelings just like the triangle we have talked about throughout these sessions.

6. Check-in on goals. (SW pg. 32)

Remind your students that in sessions 4 and 5 they thought about making goals to increase both SOCIAL and SUCCESS activities.

Ask your students: "*Did any of you take action to achieving your goals OR did any of you accomplish a goal you set for yourself?*"

If any of the students did, praise them for their EFFORT and WORK towards their goal.

If students did not take any action towards their goal tell them to look at their student workbook and review their goal. In the space provided in the session 7 part of the workbook, have students rewrite their goals and come up with smaller steps to achieve one or two goals that they can complete before the end of the next three sessions.

Tell your students that you will be checking in with them during the last sessions to see if they accomplished any of their SOCIAL or SUCCESS goals.

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7. Mood monitoring and activity chart (SW pg. 51-55)

Remind students that this curriculum is not built on homework but there are a few things that will need to be thought of outside of class. One of these things will be to utilize a mood monitoring and activity chart. This can be found in the student workbook.

Tell your students *"Our goal using this curriculum is to improve the way we feel. One way to do this is to begin monitoring how we feel throughout the course by filling out the Mood Monitoring and Activity Chart or the MAC chart. The MAC chart uses a scale from one to seven to measure our feelings and activity levels."*

Have students flip to the MAC chart and fill in their mood and activity levels from the past 24 hours. Stress that it is important for them to fill this in every day if they can.

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8. Strategy to use (SW pg. 34)

Over the next few days or over the weekend, share some time with a friend. Challenge yourself to have a long conversation with them without your phones or being distracted by a movie or TV show. Spend a couple hours walking around outside and talking about whatever you want. You can do this with one

friend or a group of friends. But the rule is to not be distracted by electronics and to have real time together.

Together as a group or with your friend plan other times where you have similar interactions, without being distracted.

Session 8 – Anxiety

1. Review strategy to use.
2. Review mood monitoring and activity chart (MAC chart)
3. What is anxiety?
4. Anxiety and our environment.
5. Anxiety and school.
6. Check-in on goals.
7. Mood monitoring and activity chart.
8. Strategy to use.

Begin this lesson by reviewing the agenda with the students and by telling them "today we will be learning about what anxiety is and how it impacts our schooling and other people and environments we interact with."

1. Review strategy to use

Ask your students if they practice the "Strategy to Use" from the previous lesson. In the past lesson your students were supposed to share some time with a friend. They were challenged to have a long conversation with their friend or group of friends without any distractions (no TV, phones, games). It was suggested they go outside if they can.

How did your students react to doing this?

2. Review mood monitoring and activity chart (SW pg. 51-55)

Have your students get their student workbook out and flip to the page with the MAC chart and their own mood/activity monitoring sheet.

Explain to your students that this is an important part of the process of understanding how our moods impact our thoughts and behaviors. Having the skills to monitor your own moods can help in the future to understand why things might not be exciting anymore or why you might not want to hang out with friends and you don't know why.

Tell your students that it is important for them to use this worksheet and mark down their mood and activity score daily. Ask your students to start by marking down how they felt and their level of activity for the past 24 hours on the correct date. Then have your students review the MAC chart worksheet and see if there are any missing dates that they did not mark down their mood or activity level. IF and ONLY IF students can clearly remember how they were feeling on those days have them mark that down. IF students cannot recollect how they were feeling or what their activity level was have them keep it blank.

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3. What is anxiety?

Your students have probably heard of the word anxiety before, start this section by asking your students *"What is anxiety?"*

DEFINITION: Anxiety is the persistent and unrealistic fear and worrying about everyday life activities.

Write a synopsis on the board of the words your students use. Most likely students will identify the symptoms of anxiety and not what anxiety is.

- Examples of anxiety symptoms include: persistent worrying, irrational fears, restlessness, trouble concentrating, overly emotional, frequent somatic symptoms (e.g., headaches, stomachaches), abuse alcohol or drugs.

Note to teacher: Be aware of students sharing things that are too personal. Remind the classroom that what is shared in this class remains in the class, and that we should all have mutual trust with one another. Please follow any mandatory reporting procedures if they are necessary.

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4. Anxiety and the environment.

"Like our discussion about depression, we are also going to talk about how anxiety can impact our environment."

Ask your students *"What are ways that having anxiety can impact our environment?"*

Write down student responses on the board. (***Note to teachers:*** that the next section will refer to some of these answers so don't erase them off of the board).

Ask your students *"How do other people who have anxiety impact ourselves?"* Remind your students of the ripple effect that you discussed in the previous lesson.

In-class activity:

i. ***Note to teacher:*** Draw a Venn diagram on the board with a large middle section. On top of one circle write Depression and on top of the other circle write Anxiety.

ii. Ask your students "Can you think back to our discussion on depression and the environment? What were some of the characteristics of depression?

iii. Fill in one side of the Venn diagram. Then refer to your previous discussion on anxiety and ask your students what are some characteristics of anxiety and fill in the other side of the Venn diagram.

iv. Do you see any similarities between how depression and anxiety impact us and our environment? What are they?" Fill in the center of the diagram.

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5. Anxiety and school. (SW pg. 35)

"To combat anxiety it is important to know in what contexts we begin to feel anxious. Sometimes we don't know if we are anxious but we do begin to start feeling some of the symptoms I mentioned before like worrying, restlessness, trouble concentrating, and stomach aches."

Have students list times and places of when and where they begin to feel anxious in their workbook. Have students take a look at some of the suggestions and have them circle the suggestions if they match, if not, use the space provided to write down their own.

Suggestions:

- Coming to school
- Taking a test
- Hanging out with friends
- Hanging with your girlfriend or boyfriend
- Giving a presentation
- Doing homework in class
- Doing homework at home
- Going to a certain class
- Changing classrooms

Tell your students *"like depression, when we start feeling anxious we begin to withdraw from the situation, we might try to avoid it all together! Sometimes this happens quickly and automatically, sometimes this happens because we start thinking about a situation and can't get it out of our head."*

Remind your students *"The important thing to remember is that WE have control! We can take charge by Acting and not withdrawing. That is a big lesson to be learned."*

So when you start to feel anxious or depressed I want you to think of CHARGE, like you are charging ahead and taking control and not letting things overcome the person you truly are.

Note to teachers: Write the following on the board (this is also in the student workbook).

CHARGE is an acronym

C	Stands for Control and reminding yourself you are in Control
H	Stands for being Healthy in your thoughts (e.g., being positive) and actions (e.g., exercising and eating right)
A	Stands for seeking Advice and getting help when you begin to feel either depressed or anxious
R	Stands for using Rational and WISE thinking
G	Stands for setting Goals to overcome barriers
E	Stands for Energizing yourself to take action

In-class activity:

  i.   Have your student's use one of the situations they circled or came up with when they were anxious.

  ii. In their student workbook have them fill out individually the "How would I section."

  iii. The "How would I" provides space for students to think about how they would approach a situation that may make them feel anxious using the CHARGE acronym.

You can provide the below example to demonstrate how to use the acronym.

Taking a test example:

C	I tell myself that I can do well on the test and that I know the material that I need to know and I will do the best that I possibly can
H	I made sure that I got plenty of sleep the night before and ate breakfast/or a snack so I wouldn't be hungry
A	I thought this test may take me a long time, so I made sure the teacher could give me extra time, like my IEP says, to make sure I can finish it.
R	Instead of thinking of failing the test, I think that I have learned a lot of material and that I studied hard and I will do the best I can.
G	My goal is to not get overwhelmed; my strategy is to do one page of the test at a time so I don't get too stressed out during the exam.
E	I tell myself "I CAN DO THIS!"

6. Check-in on goals. (SW pg. 37)

Remind your students that in sessions 4 and 5 they thought about making goals to increase both SOCIAL and SUCCESS activities.

Ask your students: "*Did any of you take action to achieving your goals OR did any of you accomplish a goal you set for yourself?*"

If any of the students did, praise them for their EFFORT and WORK towards their goal.

If students did not take any action towards their goal tell them to look at their student workbook and review their goal. In the space provided in the session 8 part of the workbook, have students rewrite their goals and come up with

smaller steps to achieve one or two goals that they can complete before the end of the next three sessions.

Tell your students that you will be checking in with them during the last sessions to see if they accomplished any of their SOCIAL or SUCCESS goals.

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7. Mood monitoring and activity chart (SW pg. 51-55)

Remind students that this curriculum is not built on homework but there are a few things that will need to be thought of outside of class. One of these things will be to utilize a mood monitoring and activity chart. This can be found in the student workbook.

Tell your students *"Our goal using this curriculum is to improve the way we feel. One way to do this is to begin monitoring how we feel throughout the course by filling out the Mood Monitoring and Activity Chart or the MAC chart. The MAC chart uses a scale from one to seven to measure our feelings and activity levels."*

Have students flip to the MAC chart and fill in their mood and activity levels from the past 24 hours. Stress that it is important for them to fill this in every day if they can.

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8. Strategy to use (SW pg. 39)

This session's strategy to use is to focus on two parts of CHARGE. What I would like you to do is to come up with one thing that you can do/change between now and the next session to be Healthy in your thoughts and actions. Then create a plan to energize yourself to make those changes so you will act on them!

Session 9 – Coping Strategies

1. Review strategy to use.
2. Review mood monitoring and activity chart (MAC chart).
3. Relaxation.
4. Journaling.
5. Check-in on goals.
6. Mood monitoring and activity chart.
7. Strategy to use.

Begin this lesson by reviewing the agenda with the students and by telling them "today we will go over a variety of strategies that can help us deal with daily stressors and stressors that may last a while."

1. Review strategy to use

Ask your students if they practice the "Strategy to Use" from the previous lesson. In the past lesson your students were to use two part of CHARGE. Students were supposed to come up with one thing that they could do/change between now and this session to be Healthy in their thoughts and actions. Then, they were supposed to create a plan to energize them to make those changes so you will act on them! Ask you students, what changes did they make? How did they energize themselves?

2. Review mood monitoring and activity chart (SW pg. 51-55)

Have your students get their student workbook out and flip to the page with the MAC chart and their own mood/activity monitoring sheet.

Explain to your students that this is an important part of the process of understanding how our moods impact our thoughts and behaviors. Having the skills to monitor your own moods can help in the future to understand why things might not be exciting anymore or why you might not want to hang out with friends and you don't know why.

Tell your students that it is important for them to use this worksheet and mark down their mood and activity score daily. Ask your students to start by marking down how they felt and their level of activity for the past 24 hours on the correct date. Then have your students review the MAC chart worksheet and see if there are any missing dates that they did not mark down their mood or activity level. IF and ONLY IF students can clearly remember how they were feeling on those days have them mark that down. IF students cannot recollect how they were feeling or what their activity level was have them keep it blank.

3. Relaxation (SW pg. 40)

Tell your students that you are going to teach them a relaxation technique they probably never have used before, but before you share it, you want to hear from them.

Have your students raise their hands and share what they do to relax during a typical day.

Tell your students that they are going to practice a new technique in class. A technique called Deep Relaxation.

"Deep relaxation can help us when we begin to feel tense." Ask your students *"What does it mean to feel tense?"*

After your students have shared what it means for them to feel tense, tell them that this technique can help.

In-class activity:

i. *Ask your students…are you ready to practice?*

ii. *Practice: First have your students tense their fists. Have them practice so they can feel that when we say tense we mean clenched and tight.*

iii. *Then have your students tense their arms and hands. Make sure they don't tense anything else and for them to just focus on their arms and hands. Hold this for 5 to 7 seconds.*

iv. *Now relax your arms and hands. Imagine all the energy going out of your arms through your fingertips. Your arms are as relaxed as spaghetti noodles. You couldn't life a finger.*

v. *Now, tense your face and head. Lift your eyebrows, squint your eyes, clench your teeth. Make every muscle in your head as tight as you possibly can. Hold this for 5 to 7 seconds.*

vi. *Now relax your face and head. Let your jaw relax, your eyelids close, and your eyebrows relax. Now all of the energy is leaving your face.*

vii. *Now tense your shoulders and back, chest, and stomach. Take a deep breath and hold it. Make your shoulders and back as tight as you can. Pull your stomach muscles up tight. Don't tighten your arms just your chest and main body. Hold it. Keep it tight, tight, tight. Hold this for 5 to 7 seconds.*

viii. *Now relax. Breathe out, and let yourself breath normally. Relax all of those muscles. Notice your deep, rhythmic breathing and the pleasant sensations it produces.*

> *ix. Now tense your legs. Tense your thighs. Lift your legs slightly off the ground. Press your knees together. Tighten your calves. Press your toes against the floor. Tighten your feet. Turn them up and point them toward your head. Hold for 3 to 5 seconds.*
>
> *x. Now relax. Tell your students to close their eyes. Let all of the tension in your body go out through the tips of your toes. Every last drop of energy is gone from your body. You are totally relaxed. Imagine yourself on a warm beach with the sun shining on your totally relaxed body. You don't have a care in the world.*
>
> *xi. Wait in this position for 2 to 3 minutes reminding your students to breathe occasionally.*
>
> *xii. Now tell your students to open their eyes. Have them begin to slowly start wiggling their fingers and toes and to slowly start moving their arms and legs.*

4. Journaling (SW pg. 41)

"Like the relaxation technique, where we were able to relax by releasing tension in our body, journaling can be a technique that allows us to release thoughts that are flowing in our head blocking our ability to think clearly."

"This kind of journaling is more than about the gossip of the day or how your sibling did something that really bothered you. This type of journaling is about taking the time to think about your feelings and the how the events of the day impacted your thoughts and behaviors."

"Remember how we talked about having automatic thoughts. They happen instantaneously, and how these thoughts can be more emotional rather than wise. Think about journaling as a way to slow down your thought process, which makes us think about situations and events differently than when they first flow through our heads."

"If you are seeing a therapist, and if you feel comfortable, you can share what you have written down in your journal as a way to document your feelings and thought process. Which can make therapy even more effective."

"The important thing to remember about journaling is that it doesn't have to be a literary work that is going to win awards, these are your thoughts and your internal processes."

"What is important is that as you write you become aware of how you write about certain events and see how things have changed the way we feel, for example if something makes us more anxious or depressed."

In-class activity:

i. If you have time ask your class to begin a quick 5-minute journaling activity.

ii. Tell them to begin writing about something that made them feel good in the past 24 hours.

iii. Direct your students to think deeply about why that event made them feel good. Your students can use the What, Where, When, Why, and How questions to help them think deeply about the event. In addition, talk to them to make sure they include how their actions, thoughts, and feelings all were interacting during that positive situation.

Tell your students *"for journaling to help it is important to take it seriously and to think deeply about actions, thoughts, and feeling and reflect back on what you have written down."*

5. Check-in on goals. (SW pg. 43)

Remind your students that in sessions 4 and 5 they thought about making goals to increase both SOCIAL and SUCCESS activities.

Ask your students: *"Did any of you take action to achieving your goals OR did any of you accomplish a goal you set for yourself?"*

If any of the students did, praise them for their EFFORT and WORK towards their goal.

If students did not take any action towards their goal tell them to look at their student workbook and review their goal. In the space provided in the session 9 part of the workbook, have students rewrite their goals and come up with smaller steps to achieve one or two goals that they can complete before the end of the next three sessions.

Tell your students that you will be checking in with them during the last sessions to see if they accomplished any of their SOCIAL or SUCCESS goals.

6. Mood monitoring and activity chart (SW pg. 51-55)

Remind students that this curriculum is not built on homework but there are a few things that will need to be thought of outside of class. One of these things will be to utilize a mood monitoring and activity chart. This can be found in the student workbook.

Tell your students *"Our goal using this curriculum is to improve the way we feel. One way to do this is to begin monitoring how we feel throughout the course by filling out the Mood Monitoring and Activity Chart or the MAC chart. The MAC chart uses a scale from one to seven to measure our feelings and activity levels."*

Have students flip to the MAC chart and fill in their mood and activity levels from the past 24 hours. Stress that it is important for them to fill this in every day if they can.

189

7. Strategy to use (SW pg. 44)

Have your students practice either the relaxation technique or journaling between now and the next session.

Session 10 – Problem Solving

1. Review strategy to use.
2. Review mood monitoring and activity chart (MAC chart).
3. Problem Solving and problem solving strategies.
4. Check-in on goals.
5. Wrap-up.
6. Thank you.

Begin this lesson by reviewing the agenda with the students and by telling them "today we will learn a quick and easy problem solving tool so we can learn and practice how best to deal with difficult situations. "

1. Review strategy to use

Ask your students if they practiced the "Strategy to Use" from the previous session. In the past session your students were asked to practice either the relaxation technique or journaling. Ask your students who practiced journaling? How practiced relaxation? Did anyone practice both of them?

2. Review mood monitoring and activity chart (SW pg. 51-55)

Have your students get their student workbook out and flip to the page with the MAC chart and their own mood/activity monitoring sheet.

Explain to your students that this is an important part of the process of understanding how our moods impact our thoughts and behaviors. Having the

191

skills to monitor your own moods can help in the future to understand why things might not be exciting anymore or why you might not want to hang out with friends and you don't know why.

Tell your students that it is important for them to use this worksheet and mark down their mood and activity score daily. Ask your students to start by marking down how they felt and their level of activity for the past 24 hours on the correct date. Then have your students review the MAC chart worksheet and see if there are any missing dates that they did not mark down their mood or activity level. IF and ONLY IF students can clearly remember how they were feeling on those days have them mark that down. IF students cannot recollect how they were feeling or what their activity level was have them keep it blank.

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3. Problem solving and problem solving strategies
(SW pg. 45)

"When we are faced with a crisis we need to know what is going to be the best response for the situation."

"Sometimes when things seem to be going so fast we think that things are out of our control, but we know that is not true. We just have to learn how to take control back. Taking control of a difficult situation can be done by problem solving."

"Problem solving allows us to slow a situation down, think about all of the events and different outcomes that could happen, and decide to make the right choice with the best outcome for ourselves."

"It is a pretty easy concept, and one that we have talked about before. Yet, there are times when we forget to problem solve. There are also times when we might feel so bad that our feelings consume us and we forget that we CAN take control by problem solving."

Ask your students, *"Have you ever been in a situation where if you could do it over again, you would?"* Have students respond. Remind them to give examples that are not too personal.

192

Follow-up: *"Think about that situation, if you just did a little problem solving, do you think a different outcome would have happened?"* Have students respond. Remind them to give examples that are not too personal.

Note to teachers: If you feel comfortable, give an example of an event where if you did a little problem solving things may have turned out differently than they actually did.

"The strategy we are going to use will be easy to remember because it is the title of this curriculum. The strategy is Think, Be, and Do."

THINK, BE, DO Problem Solving Strategy	
THINK	Think, stands for stopping and thinking about the problem at hand. • What started the problem? • How am I impacted by the problem? • Who else is impacted by the problem? • What can be done about the problem?
BE	Be, stands for being aware of all the options to solve the problem at hand. • What are the different ways this problem can be solved? • Who do I need to work with to solve this problem? • When is the best time to address the problem?

193

DO	Do, stands for choosing the best option to solve the problem and doing it. • Plan the best way for you to approach the problem. • Work with those impacted by the problem to solve it. • Carry out the choice on how to solve the problem. • Evaluate the outcome to make sure the problem has been solved.

In-class Activity:

i. Tell your students that they will be working with partners throughout the Think, Be, Do steps.

ii. Have your students individually brainstorm for 5 – 10 minutes about any issues with school (of if you feel comfortable, open the options to issues with peer relationships or family) they might be having. There is space provided in their student workbook for them to write down whatever issues they may have.

iii. Partner your students up to talk about one problem each they would like to work through together.

iv. Tell the students to use the worksheet in their student workbook to:
   a. Write a problem statement.
   b. Think about the problem.
   c. Be aware of options and write them down.
   d. Choose the best option and write what the plan of action will be.

v. Give your students 10 – 15 minutes to work through one problem each.

vi. After, have students share a school problem they may be having and

what they wrote down for the Think, Be, Do steps.

vii.   Get CONSTRUCTIVE FEEDBACK from the entire class on how best to approach the problem.

viii.   *Note to teacher:* One main objective of this activity is to show students that there are always multiple options on how to approach a problem. The best problem solvers think about all of their options and act on the best one. By getting feedback from peers students can see that different people approach problems differently. We all need to be aware of this, so we can work together to solve the problem at hand.

4. Check-in on goals. (SW pg. 48)

Note to teacher: If there is time, have your students partner up and utilize the Think, Be, Do problem solving strategy to overcome any barriers to achieving the goals they have set for themselves.

Remind your students that in sessions 4 and 5 they thought about making goals to increase both SOCIAL and SUCCESS activities.

Ask your students: "*Did any of you take action to achieving your goals OR did any of you accomplish a goal you set for yourself?*"

If any of the students did, praise them for their EFFORT and WORK towards their goal.

If students did not take any action towards their goal tell them to look at their student workbook and review their goal. In the space provided in the session 10 part of the workbook, have students rewrite their goals and come up with smaller steps to achieve one or two goals that they can complete before the end of the next three sessions.

Tell your students that you will be checking in with them during the last sessions to see if they accomplished any of their SOCIAL or SUCCESS goals.

5. Wrap-up.

Review with your students that the point of this curriculum is to help provide strategies to deal with common issues like depression or anxiety. It also reminds them that they are in control of their lives. Even when things seem out of control, they now have the skills to evaluate how their actions, thoughts, and feelings interact, and how they interact with the environment around them.

Remind your students that you are available to talk if they have any questions with the completion of the Think, Be, Do curriculum.

Collect your students Daily Mood and Activity chart at the end of their student workbook, but remind them that their workbook is something for them to hold onto and something they can use in the future if they need a reminder of the strategies they practiced in class.

6. Thank You

Dear Teachers and Students,

I would like to personally thank you for the generous time and effort you gave to implement and participate in the Think, Be, Do curriculum. I hope that you were able to learn some valuable skills to address the most common of issues that all people face during their development into adulthood. My hope is that you have benefited from this curriculum and that you will utilize the curriculum in the future when needed.

As a reminder to always know that we are in control of our lives I would like to quote Cheryl Strayed from her book *Wild*, "It was a deal I'd made with myself months before and the only thing that allowed me to hike alone. I knew that if I allowed fear to overtake me, my journey was doomed. Fear, to a great extent, is born of a story we tell ourselves, and so I chose to tell myself a different story from the one women are told. I decided I was safe. I was strong. I was brave. Nothing could vanquish me. Insisting on this story was a form of mind control, but for the most part it worked. Every time I heard a sound of unknown origin or felt something horrible in my imagination, I pushed it away. I simply did not let myself become afraid. Fear begets fear. Power begets power. I willed myself to beget power. And it wasn't long before I actually wasn't afraid."

Be powerful, be brave, and be strong.

Thank you,
James Sinclair

MAC - Mood Rating Scale

1. A score of one resembles feeling very depressed and/anxious.

2. A score of two resembles feeling down/anxious/a feeling of being overwhelmed.

3. A score of three resembles feeling a bit worse than just okay.

4. A score of four resembles feeling fair/just okay/"flat".

5. A score of five resembles feeling "okay"/"pretty good" and better than feeling just okay.

6. A score of six resembles feeling happy but that you could be happier.

7. A score of seven resembles feeling very happy and positive.

MAC - Activity Rating Scale

 1. I don't want to participate in any activities or be with friends.

 2. Activities that used to interest me don't really anymore.

 3. My energy is low and being with friends and family doesn't sound good to me.

 4. A score of four resembles feeling fair/just okay/"flat".

 5. Friends and family interest me.

 6. I enjoy being with friends and family.

 7. I want to be with friends and family.

Week 1

M	A	M	A	M	A	M	A	M	A	M	A	M	A
7	7	7	7	7	7	7	7	7	7	7	7	7	7
6	6	6	6	6	6	6	6	6	6	6	6	6	6
5	5	5	5	5	5	5	5	5	5	5	5	5	5
4	4	4	4	4	4	4	4	4	4	4	4	4	4
3	3	3	3	3	3	3	3	3	3	3	3	3	3
2	2	2	2	2	2	2	2	2	2	2	2	2	2
1	1	1	1	1	1	1	1	1	1	1	1	1	1
Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	

Week 2

M	A	M	A	M	A	M	A	M	A	M	A	M	A
7	7	7	7	7	7	7	7	7	7	7	7	7	7
6	6	6	6	6	6	6	6	6	6	6	6	6	6
5	5	5	5	5	5	5	5	5	5	5	5	5	5
4	4	4	4	4	4	4	4	4	4	4	4	4	4
3	3	3	3	3	3	3	3	3	3	3	3	3	3
2	2	2	2	2	2	2	2	2	2	2	2	2	2
1	1	1	1	1	1	1	1	1	1	1	1	1	1
Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	

M = Mood Rating
1. A one resembles feeling very depressed and/anxious.
2. A two resembles feeling down/anxious/a feeling of being overwhelmed.
3. A three resembles feeling a bit worse than just okay.
4. A four resembles feeling fair/just okay/"flat".
5. A five resembles feeling "okay/pretty good" and better than feeling just okay.
6. A six resembles feeling happy but that you could be happier.
7. A seven resembles feeling very happy and positive.

A = Activity Rating
1. I don't want to participate in any activities or be with friends.
2. Activities that used to interest me don't really anymore.
3. My energy is low and being with friends and family doesn't sound good to me.
4. A score of four resembles feeling fair/just okay/"flat".
5. Friends and family interest me.
6. I enjoy being with friends and family.
7. I want to be with friends and family.

Week 3

M	A	M	A	M	A	M	A	M	A	M	A	M	A
7	7	7	7	7	7	7	7	7	7	7	7	7	7
6	6	6	6	6	6	6	6	6	6	6	6	6	6
5	5	5	5	5	5	5	5	5	5	5	5	5	5
4	4	4	4	4	4	4	4	4	4	4	4	4	4
3	3	3	3	3	3	3	3	3	3	3	3	3	3
2	2	2	2	2	2	2	2	2	2	2	2	2	2
1	1	1	1	1	1	1	1	1	1	1	1	1	1
Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	

Week 4

M	A	M	A	M	A	M	A	M	A	M	A	M	A
7	7	7	7	7	7	7	7	7	7	7	7	7	7
6	6	6	6	6	6	6	6	6	6	6	6	6	6
5	5	5	5	5	5	5	5	5	5	5	5	5	5
4	4	4	4	4	4	4	4	4	4	4	4	4	4
3	3	3	3	3	3	3	3	3	3	3	3	3	3
2	2	2	2	2	2	2	2	2	2	2	2	2	2
1	1	1	1	1	1	1	1	1	1	1	1	1	1
Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	

M = Mood Rating

1. A one resembles feeling very depressed and/anxious.
2. A two resembles feeling down/anxious/a feeling of being overwhelmed.
3. A three resembles feeling a bit worse than just okay.
4. A four resembles feeling fair/just okay/"flat".
5. A five resembles feeling "okay/pretty good" and better than feeling just okay.
6. A six resembles feeling happy but that you could be happier.
7. A seven resembles feeling very happy and positive.

A = Activity Rating

1. I don't want to participate in any activities or be with friends.
2. Activities that used to interest me don't really anymore.
3. My energy is low and being with friends and family doesn't sound good to me.
4. A score of four resembles feeling fair/just okay/"flat".
5. Friends and family interest me.
6. I enjoy being with friends and family.
7. I want to be with friends and family.

Week 5

M	A	M	A	M	A	M	A	M	A	M	A	M	A
7	7	7	7	7	7	7	7	7	7	7	7	7	7
6	6	6	6	6	6	6	6	6	6	6	6	6	6
5	5	5	5	5	5	5	5	5	5	5	5	5	5
4	4	4	4	4	4	4	4	4	4	4	4	4	4
3	3	3	3	3	3	3	3	3	3	3	3	3	3
2	2	2	2	2	2	2	2	2	2	2	2	2	2
1	1	1	1	1	1	1	1	1	1	1	1	1	1
Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	

Week 6

M	A	M	A	M	A	M	A	M	A	M	A	M	A
7	7	7	7	7	7	7	7	7	7	7	7	7	7
6	6	6	6	6	6	6	6	6	6	6	6	6	6
5	5	5	5	5	5	5	5	5	5	5	5	5	5
4	4	4	4	4	4	4	4	4	4	4	4	4	4
3	3	3	3	3	3	3	3	3	3	3	3	3	3
2	2	2	2	2	2	2	2	2	2	2	2	2	2
1	1	1	1	1	1	1	1	1	1	1	1	1	1
Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	

M = Mood Rating

1. A one resembles feeling very depressed and/anxious.
2. A two resembles feeling down/anxious/a feeling of being overwhelmed.
3. A three resembles feeling a bit worse than just okay.
4. A four resembles feeling fair/just okay/"flat".
5. A five resembles feeling "okay/pretty good" and better than feeling just okay.
6. A six resembles feeling happy but that you could be happier.
7. A seven resembles feeling very happy and positive.

A = Activity Rating

1. I don't want to participate in any activities or be with friends.
2. Activities that used to interest me don't really anymore.
3. My energy is low and being with friends and family doesn't sound good to me.
4. A score of four resembles feeling fair/just okay/"flat".
5. Friends and family interest me.
6. I enjoy being with friends and family.
7. I want to be with friends and family.

APPENDIX C

THINK, BE, DO CURRICULUM TRAINING CHECKLIST

Item	Covered	Questions
Introduce self & others in the training.		
Read through the Introduction and specifically the suggestions for implementation.		
Go over the layout of the lessons.		
Discuss the components within the lesson.		
• What do italics mean?		
• What do grey boxes mean?		
• How do you connect the teacher edition to the student workbook?		
• What is Note to Teacher?		
Discuss that the teacher should be a facilitator throughout the lesson.		
• Teachers should increase autonomous decision-making as much as possible.		
• Teachers should utilize the curriculum to scaffold instruction and connect to background knowledge.		
• Teachers should facilitate discussion and share ONLY if they feel comfortable.		
Talk thoroughly about the MAC Chart		
Session 1		
• Expectations for the class		
• Supportive class environment		
• Overview of mental health and the environment		
• MAC Chart		
• Strategy to use		
• Teacher fidelity form		
Session 2		
• Actions, Thoughts, and Feelings		
• Mood Spirals		
• Strategy to use		
Session 3		
• Review strategy to use		
• Locus of control		

• Resilience		
• Strategy to use		
Session 4		
• This session has a lot of review from previous sessions		
• Activity domains (Social and Success)		
• Goal setting – SMART goals		
Session 5		
• Writing social and success goals o Go over the student workbook for this		
• Little Actions o Go over the student workbook for this		
• Strategy to use		
Session 6		
• Automatic thoughts		
• Wise thoughts		
• Group activity		
• Strategy to use		
Session 7		
• Depression and environment		
• Depression and school		
• Check-in on goals		
• Strategy to use		
Session 8		
• Anxiety and environment		
• Anxiety and school		
• CHARGE activity		
• Strategy to use		
Session 9		
• Relaxation		
• Journaling o Cover the elements of journaling		
• Strategy to use		
Session 10		
• Problem solving strategy		
• Wrap-up		
• Thank you		

Student Survey

Name: _____

Please follow the directions for each section.

Please answer the questions to the best of your abilities.

This is not graded and your answers will be kept confidential. Your answers on this survey will not have any negative impact on you or your grades.

This survey asks questions about your current mood, feelings, thoughts, and behaviors. This data is collected as part of James Sinclair's dissertation study.

If you feel uncomfortable about a question, you don't have to answer it. At anytime you can stop participation at anytime without any negative consequence to you.

If you do not understand a question, you can ask a question to James or your teacher at any time.

This survey should take approximately 15 minutes.

Listed below are a variety of thoughts that pop into people's heads. Please read each thought and indicate how frequently, if at all, the thought occurred to you <u>over the past two weeks</u>.

Indicate my <u>circling</u> the number that corresponds with how often these thoughts occur.

	Not at all	Sometimes	Moderately often	Often	All the time
1.1 I am no good	1	2	3	4	5
1.2 Why can't I ever succeed	1	2	3	4	5
1.3 I wish I were a better person	1	2	3	4	5
1.4 My life's not going the way I want it to	1	2	3	4	5
1.5 I'm so disappointed in myself	1	2	3	4	5
1.6 What's wrong with me?	1	2	3	4	5
1.7 What's the matter with me?	1	2	3	4	5
1.8 I'm a loser	1	2	3	4	5
1.9 I'm a failure	1	2	3	4	5
1.10 I'll never make it	1	2	3	4	5
1.11 Something has to change	1	2	3	4	5
1.12 My future is bleak	1	2	3	4	5

Listed below are a number of statements, which people have used to describe themselves.

Read each statement and then indicate, by circling the number, the extent to which each statement describes your behaviors using the following scale:

		Not at all		A little		A lot		Completely
2.1	There were certain things I needed to do that I didn't do	0	1	2	3	4	5	6
2.2	I am content with the amount and types of things I did.	0	1	2	3	4	5	6
2.3	I engaged in different activities.	0	1	2	3	4	5	6
2.4	I made good decisions about what type of activities and/or situations I put myself in.	0	1	2	3	4	5	6
2.5	I was an active person and accomplished the goals I set out to do.	0	1	2	3	4	5	6
2.6	Most of what I did was to escape from or avoid something unpleasant.	0	1	2	3	4	5	6

		Not at all		A little		A lot		Completely
2.7	I spent a long time thinking over and over about my problems.	0	1	2	3	4	5	6
2.8	I was not social, even though I had opportunities to be.	0	1	2	3	4	5	6
2.9	I engaged in activities that would distract me from feeling bad.	0	1	2	3	4	5	6
2.10	I did things that were enjoyable.	0	1	2	3	4	5	6

Listed below are a number of statements, which people have used to describe themselves.

Read each statement and then indicate, by circling the number, the extent to which each statement describes how you have felt using the following scale:

		Not at all or less than 1 day in the last week	1 to 2 days in the last week	3 to 4 days in the last week.	5 to 7 days in the last week	Nearly every day for 2 weeks.
3.1	My appetite was poor.	0	1	2	3	4
3.2	My sleep was restless.	0	1	2	3	4
3.3	I felt sad.	0	1	2	3	4
3.4	I felt like a bad person.	0	1	2	3	4
3.5	I lost interest in my usual activities.	0	1	2	3	4
3.6	I felt like I was moving too slowly.	0	1	2	3	4
3.7	I wished I were dead.	0	1	2	3	4
3.8	I was tired all the time.	0	1	2	3	4
3.9	I could not focus on the important things.	0	1	2	3	4
3.10	I felt terrible.	0	1	2	3	4

Listed below are a number of statements, which people have used to describe themselves.

Read each statement and then indicate, by circling the number, the extent to which each statement describes how you feel right now, at this moment, using the following scale:

	Not at all	Somewhat	Moderately	Very much so
4.1 I feel rested.	1	2	3	4
4.2 I feel content.	1	2	3	4
4.3 I feel comfortable.	1	2	3	4
4.4 I am relaxed.	1	2	3	4
4.5 I feel pleasant.	1	2	3	4
4.6 I feel anxious.	1	2	3	4
4.7 I feel nervous.	1	2	3	4
4.8 I am jittery.	1	2	3	4
4.9 I feel "high-strung."	1	2	3	4
4.10 I feel over-excited and "rattled."	1	2	3	4

Please mark with an X the answers to the following questions:

I identify as Male_____ Female_____ Transgender_____ Prefer not to specify_____

I am:
African American/Black_____
Latino/Latina/Hispanic_____
Asian_____
Pacific Islander_____
American Indian/Native American_____
Caucasian/White_____
Prefer not to specify_____

I identify as
Heterosexual_____
Lesbian/Gay/Bisexual_____
Other_____
Prefer not to specify_____

I am 14_____, 15_____, 16_____, 17_____, 18_____, 19_____, 20_____, 21_____

I am in grade 9_____, 10_____, 11_____, 12_____, 18-21 year old program_____

My receive special education services for:

Autism: _____
Emotional/Behavioral Disability: _____
Learning Disability: _____
Intellectual Disability: _____
Other health impairment (for example ADHD): _____
Speech or Language Impairment: _____
Traumatic Brain Injury: _____
Visual Impairment: _____
Hearing Impairment: _____
Orthopedic Impairment: _____
Multiple Disabilities: _____
I don't know what I am receiving special education services for: _____

APPENDIX E

MOOD AND ACTIVITY CHART

MAC - Mood Rating Scale

1. A score of one resembles feeling very depressed and/anxious

2. A score of two resembles feeling down/anxious/a feeling of being overwhelmed

3. A score of three resembles feeling a bit worse than just okay

4. A score of four resembles feeling fair/just okay/"flat"

5. A score of five resembles feeling "okay"/"pretty good" and better than feeling just okay

6. A score of six resembles feeling happy but that you could be happier

7. A score of seven resembles feeling very happy and positive

MAC - Activity Rating Scale

1. I don't want to participate in any activities or be with friends

2. Activities that used to interest me don't really anymore

3. My energy is low and being with friends and family doesn't sound good to me

4. A score of four resembles feeling fair/just okay/"flat"

5. Friends and family interest me

6. I enjoy being with friends and family

7. I want to be with friends and family

APPENDIX F

TEACHER FIDELITY FORM

Lesson #: _____ Teacher Name: _____

Observer Name (if applicable):_____ Number of students in class:_____

Date of lesson:_____

Answer each of the following questions about the lesson implemented by circling the number that best represents your opinion. Next write your answers to the questions below. Add specificity to your answers.

Question:	Strongly Agree	Agree	Disagree	Strongly Disagree
1. All agenda items of the lesson were reviewed?	4	3	2	1
2. The scripts and examples given in the lesson were used to achieve the learning outcomes.	4	3	2	1
3. Overall this lesson was feasible to implement with my students?	4	3	2	1
Activities:	Strongly Agree	Agree	Disagree	Strongly Disagree
4. The activities were implemented as described in the lesson plan.	4	3	2	1
5. 100% of my students were actively engaged in the activities (e.g., responding to questions, head up, participating in activities).	4	3	2	1
Describe areas in the activities that went well?				

	What parts of the lesson were difficult to implement? Describe anything that was confusing to the teacher or students or that students had trouble practicing.				
	If adaptations were made to the lesson related to materials, or the activities, describe (please be specific).				

	Lesson Mastery	Strongly Agree	Agree	Disagree	Strongly Disagree
6.	All of my students demonstrated mastery/understanding of the concepts discussed in this lesson.	4	3	2	1
7.	I was comfortable teaching and had mastery of this entire lesson.	4	3	2	1
8.	This lesson was very effective as it was implemented to my students.	4	3	2	1
	Any other comments related to the effectiveness of this lesson within the Think, Be, Do curriculum?				

APPENDIX G

OBSERVER FIDELITY FORM

Lesson #:_____ Teacher Name:_____

Observer Name:_____ Number of students in class: _____

Date of Lesson:_____

Answer each of the following questions about the lesson implemented by circling the number that best represents your opinion. Next write your answers to the questions below. Add specificity to your answers.

Overview:	100 – 90%	89 – 80%	79 – 70%	69 – 60%	59% or Less
9. What percent of the agenda items of the lesson were reviewed?	5	4	3	2	1
10. What percent of the scripts and examples given in the lesson were used to achieve the learning outcomes?	5	4	3	2	1
11. What percentage of the time did the teacher stay consistent with the scripts and in-class activities?	5	4	3	2	1
12. What percentage of the session did the teacher get through during the class observation?	5	4	3	2	1
Activities:	100 – 90%	89 – 80%	79 – 70%	69 – 60%	59% or Less
13. What percentage of activities were implemented as described in the lesson plan?	5	4	3	2	1
14. What percentage of students were actively engaged in the activities (e.g., responding to questions, head up, participating in activities)?	5	4	3	2	1

Lesson Mastery	100 – 90%	89 – 80%	79 – 70%	69 – 60%	59% or Less
15. What percentage of students demonstrated mastery/understanding of the concepts discussed in this lesson?	5	4	3	2	1
Describe areas in the activities that went well?					
What parts of the lesson were difficult to implement? Describe anything that was confusing to the teacher or students or that students had trouble practicing.					
If adaptations were made to the lesson related to materials, or the activities, describe (be specific)					

ABBREVIATED ACCEPTABILITY RATING PROFILE

	Strongly Disagree	*Disagree*	*Slightly Disagree*	*Slightly Agree*	*Agree*	*Strongly Agree*
1. This is an acceptable treatment for the child's behavior.						
2. The treatment should be effective in changing the child's behavior.						
3. The child's behavior is severe enough to justify the use of this treatment.						
4. I would be willing to use this treatment with my child.						
5. This treatment would not have bad side effects for the child.						
6. I liked this treatment.						
7. The treatment was a good way to handle the child's problem.						
8. Overall, the treatment would help the child.						

From Tarnowski, K. J., & Simonian, S. J. (1992). Assessing treatment acceptance: The abbreviated acceptability rating profile. *Journal of Behavior Therapy & Experimental Psychiatry, 23,* 101-106.

STUDENT SOCIAL VALIDITY SCALE

Student name: _____

Thank you for completing the Think, Be, Do Curriculum! Please take a moment and complete the following questions to the best of your ability. Please rate how much you agree with the following statements. Circle the number that corresponds with your level of agreement.

1. I really enjoyed participating in this curriculum.

Disagree				Neutral					Agree
1	2	3	4	5	6	7	8	9	10

2. I learned a lot about mental health by participating in this curriculum.

Disagree				Neutral					Agree
1	2	3	4	5	6	7	8	9	10

3. I would recommend that this curriculum is taught to other students.

Disagree				Neutral					Agree
1	2	3	4	5	6	7	8	9	10

4. I was always engaged when my teacher taught the TBD curriculum.

Disagree				Neutral					Agree
1	2	3	4	5	6	7	8	9	10

5. I will use the strategies that I have learned from the curriculum in the future.

Disagree				Neutral					Agree
1	2	3	4	5	6	7	8	9	10

STUDENT KNOWLEDGE QUESTIONNAIRE

1. What is mental health?
    a. A state of being that impacts your ability to cope with stressors and be a productive member of society.
    b. Someone has mental health when they are crazy.
    c. A state of well-being when an individual has the ability to cope with life stressors and continue to be a productive member of society.
    d. Mental health is something stupid that people blame for bad decisions.

2. What are the three main things that internally impact our mental health?
    a. Actions, Thoughts, and Feelings.
    b. Actions, Friends, and Family.
    c. Thoughts, School, and Family.
    d. Feelings, Work, and School.

3. What does it mean to have internal locus of control?
    a. That our teacher has control of our lives.
    b. That you have control of your life.
    c. That your family has control of your life.
    d. That you give control of your life to someone else.

4. True or False: Our behaviors can impact our environment.
    a. True.
    b. False.

5. What are Success activities?
    a. Experiences that make us feel skillful or competent.
    b. Experiences that your teacher decides for you to have.
    c. Experiences you and your friends have together.
    d. Experiences that your parents tell you to do.

6. True or False, Wise thoughts are accurate, logical, and true thoughts that are not exaggerated, filled with emotions, untrue or irrational.
    a. True.
    b. False.

7. Name two common symptoms of depression.

   a. _____

   b. _____

8. True or False: When you are anxious you are calm and at peace with your surroundings.
   a. True.
   b. False.

9. What does Think, Be, Do remind you to do?
   a. Problem-solve difficult situations.
   b. Think about your favorite class in school.
   c. Do your homework.
   d. Tell your friends how you are feeling.

10. True or False: It important to monitor our moods and activities.
    a. True.
    b. False.

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232

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