# An Adolescent Mental Health & Wellness Curriculum

# A Starter Kit for Schools

Second Edition

Editors
David Ray DeMaso, M.D. & Joseph Gold, M.D.

Acknowledgements

The purpose of this manual is to help adolescents acquire the words and the questions they need to make better decisions in the area of mental health. Regardless of age, people make better decisions when they have accurate information. We thank Bruce M. Cohen, M.D., Ph.D., President and Psychiatrist-in-Chief Emeritus, McLean Hospital and William R. Beardslee, M.D., Academic Chairman, Children's Hospital Boston for allowing this collaborative project a sufficient priority for their specialists and staff to participate. Although more time-intensive, a collaborative project helps to eliminate conflicting information for teachers. We are grateful to everyone listed in the Contributor's section but wish to specifically mention Cynthia Kaplan, Ph.D., of McLean Hospital and Caroline Watts, Ed.D., of Children's Hospital Boston for extraordinary devotion to this project.

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**CONTENTS** **PAGE**

**Preface** 9

***Part One of Three – Preparation***

**Chapter 1) Using the Adolescent Mental Health & Wellness Curriculum in Your School**
*Caroline Watts, Ed.D.*

- A Rationale for Action: Why Do Something? 11
- The Curriculum Philosophy 13
- Needs and Resource Assessment: What Is Our Readiness? 18
- Internal and External Resources to Support Implementation 20
- Overview of the Educational Modules: How To Use Them 22
- Conclusion 26
- Appendices:
  - 1-A) Implementation Checklist Example 27
  - 1-B) Survey example on Depression (staff version) 28
  - 1-C) Survey example on Depression (parent version) 29
  - 1-D) Survey example on Depression (student version) 30
  - 1-E) Questions for Developing School Resources List 31

**Chapter 2) Assessing Class Safety to Determine Curriculum Level**
*Ariel Botta, L.I.C.S.W., Nadja Reilly, Ph.D. and Caroline Watts, Ed.D.*

- Decide Which Level to Use with the Class 33
- Appendix 2-A) Class Emotional Safety Assessment 35

***Part Two of Three – Curriculum***

**Chapter 3) Stress: Causes, Consequences and Management**
*Cynthia Kaplan, Ph.D.*
- Definition and Overview 37
- Goals and Objective 37
- Prior to Activities: Determine Level of Safety 38
- Activities
  - Level 1 39
  - Level 2 50
  - Level 3 56
- Appendices:
  - 3-A) Sources of Stress Survey 59
  - 3-B) Competition Scale 60
  - 3-C) Deep Breathing Instructions 61

**Chapter 4) Substance Use, Abuse, and Dependence**
*John Rodolico, Ph.D., James Holsomback, B.A., M.A., A.B.D. and Cynthia Kaplan, Ph.D.*
- Definition and Overview 63
- Goals and Objective 64
- Prior to Activities: Determine Level of Safety 64
- Activities
  - Level 1 65
  - Level 2 71
  - Level 3 74
- Appendix 4-A) Article titled "Oops: How Casual Drug Use Leads to Addiction" 76

**Chapter 5) Depression in Adolescents**
*Nadja Reilly, Ph.D., Ariel Botta, L.I.C.S.W. and Caroline Watts, Ed.D.*
- Definition and Overview 79
- Goals and Objective 79
- Prior to Activities: Determine Level of Safety 80
- Activities
  - Level 1 81
  - Level 2 85
  - Level 3 91
- Appendices: Assessment for Risk of Suicide
  - 5-A) Questions to Guide Student Safety Assessment 93
  - 5-B) Sample Form for Student Evaluation Notes 97
  - 5-C) Student Safety Assessment Decision Tree 98

***Part Three of Three – Evaluation and Conclusions***

**Chapter 6) Evaluating Mental Health Programs in Schools**
*Emily Bliss Gerber, Ph.D. and Caroline L. Watts, Ed.D.*

- Evaluation is an Integral Part of Prevention 99
- What Works In School-Based Preventive Interventions? 100
- Pilot Evaluations of *An Adolescent Mental Health & Wellness Curriculum* 102
- The Evaluation Cycle in Your School 106
- Conclusion 109
- Appendices:
  - 6-A) Student Evaluation of the Depression Module 110
  - 6-B) Your Evaluation of *An Adolescent Mental Health & Wellness Curriculum* 111

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## Preface

Our goal is to develop a starter kit for school leaders containing information directed at promoting wellness and facilitating resiliency of the adolescents in their school. It is designed to guide educators to run a preventive mental health program either with or without outside (or onsite) mental health expertise. The rationale, philosophy, and curriculum overview are described in the opening chapter. Specific classroom educational modules on stress, substance abuse and depression are then provided in subsequent chapters of this manual. We offer an approach to guide educators on determining the need and use of expert assistance from outside mental health professionals. We have selected to focus on topics that we hope will be valuable to educators working with adolescents.

The psychosocial and conduct problems of adolescents in our schools represent a major unmet need. Optimally, educators of this age group will have knowledge and skills to understand behavioral issues and provide adolescents with preventive anticipatory guidance and counseling. Also, when problems exist, the identification can be early, and followed by appropriate management by the school or referral to a mental health professional. We hope that this starter kit will be helpful to educators in accomplishing these tasks.

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*Part One of Three – Preparation*

## Chapter 1: Using the Adolescent Mental Health & Wellness Curriculum in Your School

*"Schools are healthy places when our kids are healthy,*
*and our kids are healthy when their school is healthy."*

### A Rationale for Action: Why Do Something?

As an educator, you are deeply aware of the central role that you and your colleagues play in the lives of your students and their families. The challenges and rewards of providing a safe, stimulating, and inspiring environment in which young people develop their minds, bodies, and hearts shape your daily life. Whatever role you play within the school – teacher, administrator, coach, counselor, mentor – you are committed to children's development in general and to the particular possibilities that schools hold for their students in shaping their futures.

However, as you also may be personally aware, the field of education has been challenged perhaps as no other field in modern America. A national call for consistency in academic standards and student achievement has led to the development of intensive accountability measures and testing programs. At the same time, schools stretch their instructional mission to address the complex social, psychological, and familial pressures that adolescents face as they move toward adulthood, without a clear consensus on *how* these issues should be addressed. It is undeniable that educating America's children has become an increasingly complicated enterprise, due largely to the complexity of societal circumstances that shape children's lives and their readiness for schooling.

Thousands of American children are living in poverty, which has profound implications for their access to a quality education as well as their ability to take advantage of what educational services may be available to them. On the other end of the economic spectrum, children are programmed into multiple enrichment activities that leave them little time for genuine recreation, rest and play, teaching them at younger and younger ages about the high-speed, stress-filled pace of adult life. Expanding technology exposes children to an increasingly unfiltered multi-media world that includes violence, pornography and illicit substances. Graphic episodes of violence at schools around the country have highlighted the potentially devastating effects of bullying and social cruelty upon isolated youth. Many children live without at least one of their parents, putting them at a financial disadvantage as well as without much-needed support and guidance from an engaged adult. The opportunities to engage in risk-taking behavior come frequently and early in a child's life, requiring more vigilance and sophistication on the part of parents and other key adults to be aware and to be involved in the lives of the children they are raising.

In Boston, 2 in 5 high school seniors report recent (within the last 30 days) alcohol use, and 1 in 5 reported binge drinking. Marijuana use is also prominent among Boston high school students, with over 20% reporting current use. Of youngsters who

reported making a suicide attempt in the past year, over one-third used illegal drugs in the past month, and more than a quarter reported binge drinking (Boston Public Health Commission 2003). According to a statewide survey, high school students in Massachusetts who reported alcohol use were twice as likely to have attempted suicide in the past 12 months as their non-drinking peers (Boston Public Health Commission 2003).

More than 800,000 American teenagers suffer from depression each year, and more than 500,000 make a suicide attempt that requires medical attention (Columbia University 2003). Sixty to eighty percent of adolescents with depression go undiagnosed or untreated – and untreated depression can lead to deteriorating schoolwork, high absenteeism, dropping out, strained peer and adult relationships, and potential suicide. Depression directly or indirectly results in 1700 teen suicides per year; in a Youth Risk Behavior Survey administered annually in Boston, 20% of high school students reported considering suicide. Suicide is the second leading cause of death for Massachusetts young people ages 15-24, and suicide rates nationwide have tripled since 1950. In response to these trends, some researchers recommend that adolescents receive at least one mental health screening before graduation from high school (Columbia University 2003).

The Surgeon General's Report on Mental Health (1999) stated that the majority of children and adolescents do not receive the mental health services they need. When they do, 70% of children who receive mental health services receive them in schools. Why are schools a desirable locus for children's mental health services? Schools do not carry the stigma of mental health fears and concerns that keep some people from seeking even needed services. They include familiar personnel who see multiple facets of their students, and therefore may not be as "pathologizing" as a mental health facility. With an estimated 95% of all American youths enrolled in schools, they are increasingly viewed as the logical entry into mental health services for young people (Allensworth et al., 1997).

The purpose of the *Adolescent Mental Health & Wellness Curriculum* is to increase your awareness of adolescents' mental health needs and provide ways for you to be involved in designing and implementing strategies for meeting these needs in your school. Our goal is to provide an approach and supporting materials that allow you and your staff to develop a plan for integrating adolescent mental health issues into your overall educational program. It is based upon a wellness approach that is mindful of keeping our students, staff, and families healthy in all ways, so that they are effectively engaged in the educational process. The program uses a series of educational modules to concentrate not only on the risks adolescent face, but also upon the natural developmental role these risks have during adolescence and upon the many opportunities for guiding teens through these risky times in a productive, caring, and successful way. The goal of this chapter is to describe the program's theoretical foundations, a needs assessment, and an overview of the educational modules.

## The Curriculum Philosophy

The *Adolescent Mental Health & Wellness Curriculum* is a universal preventive intervention designed to reduce risks and enhance strengths in school children. It is *universal* because it applies to all students, not just those who have been identified as needing special help. While the responses of individual students may vary from disabling disorders to transient problems to amazing resilience, all teens face serious emotional and psychological challenges as they grow to adulthood. A great deal of their behavior, thoughts and feelings are normal and natural aspects of this major developmental transition. It is a *preventive intervention* tool, designed to work with adolescents in the face of these major developmental challenges before their behavior escalates to the point of needing treatment. The curriculum targets aspects of risk as well as protective factors through the provision of important information and support to teens and the key adults involved with them.

It is well understood that multiple risks can lead to specific emotional and behavioral problems such as depression. This curriculum helps initiate dialogue on risks in specific problem areas, (i.e. stress, substance abuse or depression), as well as generic risks (i.e., impulsivity or social isolation). The dialogue improves the protective factors that can prevent more critical outcomes. Using a combination of knowledge-based and group interactive approaches, the curriculum is designed to raise awareness, increase knowledge, promote social-emotional skills, enhance interactions and relationships with peers and important adults, and shore up school capacity to include mental health and wellness as a fundamental aspect of educational programming.

The theoretical foundations of the *Adolescent Mental Health & Wellness Curriculum* are based in resiliency, developmental, prevention, cultural, and experiential frameworks. Each of these frameworks is described below.

✓ *A Strength and Resilience Approach*

Resilience is not a thing that one has or lacks – it is a balance between the demands of one's daily life and the resources one brings to bear to manage those demands. Those resources include internal capacities (e.g., cognitive skills and intelligence) and interpersonal opportunities (e.g., caring relationships with parents and other important adults). Resilience can change over time: it is not a static entity, but fluid, as that delicate balance between demands and resources can shift with life circumstances. Being attuned to the lives of our students means that we understand that particular balance for each of them, and how we play a role in tipping the scales in the direction of resources over demand.

This curriculum is intended to address serious emotional, behavioral, and psychological concerns that affect the lives of thousands of adolescents each year – in urban, suburban, and rural areas, in poor and wealthy families and communities, across a range of racial and ethnic groups. That said, this program takes the view that adolescent health and wellness is best understood from a holistic perspective that recognizes and supports the strengths adolescents bring to the challenges they face.

While the portrait painted by the statistics reported earlier is real, it is also the case that the risks faced by American teens can be addressed by building upon the potent and accessible protective factors within an adolescent's immediate environment —including the school.

Fundamentally, the factors that can protect against the negative effects of risks are all potentially connected to schools: academic achievement, significant relationships with caring adults, extracurricular activities, and community involvement have all been shown to decrease participation in risk-taking. The goal in this curriculum is to support you in fortifying and expanding the protective elements of your school environment – making stronger what is already in place.

✓ *A Developmental Orientation*

Our approach to this work is first and foremost a developmental approach, as with all of our work with children and adolescents. What does "developmental approach" mean? First of all, it means that the curriculum has to be geared appropriately for the age and capacities of its audience. We have targeted "adolescents" as the primary audience, but that group is quite large and diverse – covering at least ages 12-19 or even older, students who are in middle school, junior high, and high school. The needs and skills of young people at the two ends of this age span—those just leaving elementary school, and those moving on to college or work – are very different, and there is a fairly substantial range in between. Importantly, one's skills and capacities do not necessarily develop in synchrony; for instance, while adolescents may have achieved the physical capability for having children, they typically do not have the cognitive or emotional maturity required for being parents. In this curriculum, we attempt to provide language and activities that are accessible to most students within this diverse age range, while at times making recommendations for targeting specific age groups.

We try to address the differences among adolescents in how they may understand and interpret the kinds of information contained in these modules. The meaning an adolescent makes of important material, events, and relationships is something that develops over time, with growing intellectual skills, age and experience. While cognitive skill and behavioral strategies (how we think and how we act) are important elements of determining adolescent risk, they are not sufficient for predicting what teens will actually do. Between what we know and how we act is a "filter" of sorts, a filter made of values and beliefs about oneself and others that is developed through one's unique experiences in the world. For a teen who has lost a parent to alcoholism, binge drinking with his peers has a very different meaning than for a teen whose parents drink moderately or not at all. This "meaning filter" is what we try to reach with the activities presented in the curriculum modules – to help kids make personal connections to the material that helps make the information and strategies more effective as a prevention tool.

Finally, we use a developmental approach to promote growth through this curriculum. "What develops is what can change," says a developmental psychologist

colleague of ours (Selman, 1980). Adolescent mental health and wellness is grounded in teens' capacity for making meaningful decisions about their lives, and in particular, helping them be invested in their futures, how they will grow, and taking a role in their own healthy development. This personal decision-making capacity needs to be nurtured within the context of caring relationships with key adult figures, at school, home, and in the community. While this curriculum does not claim to change the ways that adolescents think and act, we do aim to help *you* – the key people in their lives – establish a school environment where they feel understood and supported in their efforts to reach a healthy adulthood.

✓ *Prevention Over Intervention*

A developmental approach lends itself to a natural companion: taking a preventive approach to health and mental health risks, and being proactive rather than reactive. Our basic advice is, "Don't wait until a problem, accident, or tragedy occurs to think about these issues." While we do not want to paint a dire picture of the mental health of adolescents, we do feel strongly that young people face a number of enormous challenges in the daily enterprise of growing up safe and healthy, and that risks are a natural part of what they have to negotiate as they grow. Being proactive does not mean being over-reactive – it means thinking ahead, anticipating (where we can) what challenges your students might encounter and ways in which you can help them maneuver these rapids. Being prepared means being aware and conscious of what risks kids face and their consequences, and recognizing the active role you can play in how well your students will manage those risks and avoid the negative consequences.

Being aware means understanding the role school plays in the creation or occurrence of risks and problems as well as in their prevention. An atmosphere of intense competitiveness and pressure around academics can foster some of the negative effects of stress, including depression, self-injuring behavior, and substance use. It is inevitable that students will experience stress around their schoolwork and around their extracurricular activities. In this context it can be useful to ask yourself and your colleagues the question: To what extent does our school climate contribute to the very problems we are trying to help adolescents avoid? And, what changes can we make to help our school be as healthy as we want the students to be?

There are probably many school mechanisms currently in place that help serve a preventive or proactive function. Student support systems such as government associations, peer counseling or mediation programs, health fairs, school based health centers, and wellness programs can all integrate activities to support an overall school health initiative. Staff support systems typically take the shape of professional development programs, but may also include Employee Assistance Programs and other health benefits. We encourage school administrators considering this curriculum (and other similar tools) to engage their staff in a process of self- awareness and self-reflection as a key component of the initial needs assessment process and as a necessary mechanism for ongoing school health.

✓ *Culture is Essential Context*

Cultural factors influence attitudes about and responses to mental health and wellness programs. Indeed, health and mental health behaviors can vary greatly by culture, including one's race, ethnicity, religion, gender, country of origin, and socioeconomic status. The adolescent health patterns reported previously, for example, are general patterns for youth across the country, Massachusetts, and the City of Boston – but these patterns are not necessarily the patterns for children and youth from different racial/ethnic groups, or for boys as compared to girls.

For example, one-third of Boston high school students reported feeling sad and hopeless for at least two weeks during the previous year – girls by a substantially higher proportion (40%) than boys (25%) reported these feelings (Boston Health Commission 2003). Significantly more Latino high school students reported making a suicide attempt in the last year as compared to their White or Asian counterparts (Boston Health Commission 2003). Understanding that particular culturally related factors may affect one's vulnerability to certain risks is important in designing a school health program that is truly responsive to the actual kids in the school.

In order to effectively understand and act upon the concerns of adolescents, culture-based questions have to be openly considered and actively addressed. Cultural factors not only influence a teen's susceptibility to certain risks, but they can also shape adolescent's response to services. In some cultures, for example, there are no words comparable to the English words "depression" or "mental illness." In other cultures, seeking help outside of the immediate family can be seen as weakness or even disloyalty. Prescribing antidepressants may be resisted by families distrustful of the use of medications and disconnected from the Western medical system. The meaning adolescents make of their lives, their relationships, and their behavior - along with the conclusions they come to - are shaped in large part by their cultural identification, and the values and beliefs imparted through parenting and socialization.

In thinking about how culture influences one's response to this curriculum in specific, we encourage you to consider three distinct cultures that affect all of your students:

- *Family Culture*, including race/ethnicity, religion, country of origin, language, social class, and gender;

- *Peer Culture*, including the structure of peer groups, belonging and exclusion, the definitions of "status", and gender roles.

- *School Culture*, including "codes" for students, staff, and parents, expectations and standards for performance, and belonging or exclusion.

Ultimately, culture and diversity span beyond differences in race, class, ethnicity and gender. We conceptualize diversity as including differences in country of origin, religion, sexual orientation, age, physical and mental ability, looks and physical characteristics, language and communication styles, geographic location, life styles,

learning styles, and personality. We would like to help students recognize differences as a means of joining other students, rather than using them as reasons to alienate one another.

Finally, the culture of the staff is key to determining the overall cultural climate of the school, and the nature of the interactions between students and staff. Staff characteristics play an important role in shaping our response and the kids' receptivity to our interventions. The effectiveness of this curriculum and other such initiatives will be enhanced by the attention you pay to nurturing a diverse, aware, supportive and accepting staff community.

✓ *A Research and Practice Experience Base*

The contributors to this curriculum program bring their experiences over two decades working in a variety of school settings: public and independent, elementary and secondary, regular education and specialized treatment environments. We have worked with adolescents from a wide variety of backgrounds, ethnicities, and cultures, who have brought great strengths to bear upon the serious demands placed upon them by their age/time of life, family circumstances, future hopes and dreams, and peer networks. Consulting with school administrators and staff, we have learned a great deal about the stresses and strains of meeting adolescents where they are and engaging them academically in a meaningful way. The information we share here is a culmination of these professional and personal experiences working in the greater Boston metropolitan area, which is itself an urban and suburban environment with a particular mix of styles, attitudes and behaviors resulting from a diverse conglomeration of peoples gathered in this region. This is *our* context, the background that we bring to these materials and to our investment in working with you toward realizing the goals for your school.

**Needs and Resource Assessment: What Is Our Readiness?**

✓ *Why Do This?*

We view this curriculum as a tool in a process that you and your school are undertaking: a process of self-examination as individuals, as members of a collective committed to the education and well being of your students, and as a system. Before putting this tool — the curriculum modules – into use, we encourage you to initiate and pursue this self-examination process, and give it the same amount of time, thought, and attention you will give to the modules being used with the students. The use of the modules will be a continuation rather than the culmination of the needs assessment and problem-solving process, as it will give you important information about your school in the form of student and staff reactions to the materials, follow-up (and even some "fall-out") from the presentations, and questions, questions, questions from all sources. Through an iterative process of questioning, exploring, trying things out, evaluating the results, and developing new questions, we believe that positive change will occur at many levels – student, staff, and school.

✓ *Who is Involved in the Needs Assessment?*

The goal of the needs assessment is to identify your school's readiness to address students' health and wellness concerns; how well these concerns are being met currently in school; the interests and ideas about how these issues should be addressed (or if the school should be the place to address them at all); and the resources available to you within and outside of the school to take further steps. Therefore, the needs assessment process should include everyone who will be involved, i.e., students, staff, parents, administration, and resource personnel. As this program is best used from a whole-school climate perspective, we encourage you to reach out to all constituencies at this point – knowing that you will encounter differences of opinion, resistance, or challenge as well as interest, excitement, and engagement.

✓ *What Do We Ask?*

In the needs assessment for each group (i.e., staff, parents and students) who will be involved, you will want to develop a few select questions related to ***awareness*** *(What do we know about this issue? How much does it affect us? Who is affected?)*; ***current strategies*** *(What are we doing to address this issue? Are these strategies working?);* ***new directions*** *(What else should we try?)*, and ***resources*** *(What information, personnel, do we need? Who/what do we have available?).* While the specific questions for each group may vary, you will want them to be comparable so that you can evaluate the issues from multiple perspectives without having too much tangential information. The results from the assessment should help you think about next steps at the student, staff, and systems levels.

For example, if you were interested in responses to a proposed Depression in Adolescents program, you might conduct your needs assessment by using anonymous surveys to ask students about the prevalence of depression in the school, what they feel does or does not help with depression, and their comfort level with going to school staff to discuss depression (see Appendix 1-D for survey example); and asking parents what

advice they give their child about depression and how comfortable they feel contacting the school if their child might be depressed (see Appendix 1-C). Staff surveys would ask about the prevalence of depression as well, along with the identification of supports for students with depression (see Appendix 1-B). Having an up-to-date network of external resources would give you necessary information about which of your community partners might conduct programs and other support services you might want to bring in. Finally, you want to examine school policy related to depression prevention and intervention, assess student and staff knowledge of the policy, and consider whether the interventions and supports already in place support, contradict, or seem unrelated to the policies.

✓ *What Comes Next?*

We present these materials to you as tools, not as a solution in and of themselves. Much of the utility of this curriculum is about the fit between our approach and yours. The needs and resource assessment process is largely a process of adapting the materials to your school, to your staff, to the unique aspects of your setting, rather than using them wholesale as a "one size fits all approach." The materials we have provided are a starting point for a larger and individualized process of enhancing the overall health of your school (see Appendix 1-A for Implementation Checklist example). For this extended process to be effective, you will need support – from within the school community and from outside it. We encourage you to bring in professionals in the field who can take on this challenge with you, and can provide you with varied levels and kinds of assistance – everything from consultation on designing your needs assessment surveys, to conducting staff training for curriculum facilitators, to creating a crisis intervention and response plan for those instances where students' needs surpass the reasonable response capacity of any school.

## Internal and External Resources to Support Implementation

Every school has its own cadre of professionals responsible for the health and well being of its students. Hopefully, by the time you have come to this point, you have a common sense of purpose and a collective commitment to engaging these issues directly with your students, even while acknowledging the challenges entailed in moving ahead. It is crucial to the success of your school's health and wellness program that you have the support and engagement of all staff. At the same time, we recognize that this curriculum raises sensitive issues at a level of depth that requires specific skills. We do not expect schools to become mental health clinics, nor do we anticipate that this curriculum will put educators at ease in roles typically assumed by professional counselors or mental health practitioners. Our goal is to provide an approach and supporting materials that allow you to develop a plan for integrating adolescent mental health issues into your educational program. To effectively implement this plan, we believe that you will benefit from the participation and consultation of people who have specific training in this area.

Depending upon the staffing in your school, you may have personnel available to you to assist with the design and implementation process. Personnel in this category might include counseling staff, including guidance staff; student support coordinators; health and nursing staff; and student advisors. An important first step in the process of adopting this curriculum is to gather these people and discuss the goals for its use, the expertise and comfort level of the resource staff, and identify additional supports that might be needed for staff and for students. It is important to recognize the skills and the limitations of the personnel or staff roles within your school. For example, many schools have established student advisory systems, where teaching faculty are assigned a certain number of students for whom they serve as direct advisors for academic or other issues. The training made available to staff in these positions varies by school; in fact, many teaching staff who serve as advisors do not feel prepared to counsel students on more personal or serious issues, including mental health concerns. Therefore, in identifying your internal resources that will support the implementation of this curriculum, be sure that you are realistic about what your staff can do, and what additional support or training they will require in order to take on this new program/role.

In addition to these internal personnel, most schools have community partners that provide alternative expertise, usually around some specific topic area or need. These partners might include medical care facilities, community health/mental health agencies, religious organizations, social service agencies, police, and youth development programs. As you work with your staff to design a plan for using this curriculum, these partners may be excellent sources of training, support, and guidance for managing student and staff responses (see Appendix 1-E for questions to be answered in developing a School Resources List). Consultation to schools around mental health issues and the use of curricular approaches is a role we play actively in the community. Bringing in external partners can help both staff and students feel less shy about raising concerns or criticisms related to the school's functioning. Further, it can help participants raise more personal kinds of questions without feeling that their

confidentiality will be breached, or that there will be ramifications for their academic or professional status.

Finally, parent involvement in this curriculum is invaluable, and necessary for its ultimate success. Hopefully, you have an active parent-teacher organization or other parent advisory/parent involvement structure that can help you with the first steps in informing and working with parents around the use of this curriculum. Again, as we discussed earlier, there may be varied responses from parents based upon differing culturally-based viewpoints on mental health, the role of schools, the rights of parents, and family boundaries and privacy. Parental resistance is not a reason to abandon the course you have chosen in addressing student mental health, but should be used as an important opportunity for opening a meaningful dialogue with the families of your students. In fact, we suggest that you should *expect* resistance of some sort – it is reasonable for parents to have questions about how mental health issues will be addressed by a school, or by any professional. Anticipating the questions and concerns parents will have is another part of the internal staff process you can engage in, and responses should be built in to your evolving implementation plan.

## Overview of the Educational Modules: How To Use Them

✓ *Structure*

Content modules on selected topics in adolescent mental health and wellness begin after Chapter 2. These modules are designed to be implemented directly with students, and therefore include clear instructions and language for presenters. The modules have a common structure, with materials organized according to three levels that are progressive in the intensity and depth of the content information and the degree of personal disclosure and engagement required on the part of the students. The levels build upon one another, so the materials in each of the level sections can be used in succession as an in-depth curriculum sequence. The levels provide a mechanism for assessing the climate of the classroom in terms of the safety students feel.

- Level 1 provides general factual information on the topic area, without pressing students for personal information.

- Level 2 starts with the factual information base, and then moves to activities that ask students to reflect upon the material and share thoughts and opinions.

- Level 3 incorporates activities that require that students put themselves in the shoes of adolescents who experience difficulties related to the topic (e.g., a friend is depressed; a drunk driving incident). Through case studies, role-plays, and journal exercises, students are challenged to integrate the materials in a personally meaningful way that addresses their own attitudes, assumptions, and behaviors.

The determination of each level is detailed in Chapter 2 of this manual entitled *Assessing Class Safety to Determine Curriculum Level*.

✓ *Topics*

We selected three topics for the foundation of our curriculum: Stress, Substance Use, and Depression. These topics were chosen for many reasons. First, they are the issues most commonly mentioned by school administrators and teachers when asking for consultation around students. They are issues commonly faced by adolescents from diverse backgrounds and experiences, although their specific meaning and behavioral manifestations may vary by culture or context. These issues have some common origins, and for many adolescents are linked in meaningful ways: stress may lead to substance use; substance use and depression often co-occur; and depression can result from chronic unresolved stress. These are issues that affect many schools, and may even originate in adolescents' school experiences: testing programs, peer pressure, and concerns about one's future beyond high school are all possible factors relating to adolescent stress, substance use, and even depression. Finally, and critically, these issues increasingly have negative life consequences for adolescents, particularly if they are not recognized and addressed.

In terms of the degree of sensitivity or difficulty in presentation, the sequence of topics – starting with stress, then moving to substance use, and ending with depression

– suggests a progressive increase in the intensity of the subject, and thus an increase in the level of training and support that may be required to implement the particular module. While stress may be a subject that all faculty feel they can and should discuss with their students, not all faculty will feel equipped to manage a series of discussions on depression.

✓ *Implementation*

Each module is structured with activities to fit into typical class periods (approximately 40 minutes). Ideally, these exercises should be conducted in small groups, no larger than 15. Depending upon the assessment of classroom safety, which is the first step in each module, covering the topic can take anywhere from 2-5 periods. The days can take place within one week or across many weeks (as might happen if the module is used in a weekly health class, for example). The modules can be implemented as stand-alone pieces on a single topic, or as a sequence of topics related to adolescent mental health and wellness. For example, the module on depression may be taught without having started with the modules on stress or substance abuse. How the modules will fit into your school's classroom structure is something to be planned with your faculty prior to implementation.

We have offered suggestions about how to get started with this curriculum, including recommendations about a staff development and training process, internal and external resource identification, and parent involvement. All of these suggestions are important components of the comprehensive school-level Needs Assessment. The inquiry at the school level will set the tone for the classroom-level assessment of safety. If staff are first given the time and space for discussing the curriculum topics and the issues related to implementing a wellness curriculum, a foundation for supporting student exploration will be established.

✓ *Targeting Your Age Group*

The modules included here have been designed for use in middle and high schools settings, for students in grades 7-12, approximately ages 12 through 19. We have developed activities and selected language that will be developmentally appropriate and comfortable for this age range. However, as we noted early on in this orientation chapter, the age span we have targeted is a large and varied one. You need to assess your students and the applicability of the materials. A critical part of the adaptation process is your knowledge about your students, and the best approach for their age and capabilities. We encourage you *not* to simply adopt these materials wholesale, but to make changes where you think they are necessary in order to meet the needs and abilities of your students. (Sample lesson plans on stress targeting two different age groups may be viewed at www.AdolescentWellness.org)

✓ *Consent For Participation: Student And Parents*

We have emphasized the importance of actively involving parents and staff in the planning process for using this curriculum. Student input is very valuable as well, and especially appropriate for adolescents, who want and need preparation for

decision-making responsibility in their lives. A good topic for parent and student input is the issue of consent for participation in the curriculum activities.

What are the concerns related to consent? Here are some examples: “My child could be harmed by talking about depression and suicide – he might start thinking about it for himself.” “I don’t want anyone else talking to my daughter about drugs – that’s my job as her parent.” “My kid is too young to hear about this stuff!” “The school has no right to have these discussions in school without my say-so.” Again, anticipating these reactions will help you to plan a thoughtful response before they arise.

This curriculum is designed as a universal prevention program that can be adapted for use in school health classes or other classroom-based structures. It is not designed as a mental health intervention to provide counseling services to students, although for some students such services might ensue after this program. School administrators and faculty should think carefully through the issues around parental/student consent for participation before the curriculum is launched.

✓ *Staff Investment/Support*

To implement this curriculum effectively requires the support and investment of your staff. The rationale for its use has to be clear and it has to be shared by the faculty as a group. The recommendations we have made about how to respond to the students can be applied as well to engaging the faculty in this process. As the students are balancing multiple demands in their lives from various directions, your staff experiences competing demands upon their time and expertise. If this program is viewed as an unnecessary add-on that detracts from the primary educational focus of your school curriculum, then it will fail. If it is seen as supporting the educational mission of the school and the academic achievement of the students by strengthening the bonds between students and faculty and the awareness of faculty to student issues and needs, then it will be more likely to succeed. So start the process of engaging your students by engaging your staff and faculty thoroughly in a thoughtful planning process.

✓ *Facilitator Listening Skills*

Children's biggest complaint is that adults don't listen. For schools to be healthy places for teenagers, we need to provide opportunities for students to have their voices heard. For adolescents in particular, it makes developmental sense to empower them in school settings and teach them that they can be change agents. As a result of feeling that they have no control in their lives, our children are developing substance abuse problems, eating disorders, low self-esteems, suicidality, depression, anxiety, problems with truancy and acting out behaviors. One way of understanding these mental health concerns is that they all have to do with attempts to gain control, or a feeling that everything is out of control. This is of course not the only reason for these disorders, but it is a common reason. We need to provide children and adolescents with choices about how to handle challenges they are facing and help them to feel empowered to make healthy choices.

To do this, we need to join with them: to see them as the experts in their lives, and listen to their experiences, their concerns and wishes. In their book *Meeting at the Crossroads,* Brown and Gilligan (1992) report on a study of 100 adolescent girls where adults listened to what they had to say about the transition from girlhood into adulthood and the risks encountered along the way. Their findings include the importance of the listening process being directed by the girls themselves, as well as the actual information shared by the participants. One goal of the modules we present here is to provide a structure for a listening process between your staff and students. For this to happen, the facilitators of the modules – you and your staff – have to be open to what the students are ready and willing to say. They need to be prepared to hear things that are painful, contradictory, unsure, impulsive, and even critical, angry, and rejecting. And they need to have something to say in return.

## Conclusion

We hope that you find the challenge of meeting students' mental health needs a rewarding one, as an educator and as someone who cares deeply about children's development. We do not pretend that this will be easy, however. By now, you probably have a very long "To Do List" based on this orientation chapter: who to talk to, what to plan, what resources to contact, and so on. This is not a "quick fix" project!

Furthermore, the facilitators of this curriculum may find that the discussions launched with adolescents have a deep personal impact upon the adults. Listening in an engaged way as we suggest above, and really hearing students' pain and fears, can be a draining, daunting, and overwhelming experience, even for trained mental health professionals. Many adults have personal experiences with stress, substance use, and depression, and the adolescents' experiences may trigger painful memories – or may replicate current struggles. Our final advice to you is, "Don't go it alone." Make sure that you have built in supports for the adult facilitators involved in this process. To paraphrase one of our first suggestions: our students are healthy when we are healthy. We hope that this curriculum can be a mechanism for all members of your school community to learn more about mental health and wellness, and to take constructive action toward the better health and growth of everyone involved.

## Selected References


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## Appendix 1-A: Implementation Checklist Example

We recognize that you may not want to tackle the whole thing right away. You should focus on the piece that makes the most sense to you, has the most direct relevance to your immediate and long-term goals, and that will provide you with the information you most want to learn.

### Part One of Three - Preparation

- ✓ School Needs Assessment
  - Survey staff (see Appendix 1-B)
  - Survey parents (see Appendix 1-C)
  - Survey students (see Appendix 1-D)
  - Record responses and define objectives

- ✓ School Resources / Readiness Assessment
  - Answer questions for Resource List (see Appendix 1-E)
  - Distribute School Resource List to staff

- ✓ Staff Development
  - Initiate the Dialog
  - Discuss level of safety felt among staff, parents and students
  - Information & exercises (Train the trainer)
  - Map lesson plan and state why it is targeted.

    For example, *"We conducted a needs and readiness assessment, followed by the formation of a weekly group based on the depression module, levels 2 and 3, which ran for 8 weeks and was provided to all 9th graders. 9th graders were chosen for this group because the transition to high school can be a particularly stressful time and prevention efforts can begin earlier rather than waiting for problems to emerge".*

### Part Two of Three - Curriculum

- ✓ Collect responses on Class Emotional Safety Assessment *(see Appendix 2-A)*
  - Identify appropriate activities

- ✓ Teach Prevention / Intervention Lesson Plan
  - Leave open time after class for potential self-referral
  - Record activities taught, challenges and successes

### Part Three of Three - Outcomes Evaluation and Conclusions

- ✓ Collect responses on Student Evaluation forms *(see Appendix 6-A)*
  - Record results
  - Identify challenges, successes and suggestions for next time

## Appendix 1-B: Survey example on Depression (staff version)

These surveys are provided as examples of needs assessment tools to use in your school. Surveys should focus on a few select questions related to awareness, current strategies, new directions, and resources. While the specific questions for each surveyed group (e.g., staff, students, parents) may vary, they should be comparable so that you can evaluate the issues from multiple perspectives. The results from a needs assessment should help you think about next steps at the student, staff, and systems levels.

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## Staff Survey

We are surveying all members of our school community about their current understanding of mental illness and depression, specifically. We would like to identify ways in which we can prevent depression and promote overall mental health for our students. We would greatly appreciate your responses to the questions below. We will be discussing this topic at the upcoming faculty meeting, and forming a faculty-student-parent committee to work on the issue. We appreciate your candid responses – thank you!

1. Do you think depression among students is a problem at our school?

2. How do you know if a student is depressed – what signs would you look for?

3. How frequently do you talk to one of your students about their emotional state?
   *Daily* *Weekly* *Monthly* *Rarely / Never*

4. What do you do in your role to address depression or other student emotional needs?

5. Is there a system in place to support you when you raise concerns about depression in one of your students?

6. What suggestions do you have for improving our school climate?

## Appendix 1-C: Survey example on Depression (parent version)

These surveys are provided as examples of needs assessment tools to use in your school. Surveys should focus on a few select questions related to awareness, current strategies, new directions, and resources. While the specific questions for each surveyed group (e.g., staff, students, parents) may vary, they should be comparable so that you can evaluate the issues from multiple perspectives. The results from a needs assessment should help you think about next steps at the student, staff, and systems levels. (To reduce paper handling, you may request an online version of the survey through www.AdolescentWellness.org)

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### Parent Survey

We are surveying all members of our school community about their current understanding of mental illness and depression, specifically. We would like to identify ways in which we can prevent depression and promote overall mental health for our students. We would greatly appreciate your responses to the questions below. We will be discussing this topic at our upcoming Parent-Teacher organization meeting, so we would appreciate your prompt reply. We appreciate your candid responses – thank you!

1. Do you think depression among students is a problem at our school?

2. How would you know if your child was depressed – what signs would you look for?

3. How comfortable do you feel talking to your child about depression and suicide?
   *Not at all* *Somewhat* *Very comfortable*

4. As a parent, what advice do you give your child when he/she says he/she feels depressed?

5. Who would you feel comfortable contacting at the school if you found out your child was exhibiting symptoms of depression?

6. What response would you expect from the school - in other words, what steps do you think the school should take to respond to or prevent depression among students?

7. What suggestions do you have for improving our school climate?

## Appendix 1-D: Survey example on Depression (student version)

These surveys are provided as examples of needs assessment tools to use in your school. Surveys should focus on a few select questions related to awareness, current strategies, new directions, and resources. While the specific questions for each surveyed group (e.g., staff, students, parents) may vary, they should be comparable so that you can evaluate the issues from multiple perspectives. The results from a needs assessment should help you think about next steps at the student, staff, and systems levels.

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## Student Survey on Depression

We would like to get your opinion about the way students' emotional needs are addressed in your school. Your responses to these questions will be kept confidential. We appreciate your honest answers – thanks!

1. Do you think depression among students is a problem at your school?

2. How would you know if you or one of your friends was depressed – what signs would you look for?

3. How often do you hear one of your peers talk about depression or suicide?
   *Daily* *Weekly* *Monthly* *Never / Rarely*

4. How do you hear about these conversations? (examples: in person, through on-line journaling, from rumors, etc.)

5. Do you feel that adults are responsive when you or someone you know has reported concerns about depression?

6. How comfortable do you feel talking to an adult in your school about depression and suicide?
   *Not at all* *Somewhat* *Very comfortable*

7. Who would you contact at the school if you felt depressed, or if you were worried about one of your friends feeling depressed?

8. What response would you expect from the school - in other words, what steps do you think the school should take to respond to or prevent depression among students?

9. Overall, do you feel safe at your school? If not, why?

## Appendix 1-E: Questions for Developing School Resources List

Once resources are identified, generate a protocol with the identified individuals to handle evaluations and crises. This document should also generate conversation about what resources the school staff feel are still needed (e.g., mental health consultants). Schools can then create a Resource List handout with the names and numbers of in-school staff and some community resources that can be given to all staff as contact numbers in case of questions or emergencies.

During the initial phase of resource assessment, school personnel should identify individuals responsible for evaluating students and following up with school based recommendations. In public schools, school nurses, guidance counselors, and mental health workers within the school system are typically identified as such resources. Plans for individual schools will vary according to school district regulations and procedures. Independent schools may suggest that parents initiate an assessment through an outside resource. Following are sample questions school staff may ask:

**Medically Based Emergencies:**

- ✓ If a student presents with a medical emergency, who is contacted first?

- ✓ Who is in charge of contacting the parents and making sure the student is either taken home or sent to the hospital?

**Psychiatric Emergencies:**

- ✓ If a student presents with a mental-health related emergency, who is contacted first? Is an evaluation conducted? If so, who conducts it?

- ✓ Who is in charge of contacting the parents? (This may be the time to provide a copy of *A Parent's Guide to a Child's Psychiatric Hospitalization*. Printed copies may be ordered in advance from www.TalkListen.org in order to keep several on hand. Copies may also be downloaded at www.AdolescentWellness.org.)

- ✓ If transport to an emergency room is warranted, who is responsible for calling an ambulance? Is this the same person responsible for providing information to the emergency room clinicians regarding the student? (Ideally, when a student is sent to the emergency room, an "expect call," or a call to ER clinicians providing some information about the student and reason for referral can expedite the process and help the family.)

- ✓ Who is responsible for the student's re-entry plan into the school?

- ✓ Who is responsible for making sure school-based recommendations for the student are carried out?

**Mental Health Referrals – Non-emergencies**:

- ✓ Are mental health evaluations offered in the school? If so, who conducts the evaluations? Who can initiate a student referral for evaluation?

- ✓ Is there a "point person" designated for record keeping of referrals, evaluations, and follow-up?

- ✓ Once the evaluation is completed, who is responsible for the following components:
  - Parent feedback
  - Teacher feedback
  - Recommendation planning and implementation
  - Referral for outside services

- ✓ Are in-school therapy services offered? If so, who is responsible for this?

- ✓ If evaluations are not offered through the school, what resources in the community are available for outpatient referral? Who contacts the parents and offers resource suggestions?

- ✓ What is the mental health insurance? NOTE - many insurance plans contract or carve out mental health services to another company.
  - The adolescent's insurance card will have an 800# to access mental health services. Parents can call this number to find out which mental health providers are on the plan's list of approved mental health clinicians.
  - Many insurance company websites help families find a therapist; list some local examples as below:
    - www.tuftshealthplan.com then click on "find a doctor"
    - www.harvardpilgrim.org then click on "member services" and then under "quick links" click on "find a doctor"

- ✓ List additional national resources for obtaining outpatient services:
  - www.mentalhealth.samhsa.gov/
  - www.findtreatment.samhsa.gov
  - www.psychologytoday.com/ then click on "find a therapist"

- ✓ List additional referral considerations, including community health centers and hospital clinics, as well as individual private providers.

## Chapter 2 - Assessing Class Safety to Determine Curriculum Level

This Adolescent Mental Health & Wellness Curriculum employs a 3-level format for each curriculum module. Each level represents an increase in the intensity and amount of information presented to students. The modules are designed to be used by school staff who are comfortable and knowledgeable regarding the subject matter. The logical placement of these modules is in the school's health care curriculum and as such can be led by the course director and/or school counselor. The leader of this course may wish to seek guidance and supervision from mental health professionals affiliated with the school.

In each module you will find step-by-step instructions to guide the student presentation. Please note that regardless of the level of safety expressed by students, it is important to observe student reactions throughout the presentation. Additionally, staff should be available immediately after the presentation to attend to any student who might be experiencing difficulties or who might self-refer. Information regarding the school resources available to students experiencing any distress, at any time, should also be provided.

### Decide Which Level to Use with the Class

Due to the sensitive nature of the information contained in these modules, we recommend that an assessment of the level of safety be conducted within the group of students that will participate in the presentations. By safety, we refer to the level of comfort, confidentiality, and closeness students may feel among each other and with the presenter. In Appendix 2-A of this chapter, you will find a brief instrument to assist in determining the level of safety within your group of students. The *Class Emotional Safety Assessment* is designed as a quick guide to ascertain the level of emotional safety students feel within the classroom. This is not a research tool, but rather a method to allow students to communicate what they might otherwise not feel comfortable verbally expressing. Students are instructed to complete this measure anonymously. If you are unsure about which level to use, or any of the students rank at the lowest level of safety, we would encourage you to begin with level 1 to ensure everyone's initial comfort. Subsequent presentations can then incorporate higher levels as guided by student responses.

Below you will find definitions for each of the three module levels. The *Class Emotional Safety Assessment* measure and its scoring may be found in Appendix 2-A.

- *Level 1: Little or no safety* If most student ratings fall within this category, it indicates that either the topic is too threatening, or they do not feel comfortable sharing with each other their experiences or thoughts. Therefore, the presenter may wish to begin the discussion by using activities marked "Level 1," then, if possible, gradually introducing the information included in Levels 2 and 3.

- *Level 2: Moderate safety* Student ratings within this category indicate moderate levels of confidentiality and comfort. The presenter may wish to begin by introducing facts as a way to initiate discussion, and determining whether to remain in Level 2 activities or proceed to Level 3 depending on student involvement and response.

- *Level 3: High safety* Students within this category feel a high level of comfort with each other and the presenter and are ready to participate in more detailed or personal activities.

Once the presenter has identified which level to use with the group of students, he or she will find in each of the modules specific activities to be used according to the level of safety. (i.e., Level 1 activities are used with Level 1 safety levels).

## Appendix 2-A: Class Emotional Safety Assessment [1]

This measure is an anonymous questionnaire. Students should be reminded not to put their names on the assessment to ensure confidentiality.

1. Do you feel comfortable sharing personal information with your classmates and the presenter?

| *1* | *2* | *3* |
|---|---|---|
| *(Not comfortable with any topics)* | *(Comfortable with some topics)* | *(Comfortable with most topics)* |

Please describe any topics you might not feel comfortable sharing: _____

2. Do you feel the information you share in your class will be kept confidential by your classmates and the presenter?

| *1* | *2* | *3* |
|---|---|---|
| *(Not at all)* | *(Maybe)* | *(Yes, definitely)* |

Have you had prior experiences that have impacted your feelings about confidentiality? If so, what were they? _____

3. Are you concerned there might be negative consequences (e.g., teasing, feeling shamed, feeling judged, being stigmatized or stereotyped, feeling like future opportunities might be hindered) from your classmates, presenter, or school, if you share personal information?

| *1* | *2* | *3* |
|---|---|---|
| *(Very concerned)* | *(Moderately concerned)* | *(Not at all concerned)* |

If you are concerned, what are some of the specific things you worry about? _____
_____

4. Do you feel that individual, racial, cultural, gender, and religious differences will be respected by your classmates and the presenter?

| *1* | *2* | *3* |
|---|---|---|
| *(Not at all)* | *(Somewhat)* | *(Yes, definitely)* |

If not, why? _____

**Staff Instructions and scoring:**

1. Add the total number of points in each assessment.
2. Total individual scores: 4 to 6 = Level 1 (little or no safety); 7 to 9 = Level 2 (moderate safety); and 10 to 12 = Level 3 (high safety)
3. Determine number of students falling within each level and begin with appropriate level.

[1] Developed Botta A, Reilly N, Watts C (2003) Children's Hospital Neighborhood Partnership, Department of Psychiatry, Children's Hospital Boston.

*Part Two of Three – Curriculum*

## Chapter 3 – Stress: Causes, Consequences and Management

### Definition and Overview

Stress is a normal part of life. Stress is experienced as feelings of fear, anxiety, worry, or general discomfort. It can be accompanied by an array of physical symptoms including headaches, stomachaches, pounding heart, sweating, trembling, tingling sensations, or fatigue. In small quantities stress can motivate people in a positive sense to be more productive and proactive. It is known to enhance productivity. However, too much stress is known to actually harm the brain and body—unrelenting and persistent stress can lower the immune system and lead to psychological problems that require professional assistance.

Stress is experienced from four basic sources (Davis et al., 2000). One must cope with social stressors such as deadlines, presentations, disagreements, or time demands. Another powerful source of stress is one's own thoughts. The brain interprets complex changes in the environment and body and determines the appropriate response. For example, pressures to succeed both socially and academically can become intense in adolescence. Adolescence is a time when one's physical appearance and prowess vary dramatically and when relationships with adults are often complicated due to the adolescent's push for independence. The third and fourth sources of stress are physiological, such as lack of exercise or inadequate sleep, and environment, including weather and noise.

### Goals and Objective

✓ *Goal 1*

This module is designed to present useful information and an understanding of stress to middle and high school students. The intent is to provide relevant information to students via an interactive approach utilizing the presentation of factual information and group activities. The module addresses causes of everyday stress, consequences or symptoms and manifestations of stress, and management or ways to relieve stress and treatment.

✓ *Goal 2*

This module is also meant to provide education and guidance for school professionals. It is hoped that teachers, counselors and other school staff will develop an appreciation for the heightened level of stress that many adolescents experience and understand the adolescent's perspective on factors that contribute to stress. Ideally, school professionals will see symptoms of stress with a view toward evaluating their seriousness and/or chronicity, and will help teenagers connect with adult support and medical professional systems when needed.

✓ *Objective*

This module will help both students and school staff identify causes and symptoms of stress and develop some basic stress management skills. Students and school staff will be able to delineate the differences between transient stress reactions and the development of stress that is more serious and mood disorders. Students and school staff will know to initiate a conversation about serious stress with someone they feel may be at risk and with an adult who can help.

**Prior to Activities: Determine Level of Safety**

Due to the sensitive nature of the information contained in these modules, we recommend that an assessment of the level of safety within the group of students that will participate in the presentations be conducted. By safety, we refer to the level of comfort, confidentiality, and closeness students may feel among each other and with the presenter. For specifics, please see Chapter 2 in this manual entitled *Assessing Class Safety to Determine Curriculum Level*.

Once the presenter has identified which level to use with the group of students, he or she will find in each of the modules specific activities to be used according to the level of safety. (i.e., Level 1 activities are used with Level 1 safety level).

**Level 1 Activities**

✓ *Activity A: Factual Information Regarding Cause, Consequences and Management of Stress*

Estimated time: 45 to 60 minutes. This activity level is primarily factual in nature. The material presented is designed to provide students with a beginning understanding of the prevalence of stress reactions and to develop a framework to help students and staff think about ways to manage and minimize stress in order to prevent more serious difficulties. Both the student responses to the informational presentation as well as responses to the initial "Sources of Stress" survey can be used to promote class discussions and to expand student knowledge about this topic.

There are two basic components to this activity. The first is a didactic review of the causes and symptoms of stress along with strategies for daily stress management. The second is an open-ended format where the presenter encourages discussion.

*(A-1) Didactic Presentation*

*Presenter: Introduce self; mention purpose of presentation and overview of topics to be covered. In the section below are included the overview of this topic, as well as causes, symptoms of stress and some basic guidelines for stress management.*

*An alternative to beginning with a didactic lecture is to use the Sources of Stress Survey (Appendix 3-A). This survey divides the potential sources of stress into school, relationships, or changes in teenagers. You can ask the students to fill out the survey, which can then be reviewed. Or, you can paste three large pieces of paper (e.g., easel paper) in front of the room. Then using the categories from the survey, the first is labeled "school," the second "relationships," and the third "changes during adolescence." Students are then asked to take a minute and come up with different examples of sources of stress that fall within each category. By eliciting student response, you can be sure to address all particular concerns of the group. Their responses can then be supplemented by the following didactic information.*

Overview of Topic

While stress used to be an infrequently employed term to describe the life of adults with multiple responsibilities and obligations, it has now become alarmingly pervasive among teenagers. Expectations for success in multiple arenas (i.e., school or relationships) has placed many teenagers in a position of having to "go around the clock" to meet all their personal objectives. This, together with the increased lines of communication and inter-connectivity secondary to the Internet, cell phones, etc., has left teenagers with a dizzying array of sometimes conflicting expectations and choices. The net result is stress, with over 90% of high school students reporting some period of significant stress. (Peterson & Spiga, 1982)

Causes of Stress

✓ *School*

- Academic Performance: Exams and papers are part of academic performance and can contribute greatly to adolescent stress. Generally, all students are under pressure from home, peers, and themselves to do well and pass their tests with favorable results. If your self-esteem is especially tied in with performing well, you may compel yourself to study hard and expect to receive good grades.

  Many parents likewise expect teenagers to do well in school. Adults generally believe that academic success is positively correlated with having a happy future. They believe, alternatively, not performing to one's "capacity" will spell disaster for the future. These adult expectations can cause a great deal of stress.

  Self-imposed expectations for success can significantly contribute to stress. As one adolescent noted, one of the greatest sources of stress for teenagers is our own "perfectionism." To some students, receiving a "B" is tantamount to a failure. They are unwilling to accept an "average" performance, because to them, "average" equals "second-rate." They constantly compare themselves to others and are often distressed if other people perform better than they do. Most perfectionists try to do too much at one time and frequently set extremely high standards for themselves and others. Setting high standards is not the problem. Setting high standards that cannot realistically be attained is the problem, and it can be self-destructive. Individuals with perfectionist tendencies expect everything to be 100% or they become frustrated, irritated and unhappy. Perfectionism is based on a belief that unless I am perfect, I am not okay.

- Classmates and Teachers: Feedback from teachers and classmates can be an additional source of stress in adolescence. Just as students can be too hard on themselves in terms of unrealistic expectations, teachers can also inadvertently make you feel like you are not "measuring up." Feeling that you are letting your teachers down can be a cause of heightened stress. Intense competition with classmates can also contribute heightened stress.

✓ *Relationships*

- Parents: Parental pressure takes many forms, including pressures to succeed in school extra-curricular activities and to make "good" choices in friends and general conduct. In actuality, few teenagers can meet their parents' expectations across all areas of functioning. For many, the major challenge is facing the (often) conflicting expectations between parents and friends. For example, it may be important to parents that their daughter continues to play a musical instrument; however, this commitment may preclude her from engaging in social activities with her peers. It is easy for an adolescent under these circumstances to feel heightened stress and begin to experience confusion and decreased performance.

Intermittent lack of communication between teenagers and their parents is common. Adolescence is a time of finding one's own "path" .Home, which had formerly been a sanctuary, can become a place fraught with conflict and emotion. Problems at the school or with friends can become magnified, if home is no longer a safe haven. The inability to confide in family members may lead to the sense that problems cannot be shared and remedied which, in turn, can lead to either isolation or more dependence on peers.

When cultural differences arise between parents and their children, additional stress may arise. Within families of other cultures, there are often different levels of acculturation between the generations. For example, parents may hold on more steadfastly to their cultural beliefs and expectations, whereas the children may espouse beliefs or values consistent with the mainstream culture. This presents not only a conflict between parent and child, but also one of identity for the adolescent trying to figure out which road to travel. To further complicate matters, words used to describe stress and sadness may not directly translate to the parent's first language. Therefore, communication is impeded by a number of factors including age, acculturation, and language.

While the potential conflicts between parent and adolescent described above may certainly trigger stress in the family system, it is also important to recognize that parents may be important sources of protection against stress. Although differences in opinion will likely rise between parent and child, the availability of a stable parental figure, and the ability to problem solve and share opinions together will likely help protect teenagers against stress.

- Peers: Peer pressure affects most teenagers. Peers generally influence each other in a variety of ways. It is common for teenagers to worry about not being able to get along or "fitting in" with others whether due to dress, appearance, extracurricular success, or academic achievement. Peer pressure can be challenging and stressful leading to periods of tumultuous relationships.

  Peer pressure can motivate teenagers in a positive sense to be more productive and supportive. It becomes negative when it results in pressure to do something an adolescent would not ordinarily do (nor approve of) simply because the person involved wants to be accepted by peers. Under these circumstances, an adolescent can lose his or her personal focus and make a choice that has adverse ramifications. Whether a teenager acquiesces or resists peer pressure, the mere existence of this pressure adds a source of stress.

  Particularly in adolescence, friends have a tendency to pressure each other about what they think is best and offer opinions whether they are welcomed or not. Some of the major areas of contention associated with peer pressure in this country are substance abuse, drinking, and sexual activity. Often, young people experiment with illegal drugs, alcohol or cigarettes after being exposed to these substances by an older or more experienced peer. Very often an adolescent

starts out 'experimenting' not realizing that these agents can be habit-forming or that their use can have unanticipated and devastating physical, legal and personal consequences. Thus, teenagers can become caught in a vicious succession of conflicts involving both their peers and their parents. These struggles can, in turn, create a tremendous distraction to the adolescent contributing to a cycle of heightened stress and discouragement.

- Siblings: There is no doubt that siblings can be difficult to handle. Depending on the climate at home, relationships with siblings can add an enormous amount of stress to an adolescent's life. Competition between siblings can also be stressful, especially if extreme jealousy is involved. Here again, while some competitiveness can be good, too much may lead to conflict. This, in turn, can lead to an escalating cycle of stress within a family context.

  It is important for an adolescent and his or her family to recognize and accept the strengths and differences between siblings. It is helpful for an adolescent to find ways to get support and feel accepted for his or her own unique abilities and accomplishments. Adolescence is a time of fluctuating relationships and family dynamics. Former family allies can become enemies and families can become divided over issues of relative cooperation and achievement. As one sibling grows to 6 foot 2, another may remain 5 foot 8. As one sibling remains lithe and athletic, another may suffer from adolescent weight gain.

- Romantic Relationships: Romantic relationships become more important in adolescence. These relationships can play a key role in either supporting or undermining a particular adolescent's adjustment and level of stress. For example, if one adolescent dates another with overlapping values the relationship may promote emotional well-being. If, on the other hand, the relationship is fraught with conflict and differing values and interests, romance can wreak havoc in an adolescent's life. The interpersonal equilibrium with other peer relationships can be thrown off balance. Parents and even friends may oppose the relationship. "Broken hearts" are always painful and stressful. Pressures to be sexually active before one is ready can be intense. Some relationships can even by emotionally or physically abusive.

✓ *Changes during Adolescence*

- Puberty: Puberty is a time of accelerated physical, hormonal, and psychosocial changes. It is the period of physiological and anatomical development when the reproductive organs mature and become functional. During this period, teenagers become more concerned with their emerging sexuality. Puberty is often also a time of emotional and self-discovery. It is the rapidly changing external and internal circumstances that define puberty that can make this time of life particularly stressful. Not understanding or being able to predict the changes in one's body adds to overall stress.

Thus, many teenagers become intensely concerned with their physical appearance during this time. They may feel too short or tall, too thin or fat and, overall, struggle with the sense that they are unattractive and awkward. While girls who mature early may feel self-conscious about being overly developed, boys may worry excessively about their stature, strength and athleticism.

Most teenagers feel overwhelmed and confused because of the many physical changes. These changes can interfere with an adolescent's sense of personal identity, that is, the awareness of oneself as a consistently whole and unique person. Many teenagers experience identity crises where they keep asking themselves what kind of image they project to their friends and to themselves.

Late-maturing teenagers tend to have a poorer self-image than do teenagers who mature early or at an average rate. They may also have difficulty choosing and/or making friends. Teenagers feel a strong need to compare favorably with others their age. Anything that makes them different will likely trouble them. Teenagers often report feeling extremely isolated during periods of heightened physical change and may have trouble confiding these insecurities to either friends or family. This can lead to confusion, worry and disruption of mood. (Colton, et al., 1991)

- Increasing Responsibilities: As teenagers grow older and become adults, they are exposed to more responsibilities. The challenge of fulfilling multiple obligations and duties can add to a teenager's stress level. Most teenagers welcome more responsibilities and independence. Some, on the other hand, may have difficulty in handling the challenge. To accept responsibility, a person needs self-confidence. However, self-confidence can be hard to develop if one is also experiencing uncertainty and stress about performance as a student, athlete, or their own sexual status.

  As teenagers get older they are often required to start earning money, assume more responsibility for household chores, help more actively in family obligations, etc. This requires the ability to 'multi-task', which means prioritizing and rotating competing responsibilities. This may be the first time that an adolescent really feels that he or she cannot keep up with all the demands placed on them and, in response, starts making rash decisions, mishandling time or withdrawing. This difficulty can be exacerbated if the addition of responsibilities (e.g., finding a job) is due to financial reasons rather than for recreational reasons.

✓ Additional Causes of Stress

- Loss, Trauma and Change: A major event such as the death of a family member inevitably leads to upset. Experiencing sad and angry emotions may create anxiety for an adolescent and trigger periods of emotional dysregulation. Deep sadness, confusion and anger can also be experienced, particularly in adolescence, around other losses such as the relocation of a friend or the death of a beloved pet. Changes in family composition such as siblings leaving for

college, a parent losing their job, or illnesses of family members can also cause significant anxiety and stress.

This kind of response is called reactive stress in that it comes in response to external factors over which the adolescent has no control. At times external factors can become so overwhelming that sleeping, eating, studying and relationships are all disturbed. When these symptoms last over a period of months or worsen, professional help needs to be sought immediately. Anxiety of this duration and magnitude can actually become a disorder known as Acute Stress Disorder, a treatable condition that may require therapy and medication in order to improve. (Larson et al., 2002)

Consequences of Stress

✓ *Physical Symptoms of Stress*

- Physical symptoms of stress are more likely to appear when the degree of worrying becomes more than the problem or feared outcome actually warrants. These uncomfortable physical or "somatic" feelings include restlessness, becoming tired quickly, muscle tension, and trouble falling asleep or staying asleep. Other common ways our bodies express significant stress include headaches, muscle tension, sleep difficulties, and fatigue (Diagnostic and Statistical Manual of Mental Disorders, 1994).

- Tension headaches are often caused by stress that leads to tensing of the muscles in the scalp. There are also a variety of common medical causes of headaches ranging from the need for new eyeglasses, to allergies or sinus problems to headaches. If aspirin, ibuprofen (Advil, Motrin) or acetaminophen (Tylenol) is needed more than occasionally, then headaches are a problem and worth a conversation with a doctor. He or she can tell you if it is from stress and help you make a plan to relieve it.

- Muscle tension can appear as sore muscles or shakiness. (Diagnostic and Statistical Manual of Mental Disorders, 1994). It is the body's way of telling us that something needs to change or get easier. For competitive athletes, muscle soreness and fatigue is expected. However when the pressure is high, some of muscle symptoms may be stress related. Continuing to play despite injuries or training excessively can deprive your body of the needed recovery time and can lead to poor performance, pain, injury, and subsequent burn out.

- Sleep difficulties can be a sign of stress and contribute to fatigue and being worn down. While everyone has occasional difficulty falling asleep or waking up during the night, when either or both of these become prolonged and frequent one needs to take notice and seek a solution. The first step when awake in bed is to not worry about when you will fall asleep. Instead, focus on things that you enjoy. Pleasant thoughts or memories will tend to relax you and facilitate your sleeping. It is also helpful to cut down on caffeine containing beverages such as coffee, tea, or soft drinks.

- Fatigue or tiring quickly can be an indication that your muscles are working hard from the unnecessary tension of stress, that sleep problems or simply not having or giving yourself enough time to sleep are wearing you out or that you are run down and getting ill. For some people who prefer not to exercise and find ways to avoid it, even at school, fitness level and stamina fall and add to the fatigue. For others, excessive exercise may be the issue. In any case, if one experiences persisting fatigue then something bears a look and some change.

✓ *Psychological and Behavioral Responses to Stress*

The prominent emotional signs of stress include reduced concentration and irritability (Diagnostic and Statistical Manual of Mental Disorders, 1994).

- Reduced concentration is common in stressful circumstances. It can be readily obvious or only noticed later when little has been accomplished (e.g., homework). There is sense of being "scattered" and an inability to focus on the task at hand. It is hard to remember what has been read or studied or only half-listened to in class. It is worsened by physical exhaustion, sleep problems, and fears about falling behind and an inability to catch up.

- Irritability is seen when one has a "short fuse", rude things are said without thought, intense rages over small annoyances, or one gets into frequent fights. The anger is much more than one's usual demeanor. The irritability can be confusing and hard to easily label as "stress" because it shifts so quickly to "intense angry". The anger does not quiet down easily and often results in hostile interchanges with friends and family. Even if contained, it takes little outside pressure to bring it back. Persistent irritability is common in depressive and anxiety disorders.

Management or Ways to Relieve Stress

A critical premise in stress reduction is that fact that "taking out one or two things" reduces stress. There is no need to remove all stress. Even taking just a few minutes each day can make things better.

It is also important to not deal with stress alone. Successful stress reduction is also based upon gaining input from others to help develop effective coping strategies. For an adolescent, this includes friends but it helpful to also have at least one adult (i.e., parent, religious leader, teacher, counselor, coach, therapist, etc.) understand his or her distress.

The following are a number of interventions for teenagers to consider if they start to experience any of the physical or psychological signs of stress (Schor, 1991).

✓ *Interventions to reduce stress*

- Eating properly: Eating can be one of the best ways of de-stressing. Food is a way to recharge your body. Herbal teas and nutritious foods help your body to

operate better. The body is a machine, and like all machines, it requires fuel. This is fine so long as it is not done to excess. Continuous snacking for stress-relief may run the risk of developing a secondary eating problem; the key is to eat in moderation, particularly “high-energy” foods.

- Sleeping adequately: Feeling tired and drowsy can be due to your heavy workload or schedule. It is not always possible to simply stop yourself from feeling this way. Sleeping is a good and cost-free method of relieving stress. When you sleep, you are resting your body and mind, exactly what your body needs when you are tired.

  Establishing a regular sleep or bedtime is helpful. Consider taking a nap; set a time for how long you want to sleep in order to make sure you have enough time left to do your work afterwards. Set an alarm clock to wake up. Then, wash your face or take a shower to freshen up and you will feel ready to take on your work.

- Making time for recreation: Take time from your schoolwork to get together with a friend or friends for a non-work related activity (e.g., exercise, movie, club, talk with a friend, etc.). Recreation is an efficient way to relieve stress because you divert your focus away from your stresses. If you are tired after a long day, talk with a friend or plan to do something ‘just for fun’. Once your stress has been reduced, you more easily return to your work.

- Reading: No matter your age, reading can be enjoyable. Reading helps by putting aside required stressful work and allowing you to sit quietly to stimulating your mind while at the same time resting your body.

- Listening to music: Music is another effective way to reduce stress. Research has shown that music, especially soothing or classical tunes, can increase concentration. Music helps reduce disturbing thoughts or worries in one’s mind. It can be helpful to take a study break to relax and listen to your favorite radio station or CDs. For some, listening to music while doing work is beneficial. It is important however, to try working both with and without music to ensure that you are not actually decreasing your productivity and distracting yourself should you listen while working.

- Exercising moderately: Some experts suggest that exercise pumps stress-busting endorphins into the bloodstream. Others describe how exercise provides a physical response that meets the body's need to counteract the stress response. Still others discuss how exercise offers a relaxing time-out from the normal routine by increasing the brain's output of alpha waves, which are commonly associated with relaxation. Whatever your choice of theory, there is substantial evidence to support that regular exercise does lead to a reduction in stress.

Regular vigorous exercise, for as little as half an hour 3-4 times per week, conditions the body to operate more efficiently, so that we feel better physically and emotionally. It works to relieve tension, anxiety, anger and depression while increasing a sense of self-control. Since vigorous exercise provides effective stress reduction, any activity that involves continuous motion and keeps our hearts pumping vigorously will work.

Brisk walking, jogging, cycling, swimming, rowing and aerobic dancing are all examples of vigorous exercise. These activities are also great opportunities for sharing time with friends. Sports such as handball, racquetball, soccer and basketball are also suitable activities as they involve continuous motion. By challenging your body with physical exercise, you are helping to make yourself more resistant to stress. 2 hours a week spent in regular vigorous exercise can help you feel more relaxed, sleep better, be healthier, and enjoy more energetic productivity.

- Relaxation, meditation, yoga and non-aerobic exercises: Meditation can empty the mind of unwanted thoughts and worries, relax the body and prepare us for the rest of the day. There are many methods of meditation. Some are religious or complex but others are pared down, simple and efficient. Most involve sitting quietly for up to 20 minutes and achieving a quiet mindfulness. For those who prefer to be in motion, yoga or movement meditations such as T'ai Chi may feel more natural. These, too, can provide a quieting of our hectic thoughts, a relaxation of our muscles and a renewed sense of energy.

- Time-management techniques: It is critical for students to manage their time efficiently. As academic demands increase, students often experience heightened stress secondary to not prioritizing their academic responsibilities. The workload in high school, for example, is much greater than in junior high school and involves meeting competing demands from numerous teachers. The following techniques have proven helpful.
  - Set both daily and weekly goals for each subject area.
  - Write these goals down in a centralized location where they are visible and easy to review.
  - Create clear deadlines for when you plan to complete each phase of a project.
  - Break all tasks/assignments down into smaller component parts that are manageable.
  - Check things off as they are finished so you can see the decrease in your workload and decrease the stress that comes from feeling there is "too much to do".
  - Reward yourself with enjoyable activities after reading component objectives.

*(A-2) Open-ended Format*

*Questions to Guide Discussion and Possible Presenter Responses*

1. By a show of hands, were most of you familiar with the definition of stress?

   *Presenter: Encourage discussion about any level of exposure to the topic of stress and its symptoms.*

2. Was there anything in the description of stress that was new information for you? If so, what?

   *Presenter: Encourage students to discuss any misconceptions or wrong information they may have had that was challenged by this factual information.*

3. Were you familiar with the causes of stress? What was your understanding of the causes of stress/anxiety prior to this presentation?

   *Presenter: Encourage students to discuss any misconceptions or wrong information they may have had that was challenged by this factual information.*

4. Were you surprised by any of the major consequences of prolonged stress?

   *Presenter: Understanding what most "surprised" students will provide a window into understanding in what information they are most interested. Keep a record of questions so they may be addressed in future meetings with the students.*

5. Were you worried by any of the information presented? If so, what?

   *Presenter: The answers students share to this question might provide a window into their concerns about themselves or loved ones. It will be important to reassure students that everyone will experience intermittent periods of stress, but it is the continuity, severity, and amount that makes the difference between regular stress and more serious problems. It will be important to have time available to meet with students individually should they continue to express worries or concerns.*

6. If this new information has made you wonder if someone you know might be suffering from a serious stress reaction, how would you approach him or her about it?

   *Presenter: We do not encourage giving specific advice to students about how to do this. However, it would be appropriate to guide students in identifying professionals or resources to help them (e.g., school nurse, guidance counselor, school psychologist, or social worker, member of clergy, family doctor). The primary message to students should be not to feel solely responsible for helping someone who is having a difficult time.*

7. Are there any further questions, or is there a particular topic related to stress that you would like to learn more about?

   *Presenter: You may wish to ask this question verbally, or provide students with index cards where they may share their questions anonymously. It has been our experience that students feel more comfortable sharing their questions and concerns in writing.*

✓ *Activity B: Stress as it Relates to Competition and Perfectionism*

Estimated time: 45 minutes to one hour. While the previous lecture format of the first activity can be informative, discussion and class participation have been shown to further increase learning. This following activity is conducted as a group project.

*Presenter: An internal sense of perfectionism and competitiveness can underlie chronic feelings of stress and tension which can, in turn, lead to the development of more pervasive mood and anxiety problems. Divide the classroom into smaller groups of students, and ask each one to discuss and complete the Competition Scale (Appendix 3-B). The class will then come together again and discuss each group's responses. The following questions can also be used to facilitate discussion.*

1. In your family as well as in your larger community and culture, how do people encourage competitiveness? What is the reaction you believe prevails when someone is seen as "not reaching their potential?"

2. When you are feeling particularly hard on yourself or that you have disappointed someone else's expectations for you, are there people you can confide in?

3. Do you feel that there are people in your life who will advocate for you when you want to decrease stress by dropping a sport? Decreasing a class level? Increasing leisure time activities?

**Level 2 Activities**

Level 2 begins by providing the same factual information and discussion as is described above in Level 1 activities. However, Level 2 moves beyond facts to introduce exercises and treatment options.

✓ *Activity A: Factual Information Regarding Cause, Consequences and Management of Stress*
Estimated time: 45 to 60 minutes. See Level 1 Activities above for details.

✓ *Activity B: Stress as it Relates to Competition and Perfectionism*
Estimated time: 45 minutes to one hour. See Level 1 Activities above for details.

While experiences of stress appear to be an inevitable part of daily life, the good news is that exercises exist to help fight the mental and physical impact of stress. In the same way a treadmill helps to train muscles, breathing, relaxation exercises, and imagery can help to train the mind and body to fend off negative consequences of stress. The following relaxation activities can be used with a group of teenagers to introduce them to these relaxation exercises. You can use one or all pending on the interest of your class.

<u>Note to Presenter</u>*: To help students feel more relaxed, many of these activities involve having them close their eyes, evoke memories, or pay significant attention to body cues. While generally these can be relaxing activities, for some students the experience might conjure up negative memories or cause anxiety. It will be important to let students know, prior to beginning the exercises, that if they feel uncomfortable at any time, they may stop and just engage in a quiet activity. Support should be available after the activity should any student require individual assistance.*

✓ *Activity C: Deep Breathing Exercise*
Estimated time: 15 minutes. Ask students to sit comfortably in their chairs. They may sit on the floor if that is more comfortable. Students may choose to close their eyes or keep them open. The instructions and script contained in Appendix 3-C are then followed. A fun variation of this activity involves using bubbles. In order to blow big bubbles, one must use long, concentrated deep breaths versus short ones. Ask students to blow bubbles so they can practice using long breaths, and then begin formal training.

✓ *Activity D: Progressive Muscle Relaxation*
Estimated time: 30 minutes. Indicate to students that in this exercise, they will participate in progressive muscle relaxation. This means that they will tense, and then relax specific muscle groups throughout their bodies.

*<u>Script to use with students</u>: This exercise is used to help you become more aware of the tension you carry in your muscles, and to find a way to relieve that tension by consciously relaxing your muscles. If you have injuries or illness that involve your muscles, please do not do these exercises prior to consulting your physician. I will ask you to tense a specific muscle group for 5 seconds, and then relax it for 15 seconds. Then we will move on to the next muscle group. While relaxing your muscles, do so completely and abruptly; let the muscle go completely limp. Otherwise, some tension will remain in your muscles. While relaxing, remember the pleasantness associated with the relaxation. When we are finished, count backward from 10 to 1 and open your eyes when you are ready. While we will be covering a group of muscles, it is not always necessary to go through the whole exercise. That is, you may wish to target a particular muscle group where you feel the most tension (e.g., neck and shoulders).*

1. Hold your right arm straight out in front of you and bend your hand upward pointing your fingers toward the ceiling. Hold that tension 5 seconds. Now relax. Let your arm drop to your side and allow the muscles to go completely limp. Wait in this position for 15 seconds, noticing the relaxed feeling in the muscles.

2. Hold your left arm straight out in front of you and bend your hand upward pointing your fingers toward the ceiling. Hold that tension 5 seconds. Now relax. Let your arm drop to your side and allow the muscles to go completely limp. Wait in this position for 15 seconds

3. Raise both arms and touch your shoulders with your fingers. Tense your biceps. Now relax.

4. Shrug your shoulders; raise them as high as possible. Notice the tension. Now relax.

5. Sit up straight in your chair. Arch your back. Bring your shoulder blades back and together. Now relax and sit back in your chair.

6. Close your eyes tightly. Relax.

7. Press your lips together tightly. Relax. Let your jaw go limp while keeping your lips closed.

8. Press your head backward, and point your eyes toward the ceiling. Bring your head back to its normal position.

9. Press your head forward, burying your chin in your chest. Bring your head back to its normal position.

10. Tense your stomach muscles as if preparing for a blow to the stomach. Relax.

11. Straighten your legs. Tense all the muscles in your legs. Hold them out in front of you. Now let them go limp and fall to the floor.

12. Point your toes upward toward your face while keeping your feet on the ground. Note the tension in your calves. Relax.

✓ *Activity E: Visualization and Imagery*

Estimated time: 1 hour. A strong connection exists between the mind and the body. That is, thoughts, memories, sights, sounds, and even smells can trigger body responses and evoke feelings. Therefore, using exercises that involve visualization and imagery can positively impact the body and reduce a stress response. The following is an introduction into creating visualization and imagery scenarios that can compliment stress reduction techniques.

*Presenter: We will go through some instructions for using visualization and imagery techniques. For these exercises, I will ask you to relax, close your eyes, and create pictures in your mind. If you feel uncomfortable at any time, please feel free to stop.*

*Script to use with students:*

*Do you remember ever feeling motivated to get through a hard period because at the end there would be a wonderful experience? For example, getting through midterms so you could have a winter vacation. You can see yourself waking up late, not having to deal with studying for tests, and watching TV to your heart's content. What you have been doing is called visualization. Often, people visualize a desired outcome as a way to help motivate and decrease the stress of the process of getting to the outcome. Putting up a picture of the college campus you would like to attend, a picture of a vacation spot you would like to go to, or a picture of a car that you are saving for might all be ways to visualize what you want. While visualization does not decrease all the stress associated with some time periods, it does help with gaining control over the situation and knowing there is an end point. When you allow yourself to dream about the outcome, you also allow yourself to problem-solve in new and creative ways. Problem solving, experiencing the positive feelings associated with what you want, and taking the time to think about your goals are all ways to reduce stress.*

*Questions to students:* Have any of you ever done this before? What kinds of things did you visualize? Was it helpful to reduce stress?

*Guided imagery script:*[2]

*When you go to the movie theater or watch a video at home, you may find that you are completely focused on the plot and action and become oblivious to your surroundings or even your own body. During this time, your emotions are influenced by what you see and hear. In the same way, we can consciously focus on and experience relaxing scenes in our mind and bring about the relaxation response. Together, we will go*

[2] Developed by Logan D, Reilly N (2003), Medical Coping Clinic, Children's Hospital, Boston.

*through some instructions for using this technique. You can then practice this at home and add more detail to your image.*

1. Choose a relaxing scene. Think of the most relaxing place you have ever been. The place can be real, or it can be imagined. For example, your place can be a mountainside cabin, or it can be a castle in the clouds. There are no right or wrong answers, and your imagination is limitless! When you have chosen your place, take a piece of paper and write a script of the scene using all your senses - sight, sound, touch, smell, taste, and temperature. Describe this scene in full detail and using the first person (e.g., I am standing on a balcony with the ocean waves below. It is warm and smells like salt from the sea.)

2. Chose a word or phrase that will help you recall this scene (e.g., ocean, my relaxing spot).

3. Try to memorize what you have written, so that when you practice you do not have to refer to the paper. Practice at least two times per day. Repeat your word or phrase several times to yourself at the end of your practice when you are relaxed.

4. As you become more confident in using this imagery technique, try using it during the course of your day. You can practice during a study period, for example, or on your way to school.

*Questions to students:* Any volunteers to share their scene? What piece of it is most relaxing for you? Finally, let us take a few moments to practice the guided imagery. Find a comfortable place, sit and close your eyes. Review the scene and allow your mind to guide you through the relaxation response.

✓ *Activity F: Getting Help When You Are Stressed*

Estimated time: 45 to 60 minutes. This is an exercise to help students to self-identify when and how to get help when under stressful circumstance. The presenter should use the following material to facilitate classroom discussion.

*Script to use with students:*

*If you had to determine whether someone seemed unduly stressed to you, what would you look for? What signs?*

Looking for evidence of stress

- Mood: sadness, irritability, anger, tearfulness
- Feelings: discouraged, hopeless, jittery, worried
- Behaviors: forgetfulness, indecisiveness, decreased concentration, difficulty eating or sleeping

- Thoughts: obsessive worrying, confusion, ambivalence, low self-esteem

*Script to use with students:*
*At some point, people will likely experience these symptoms of stress. For example, this may occur when you go through the college application process, a high-stakes extracurricular event, an increase in family conflict, or an illness. Let's talk about ways to determine whether the symptoms someone is experiencing are either part of a temporary stressful situation or whether they are indicative of a more potentially serious situation.*

Stress Signs and Symptoms

- Significant increase in symptom severity (intensity and duration)
- Declining functioning across family, school, peers, and health domains
- Increased burden of suffering with distress, anguish, and difficulty coping
- Significant decrease in ability to multi-task and effectively prioritize daily activities
- Difficulty sleeping, loss of appetite, over or under-reacting to daily events, preoccupation with worries, anticipation/dread of negative outcomes or fear of failure, and both over and under working at tasks.

*Presenter: After the above discussion, the presenter can present the following material or can ask students what they know about the possible sources to obtain help. The presenter should be knowledgeable about sources of help available within the school.*

Getting Help / Treatment

- Stress reactions are highly treatable. Psychotherapy and medications have been shown to be effective treatments. Usually, psychotherapy is tried first. If the person does not improve, then medication is also used.
- Counseling can help focus on changing thinking, and can help the person develop better ways to cope daily with stress. Emphasis will be placed on examining self-expectations, prioritizing daily tasks and anxiety-management skills.
- Group and family therapies can sometimes be helpful as well, as you are able to interact with others and know that you are not the only one having similar difficulties.

What You Can Do in the School

- If you have identified any change in your own stress level that appears to be lasting longer than you would like and affecting you in a negative fashion, or if you simply do not feel right, there are many people who are willing to help. For example, within the school, you can contact a teacher, a nurse, or your guidance

counselor. Each is willing to listen and to find help for you in a safe and confidential manner. People within the school setting will help you find counseling, if that is something you will need.

- Sometimes, you might notice these symptoms in a friend, and perhaps that friend has not identified the symptoms in him or herself. Do not feel like you are betraying them if you speak to a teacher, nurse, or counselor about your concerns. Remember, identifying and treating stress early helps make outcome better and may prevent the development of a full-blown anxiety disorder or clinical depression. Therefore, you are helping your friend. Also, remember that he or she might react in an angry fashion with you initially. Helping your friends is not shameful or "telling on them."

**Level 3 Activities**

Level 3 begins by providing the same factual information and discussion as is described above in Level 1 and in Level 2 activities. However, Level 3 moves beyond general discussions to role-playing and discussion of personal experiences.

✓ *Activity A: Factual information Regarding Cause, Consequences and Management of Stress*
Estimated time: 45 to 60 minutes. See Level 1 Activities above for details.

✓ *Activity B: Stress as it Relates to Competition and Perfectionism*
Estimated time: 45 minutes to 60 minutes. See Level 1 Activities above for details.

✓ *Activity C: Deep Breathing Exercise*
Estimated time: 15 minutes. See Level 2 Activities above for details.

✓ *Activity D: Progressive Muscle Relaxation*
Estimated time: 30 minutes. See Level 2 Activities above for details.

✓ *Activity E: Visualization and Imagery*
Estimated time: 60 minutes. See Level 2 Activities above for details.

✓ *Activity F: Getting Help When You Are Stressed*
Estimated time: 45 to 60 minutes. See Level 2 Activities above for details.

*<u>Note to Presenter</u>: Activities G, H and I offer either a class discussion format or expand upon the previous relaxation exercises. You should decide which activities to select based upon suitability for your group of students.*

✓ *Activity G: Assumptions About Stress Reduction*
Estimated length: 30 minutes. Two vignettes are read aloud to the class with discussion focused upon the following questions:

1. What is your definition of being overly stressed?

2. What would be your guideline of when you would talk to a peer / parent / adult?

3. If someone asked you if you go to therapy to manage your anxiety, what would you say?

4. What do you think people would assume about you if they knew you were "lightening your load" to manage your stress?

- Vignette G-1: Laura is a 17-year-old senior in high school. She has an older brother and sister who both attended Ivy League schools. Laura plays three varsity sports and is trying to work on her college applications. She tries to

socialize on the weekend and still leave time for practices and schoolwork. She has recently become irritable and jumpy, forgetting essential things she needs and always worrying about failure of some kind. She wants to attend a Division 1 college where she can play soccer.

- Vignette G-2: Matt is a 17-year-old senior in high school. He is the oldest of three children and plays one varsity sport. His parents are divorced and he works weekends at an ice cream parlor for money. Matt likes to 'party' but has not been known to drink too much or engage in any seriously delinquent behaviors. He is applying to a half-dozen tier-two colleges and seems to be relaxed and happy most of the time.

*Additional class questions: What are your reactions to these two individuals? Who do you think will fare better in the long run? Do you like and/or admire one of these individuals more? If so, why? Who would you rather be?*

✓ *Activity H: Role Plays*

Estimated time: 45-60 minutes. This activity encourages discussion via role-plays. Students should discuss their experiences during the role-play, as well as the reasoning behind their responses.

- Role Play H-1: "Ann, I need to talk to you—I really hate (playing 3 sports / playing an instrument, etc.) but I know my parents will be all over me if I try to stop. They will give me a million reasons why I should keep working as hard as I do but, frankly, it's my life isn't it?"

- Role Play H-2: "If I tell you something will you promise to keep it to yourself? The pressure around college is getting to me along with all the other things I'm doing. I actually haven't been sleeping, probably because I've been drinking coffee at night to keep myself up. Then, I'm all jittery at school. I can't really concentrate. Sometimes I even take some Sudafed to keep myself awake for practices. The other day I felt so anxious that my heart was racing and I felt dizzy. My stomach hurts every morning. I guess I just need to keep going until the end of the year. Someone told me if I could try some Ritalin it might help. Now remember, you're not to mention this to anyone."

✓ *Activity I: Play to Relax*

Estimated time: 45 minutes per exercise. Play is one of the most fun ways to reduce stress. In a setting where academic demands and deadlines loom large, having a designated time to play and discuss what impact the stress is having is helpful. Following are several exercises that can be done in groups to play, decrease stress, and discuss important topics directly related to health and wellness. Ideally, these exercises should be conducted in small groups, no larger than 15.

- Exercise I-1: The Pie. This exercise is based on the idea of a pie graph. Ask students to draw a pie graph and indicate the different parts of themselves, along with the percentage of value they place on each. After the students are finished, ask each person to discuss his or her pie graph.

- Exercise I-2: Qualities of a Whole Person. Have a cut out outline of a person for each student. Inside, ask them to write the qualities that make a "whole" person.

  This exercise stimulates thought about how to become well rounded. This is especially helpful for students who are stressed by academic demands. Discuss each quality, and use them to help students remember that there is far more to becoming a "whole" person than just getting good grades.

  Presenter questions:
  - *Does this help visualize parts of you that are blocked out by stress?*
  - *What can you do to help maintain the other parts of you in times of stress?*
  - *What part of this graph or person are you most proud of, or of what positive qualities does it remind you?*

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## Appendix 3-A: Sources of Stress Survey[3]

Below is a list of the more common sources of stress in adolescence. Please indicate which, if any of these, you have personally experienced.

| Sources of Stress | YES<br>Source of stress | NO<br>Not a source of stress |
|---|---|---|
| **School** | | |
| 1. Tests and exams | | |
| 2. Classmates and teachers | | |
| 3. Extra-curricular activities | | |
| **Relationships** | | |
| 1. Parents | | |
| 2. Peers | | |
| 3. Siblings | | |
| 4. Boyfriend / Girlfriend | | |
| **Changes during adolescence** | | |
| 1. Puberty | | |
| 2. Increased responsibility | | |
| 3. Changes in the family | | |
| 4. Peer pressure | | |

Indicate any other stresses not mentioned above:

[3] Developed Kaplan C (2003) McLean Hospital, Belmont, Massachusetts

## Appendix 3-B: Competition Scale[4]

Check the box next to each statement that corresponds with the number that best represents the way you behave in your everyday life.

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| I must not lose in any competition. | | | | | | | | | | | I'm not bothered by winning or losing. |
| If I don't do well, people won't respect me. | | | | | | | | | | | I'm not affected by the opinions of others. |
| I must read everything written about a school assignment. | | | | | | | | | | | I'll only read what I need to get the job done. |
| I feel uncomfortable when I hear of a friend's success. | | | | | | | | | | | I'm glad when my friends are successful. |
| I don't like people who are better than I am. | | | | | | | | | | | I have no ill feelings towards people who are better than me. |
| Losing any competition is embarrassing for me. | | | | | | | | | | | Losing does not embarrass me. |
| I feel nervous when I don't have all the information I need. | | | | | | | | | | | I'm calm even when I'm not fully prepared. |
| I think most people want to be better than me. | | | | | | | | | | | I don't think most people want to be better than me. |
| I want things that other people have. | | | | | | | | | | | I don't feel a need to have things that other people have. |
| I don't like sharing information with others. | | | | | | | | | | | I have no problem sharing information with others. |

[4] Developed Kaplan C (2003) McLean Hospital, Belmont, Massachusetts

## Appendix 3-C: Deep Breathing Instructions[5]

Begin this exercise by sitting quietly in a comfortable position. Close your eyes and follow the instructions below.

1. Put one hand on your abdomen and one hand on your chest.

2. As you breathe in allow your abdomen to extend and your chest to remain relatively still. This is called diaphragmatic breathing.

3. Breathe in slowly and count to yourself to about 5 or 7, whichever allows you to just reach the point where your lungs are expanded fully.

4. Pause briefly while your lungs are expanded. Then exhale slowly counting to 5 or 7 again.

5. You do not need to force all the air out of your lungs when you exhale. Just allow your breathing muscles to come to rest as you normally do when you breathe.

6. Take three of these deep breaths in a row. Then breathe normally for a minute. Then take three more deep breaths. Continue this cycle of deep breaths and normal breathing until you feel relaxed enough.

7. If you begin to feel dizzy or light-headed, just begin breathing normally for a while.

While learning this technique, practice using it several times per day. Whenever you feel symptoms of distress, practice the deep breathing exercise. You can practice it before you know you are going to have to perform some stressful activity like taking an exam.

It is important to realize that although you may receive benefits from your first use of a skill, it may take days or weeks to learn the skill and receive full benefit from it. How much benefit will be derived from a skill will likely be in direct proportion to how often and consistently you practice.

[5] Developed by Logan D, Reilly N (2003), Medical Coping Clinic, Children's Hospital, Boston.

*Part Two of Three – Curriculum (continued)*
**Chapter 4 - Substance Use, Abuse, and Dependence**

## Definition and Overview

We live in a society where great gains have been made in pharmacology. These accomplishments encourage a quick fix mentality. If there is a problem, we have a chemical that can help. Ads in the media offer compounds to help with attention, depression, eating, pain, and anxiety. 'Chemicals deliver a quick, easy way to solve problems' may be the message to our young people.

There are some basic facts that are necessary to know before we can differentiate between facts and myths about substance use. The most important aspect of this module is to give you the facts about substances that are used and abused by young people in this country. Whether to experiment with alcohol and other substances is a major decision that every young person has to make often. Learning the facts can influence the decision a student makes. In a survey taken in the mid-nineties two-thirds of 12th graders interviewed felt that they had to choose whether or not to use drugs. (NIDA, 2003)

The word substance in this module is defined as any mood-altering drug that is used for non-medical reasons. Among the substances used are alcohol, tobacco, marijuana, cocaine, opiates, 'ecstasy', stimulants, hallucinogens, inhalants, prescription drugs, and steroids. The scope of this module is limited to the major drugs used by teenagers today.

Alcohol and substance abuse among teenagers is substantial. Among youth 12 to 17 about 1.1 million meet the criteria for substance dependence and 1 million are treated for alcohol dependence. (NIDA, 2003)

From the National Institute on Drug Abuse:
The 2002 Monitoring the Future Study reported that for the fifth year in a row overall illicit drug use among teenagers has stabilized and in some drug categories had decreased. The few increases were cocaine, heroin, and prescription drug use.

Some questions to entertain:

- Of the following four substances, which is the most addictive - marijuana, heroin, nicotine or caffeine?

- What is the first and foremost thing you should do when you come across someone who has passed out from alcohol?

## Goals and Objective

✓ *Goal 1*

This module is presented to give the student a better understanding of the facts about the most commonly abused drugs in our society today. The emphasis is on factual material and not misconceptions or myths that have been entertained by teenagers and adults for generations. This module discusses trends of substance use, stages of substance use, physical and psychological traits of substances, treatment and peer support.

✓ *Goal 2*

A second goal is to inform educators and suggest ways to broach this sensitive topic with students. The following topics are addressed for education professionals: What drugs are being used among our teenagers today? Understanding the different levels of drug use. How to match the level of drug use with the proper intervention.

✓ *Objective*

This module is designed to help both students and faculty better understand the facts about substances that are abused and the dangers connected with the use of these mood-altering substances. In addition, this module will help students make better decisions around drug and alcohol use and open a dialogue between students and the adults in their lives.

## Prior to Activities: Determine Level of Safety

Due to the sensitive nature of the information contained in these modules, we recommend that an assessment of the level of safety be conducted within the group of students that will participate in the presentations. By safety, we refer to the level of comfort, confidentiality, and closeness students may feel among each other and with the presenter. For specifics, please see Chapter 2 in this manual entitled *Assessing Class Safety to Determine Curriculum Level*.

Once the presenter has identified which level to use with the group of students, he or she will find in each of the modules specific activities to be used according to the level of safety. (i.e., Level 1 activities are used with Level 1 safety level).

**Level 1 Activities**

✓ *Activity A: Factual Information About Drug and Alcohol Use Among Teenagers*
Estimated time: 45 – 60 minutes. The facts presented below are designed to stimulate discussion about developmental choices students have to make about drug and alcohol use. In the beginning of this activity, there will be much factual information covering topics such as the historical trends of teenage substance use, the difference between use, abuse, and dependence (addiction), and finally some legal aspects of adolescent drug use.

There are two components to this activity: (A-1) a didactic presentation of the definitions and factual information and (A-2) an open-ended format where discussion is encouraged by the presenter.

*(A-1) Didactic Presentation*
*Presenter: Introduce self; mention purpose of presentation and overview of topics to be covered.*

Overview of Topic
We will talk about historical trends in drug and alcohol use along with some important facts about the effects these chemicals have on our bodies and, most importantly, how this applies to you.

Recent Trends and Facts
Over the past three decades, American youth have exhibited extraordinary levels of illicit drug use. This is in comparison with not only national statistics but also on an international level. Today 53% of young people have used an illicit drug. This is down from the 1981 high point of 66%. Drug use during the rest of the 1980's tumbled down to 41% in 1992 then began to rise again to the present level (NIDA, 2002).

Alcohol: To a considerable degree, alcohol trends tend to parallel those of other illicit drugs. This trend tends to include a slight increase in binge drinking in the beginning of this decade but has since leveled off. A myth that is heard often about alcohol is that other drugs tend to replace it. This has been shown to be a myth. In fact, alcohol remains the most abused and one of the most dangerous drugs used among young people today.

The effects alcohol has on the body are very predictable whether the person drinks one time per year or several times per week. It is a mood-altering drug that is considered a depressant. Alcohol can affect every cell in the body and many systems such as the gastrointestinal tract, the brain, reproductive system, and the immune system. It also has an impact on the way you look, aggravating acne, causing dry hair, glassy eyes and giving someone a puffy appearance. (Kinney and Leaton, 1995)

Blood alcohol level or blood alcohol concentration (BAC) has many variables that

contribute to it. Therefore, it is safe to say that no two people process alcohol in the same way. Body weight, gender, age, situation, mood, and body fat all contribute to the metabolism of alcohol, which in turn affects BAC. This is why when looking at a BAC chart (see example below) one should take caution because it is not definite but just a guideline.

| Blood Alcohol % | # of Drinks | Effect |
|---|---|---|
| .02 | 1 | more relaxed, slight change in mood |
| .05 | 2.5 | lowered inhibition, impaired judgment |
| .10 | 5 | poor coordination, legally drunk |
| .15 | 7.5 | impaired coordination |
| .20 | 10. | legally drunk for 6 hours, erratic emotions |
| .40 | 1 pint | loss of consciousness, stuporous |
| .50 | > 1 pint | coma, death |

Other Facts About Alcohol:

- **Drinking and driving is the #1 killer of Americans between ages 17-24**
- 69% of all drowning deaths are alcohol related. (Radford, 1996)
- One in every three suicides involves alcohol. (Radford, 1996)
- 33% of Americans do NOT drink alcohol (Radford, 1996)
- Between 2% and 3% of the current American college population will die from alcohol related causes (Radford, 1996)
- Drinking coffee or taking a cold shower does not sober a person up - it just keeps them awake
- When a person is very intoxicated you should treat it as a medical emergency

Marijuana: The most common myth about marijuana use is that it was used most abundantly in the 1960's. The fact is that its peak use was in 1979, after a gradual increase throughout that decade. The next decade showed marijuana use decrease significantly until the mid nineties, when again it spiked to its present level.

Research with young people below college age suggests that regular marijuana users have lower achievement than non-users, along with poor relationships with parents, and

higher incidence of aggressive and deviant behavior. These are just a few negative effects of regular marijuana use. Before we get into more of these effects, let's look at what marijuana does to the brain. A National Institute on Drug Abuse (NIDA) study has shown that marijuana changes the way sensory information gets to the part of the brain that processes and is crucial for learning, memory and the integration of sensory experiences. Part of the attractiveness of marijuana is that it slows the cognitive process and gives the person a more relaxed feeling. (NIDA, 1999)

The most commonly asked questions about marijuana are whether you can build up a tolerance for it and if it is addicting. Tolerance, which is defined here as needing a larger amount of the drug in order to get the same effect as when you first started, has been a mystery to marijuana researchers. Some heavy smokers say they need more of the drug to get a good "buzz" and some say they need less. When testing these hypotheses marijuana smokers had a tolerance not only to the active marijuana cigarette but also to the non-active cigarette. Therefore, you can see that tolerance is still a debate that is not settled yet. Whether a person can become dependent on marijuana rests on your definition of dependence. If you use criterion that include tolerance and risk of physical withdrawal, it would be hard to say that somebody could be marijuana dependent. However, if you define dependence with compulsive use as a criterion along with negative health consequences and social problems, then there is evidence that it is addictive. A point to know is that over 100,000 young people enter treatment each year for marijuana addiction. (Kuhn, et.al., 1998)

Cocaine: There have been some important changes in cocaine use over the past several decades. Overall use started in the late 1970's, gradually increasing until 1986. From that point there has been a steady decline in the use of cocaine among teenagers, except from 1992 to 1999. During this time, cocaine use started to increase and from 1999 to 2002 it maintained a steady rate.

Cocaine is one of the most addictive drugs that people may encounter in our society. As with many pleasurable things, it activates the reward system in the brain which, in turn, produces a pleasurable feeling. This chemical reaction is so reinforcing that the person immediately wants more. Some users of cocaine report feelings of restlessness, irritability, and anxiety. A person can develop a tolerance to the high and this tends to cut down on the feeling of normal pleasure. An added danger is when cocaine is combined with alcohol. This can cause a chain of chemical reactions by the body, which in turn increases the risk for sudden death. (NIDA, 1999)

Nicotine: Among high school seniors, smoking peaked in 1976 at 39%. This figure dropped 10 percentage points by 1981 and stayed there for at least one decade. During the mid-nineties smoking began to climb once again hitting a high of 36% in 1997. Since that period, there once again has been a steady drop in cigarette smoking among young people. This rollercoaster ride of numbers has been produced mostly by the mixed messages that young people are given through the media. Over the past five years there has been societal pressure placed on advertisers of tobacco products.

Nicotine is just one of the many chemicals found in the smoke produced by a cigarette. It is recognized as one of the frequently used drugs in our society today and is one of the most addictive. What people do not realize is that the cigarette is a work of great engineering. It is the most efficient way to get nicotine, the addictive agent in cigarettes, to the brain. This is why it is seen as one of the most addictive behaviors.

Use versus Abuse, Dependence

There are many definitions of addiction and its symptoms. The easiest criterion to remember is the use of a chemical getting in the way of your life. This simplistic definition is easy to remember but not as accurate as some of the more scientific definitions. This is because most definitions have many criteria and people show addiction in different ways. For example, a 20-year-old man who drinks every weekend to intoxication, has blackouts, and gets into physical and verbal fights would be considered someone who is dependent on alcohol despite the lack of cravings and withdrawal. The most common myth about addiction is that if you don't crave it or need it then you don't have a problem with the drug. The fact that craving or physiological dependence is not observed does not mean that a person is not addicted to a drug.

The criteria used by most mental health professionals are listed below. It is important to keep these in mind when discussing whether a drug is being used or abused.

Substance Abuse (1 out of 4)

- The person often uses the drug when they are doing something important like working, going to school, or taking care of children.
- The person uses the drug in dangerous situations e.g. Drinking and driving
- The person has gotten in trouble with the law because of drug use.
- Drug use has caused problems with family members, friends or people at school.

Substance Dependence (3 out 7)

- When the person starts using a drug more than they planned.
- They have tried to cut down or have thought about cutting down for some time.
- The person spends a lot of time using the drug, getting the drug, or recovering from the use of the drug.
- The drug use has caused psychological or physical problems and they continue to use the drug despite its negative consequences.
- They use the drug instead of going to school or work, playing sports, or spending time with friends or family.

- Tolerance is achieved.

- Withdrawal occurs when the drug is abruptly stopped.

Other Basic Principles About Addiction

- Addiction is the repetitive, compulsive use of a substance that occurs despite negative consequences to the user.

- Addictive drugs activate circuits in the brain that respond to normal pleasures. Every brain processes these circuits, so every person could become addicted.

- Drug taking is maintained by many factors including changes in the brain, the desire to experience pleasure from the drug, and to avoid the uncomfortable feelings of withdrawal. (Kuhn et.al., 1998)

*(A-2) Open-ended Format*
*Questions to Guide Discussion and Possible Presenter Responses*

*1.* Have the students each rank drugs from the most dangerous to the least dangerous, and then ask them to agree on a unified list.

*They will probably list heroin or cocaine as the most dangerous and marijuana as the least dangerous. The discussion should be guided toward the fact that alcohol is a very dangerous drug and it should be toward the top of their list. It is important for the presenter not to argue if they list marijuana as least dangerous. Remember we are presenting the facts and the fact is that nobody has ever died of an overdose of marijuana.*

2. How much of the material being presented today were you already familiar with and what other topics would you like to discuss?

*The presenter should take notes about the topics the students want to learn about and then research them together.*

3. What is the difference between someone using a drug and someone being addicted to a drug? What is the difference between abusing a drug and being dependent on a drug?

*The presenter should use text from the first activity (A-1) Didactic Presentation above to guide this discussion. It is very important for students to know the difference between use, abuse and dependence.*

*4.* Write a description of a person who is addicted to marijuana and discuss whether this person's life would be different if marijuana were legal.

*The presenter should anticipate a lively discussion here. The point of this provocative topic is to get students to see that the legalization issue has little to do with the issues of addiction.*

*5.* If you find someone at a party who is intoxicated and cannot stand up, what is critical that you should do*?*

*The presenter should use material from Activity B; after some class discussion, list the things that should be done in this situation. It is important for the presenter to emphasize this is a medical emergency and not something to be taken lightly. Almost all of the deaths due to alcohol poisoning could have been avoided if medical attention had been rapidly provided.*

*6.* Are there any questions; is there a particular topic related to substance use, abuse or dependence you would like to learn more about?

*The presenter may wish to ask this question verbally, or provide students with index cards so they may share their questions anonymously. It has been our experience that students feel more comfortable sharing their questions and concerns in writing.*

**Level 2 Activities**

Level 2 begins by providing the same factual information and discussion as is described above in Level 1 activities.

✓ *Activity A: Factual Information About Drug and Alcohol Use Among Teenagers*
Estimated time: 45 to 60 minutes. See Level 1 Activities above for details.

✓ *Activity B: Important Information About Alcohol*
*Presenter: Introduce self; mention the purpose of the presentation and overview of the topics to be covered. Below you will find each section to be discussed in this activity.*

The Input and Output of Alcohol
Input: Once alcohol is swallowed, it is not digested like food. Instead, a small amount is absorbed directly by the lining of the mouth. Once in the stomach, alcohol is absorbed directly into the blood steam through the tissue lining the stomach and the small intestine. This is why food, water, and fruit juice help to slow the absorption of alcohol. Once alcohol is in your blood stream, it is carried to all the organs of your body. In the majority of healthy people, blood circulates through the body in 90 seconds, thereby allowing alcohol to affect your brain and other organs in 90 seconds. The affects of alcohol in the body will vary according to the individual, gender, their body make-up, the amount and type of alcohol consumed, the situation, and the presence of food in the stomach.

Output: Alcohol for the most part is a toxin or poison that your body has to change into a non-harmful chemical. Ten percent of the alcohol is eliminated in the sweat, urine and breath. Your liver then must take over and finish the job of detoxifying this poison in your body. The liver breaks down alcohol at a rate of one-half an ounce per hour. It should be noted that some people cannot detoxify that much alcohol in an hour. This process cannot be made to go faster. When the rate of alcohol consumed exceeds the rate of detoxification, the amount of alcohol in the bloodstream continues to increase, which can cause intoxication, brain impairment, coma or death. The important fact to take away from this is that when people pass out from alcohol use it is extremely dangerous. In fact, when a person passes out, it is due to the body's inability to keep up with the amount of alcohol consumed. The amount of alcohol that it takes to make you pass out is dangerously close to the amount that it takes to cause death.

How to Identify and Care for an Intoxicated Person
When you observe a person who is obviously intoxicated it is important to make sure that they are safe. Here are a few important guidelines for taking care of someone who is intoxicated:

- Stay with the intoxicated person.

- Always be prepared for the unexpected and assess the seriousness of the situation.

- If you have been drinking, get a sober person to help you.

- Be aware of the physical dangers that could present themselves and get immediate medical attention.

- If the person's skin is pale, cold, bluish in color or sweaty, call 911.

- Stay with the person. Try to keep the person sitting up - if they must lie down, keep them on their side to prevent choking.

- **Do not** let the person drive anything, including a bicycle

- **Do not** give the person a cold shower; the shock of the cold water could cause unconsciousness

- **Do not** give the person any liquid or food.

- THE ONLY THING THAT CAN SOBER A PERSON UP IS TIME!

Alcohol and the Law

This part of the activity will mostly deal with driving under the influence. Drinking and driving is still a major problem in our society today. You can find details for your state on the Internet. We have selected Massachusetts as an example:

- In 2001, 234 people died in Massachusetts alcohol-related accidents.

- Massachusetts has a zero-tolerance law; if you are under 21 and are found to have a BAC as low as .02% while you are driving, you will lose your license.

- If you refuse the Breathalyzer or blood test, your license will be suspended.

- Buying, possessing or transporting alcohol will result in a 90 day to 1-year suspension of your license.

- False or altered licenses or identification cards are also against the law, along with using another person's identification. This is a felony and serious penalties could be given.

✓ *Activity C: How Casual Drug Use Can Lead to Drug Abuse*

*Presenter: Have the class take 20 minutes to read the article provided by former NIDA Director Alan Leshner (Appendix 4-A: Oops: How Casual Drug Use Leads To Addiction) and have them discuss the following questions.*

- How does a person progress from an experimenter to an active or addicted person?

- How would you define the stages of drug use, experimental, social, active use, and addiction?

- Why should a person with an addiction not be viewed as a “person of weakness” and more as a person with a disease that needs professional attention?

**Level 3 Activities**

Level 3 begins by providing the same factual information and discussion as is described above in Level 1 and Level 2 activities.

✓ *Activity A: Factual Information About Drug and Alcohol Use Among Teenagers*
Estimated time: 45 to 60 minutes. See Level 1 Activities above for details.

✓ *Activity B: Important Information About Alcohol*
See Level 2 Activities above for details.

✓ *Activity C: How Casual Drug Use Can Lead To Drug Abuse*
See Level 2 Activities above for details.

✓ *Activity D: Questions and Answers About Marijuana*
*Presenter: This activity will present some facts in a question and answer format. The students are encouraged to ask their own questions and develop answers from tools that the presenter provides or from consultations with other addictions specialists.*

1. *What is marijuana? Are there different kinds?*
   Marijuana is a green, brown, or gray mixture of dried shredded leaves, stems, seeds, and the flowers of the hemp plant. Marijuana has many names - over 200, in fact. The most popular ones are weed, pot, or chronic.

   All forms of marijuana are mood altering. In other words, they change how the brain works. They all contain THC (delta-9-tetrahydrocannabinol) the main active ingredient in marijuana. They also contain more that 400 other chemicals. THC potency of marijuana has increased since the 1970's but has been about the same since the mid-1980's.

2. *How long does marijuana stay in a person's body?*
   THC in marijuana is strongly absorbed by the fatty tissues in the various organs. Generally, traces of THC can be detected by standard urine testing methods several days after a smoking session. However, in heavy users the THC can stay in the system longer, up to several weeks.

3. *What are the short-term effects of marijuana use?*
   The short-term effects of marijuana include:
   - Problems with memory and learning
   - Distorted perception
   - Trouble with thinking and problem solving
   - Loss of concentration
   - Increased heart rate and anxiety

4. *Does marijuana affect school, sports, or other activities?*

It can, because it affects memory, judgment, and perception. These are each needed to do well in school, sports and other activities. It has been found that marijuana also affects motivation, which affects performance in all areas of life.

5. *What are the long-term effects of marijuana use?*
   Findings so far show that regular use of marijuana or THC may play a role in some kinds of cancer and in problems with the respiratory and immune systems.

6. *How does marijuana affect driving?*
   The effects of marijuana and driving have been minimized throughout the years. If you use a drug that affects judgment, perception, coordination and the ability to react quickly, *of course it will affect the way you drive*. The interesting thing about marijuana is that it can increase attention on an individual task, but when somebody is multi-tasking, performance goes down. This also why people believe they are driving well – they may in fact be doing one aspect of driving well but other aspects quite poorly.

✓ *Activity E: Focus Groups*

*Presenter: This is a general discussion with students about their own experiences with substances. Due to the personal nature of this activity and the conflict of interest this might have with some school's code-of-conduct it is recommended that an outside facilitator be used. This facilitator can be someone who has a story of their own to tell or a professional in the field of addiction.*

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**Appendix 4-A: NIDA article titled "Oops: How Casual Drug Use Leads to Addiction"**

## "Oops: How Casual Drug Use Leads to Addiction"

By Alan I. Leshner, Ph.D., Director, National Institute on Drug Abuse, National Institutes of Health

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It is an all-too-common scenario: A person experiments with an addictive drug like cocaine. Perhaps he intends to try it just once, for "the experience" of it. It turns out, though, that he enjoys the drug's euphoric effect so much that in ensuing weeks and months he uses it again -- and again. But in due time, he decides he really should quit. He knows that despite the incomparable short-term high he gets from using cocaine, the long-term consequences of its use are perilous. So he vows to stop using it.

His brain, however, has a different agenda. It now demands cocaine. While his rational mind knows full well that he shouldn't use it again, his brain overrides such warnings. Unbeknown to him, repeated use of cocaine has brought about dramatic changes in both the structure and function of his brain. In fact, if he'd known the danger signs for which to be on the lookout, he would have realized that the euphoric effect derived from cocaine use is itself a sure sign that the drug is inducing a change in the brain -- just as he would have known that as time passes, and the drug is used with increasing regularity, this change becomes more pronounced, and indelible, until finally his brain has become addicted to the drug.

And so, despite his heartfelt vow never again to use cocaine, he continues using it. Again and again.

His drug use is now beyond his control. It is compulsive. He is addicted.

While this turn of events is a shock to the drug user, it is no surprise at all to researchers who study the effects of addictive drugs. To them, it is a predictable outcome.

To be sure, no one ever starts out using drugs intending to become a drug addict. All drug users are just trying it, once or a few times. Every drug user starts out as an occasional user, and that initial use is a voluntary and controllable decision. But as time passes and drug use continues, a person goes from being a voluntary to a compulsive drug user. This change occurs because over time, use of addictive drugs changes the brain -- at times in big dramatic toxic ways, at others in more subtle ways, but always in destructive ways that can result in compulsive and even uncontrollable drug use.

The fact is, drug addiction is a *brain disease*. While every type of drug of abuse has its own individual "trigger" for affecting or transforming the brain, many of the results of the

transformation are strikingly similar regardless of the addictive drug that is used -- and of course in each instance the result is compulsive use. The brain changes range from fundamental and long-lasting changes in the biochemical makeup of the brain, to mood changes, to changes in memory processes and motor skills. And these changes have a tremendous impact on all aspects of a person's behavior. In fact, in addiction the drug becomes the single most powerful motivator in the life of the drug user. He will do virtually *anything* for the drug.

This unexpected consequence of drug use is what I have come to call *the oops phenomenon*. Why oops? Because the harmful outcome is in no way intentional. Just as no one starts out to have lung cancer when they smoke, or no one starts out to have clogged arteries when they eat fried foods which in turn usually cause heart attacks, no one starts out to become a drug addict when they use drugs. But in each case, though no one meant to behave in a way that would lead to tragic health consequences, that is what happened just the same, because of the inexorable, and undetected, destructive biochemical processes at work.

While we haven't yet pinpointed precisely all the triggers for the changes in the brain's structure and function that culminate in the "oops" phenomenon, a vast body of hard evidence shows that it is virtually inevitable that prolonged drug use will lead to addiction. From this we can soundly conclude that drug addiction is indeed a brain disease.

I realize that this flies in the face of the notion that drug addiction boils down to a serious character flaw -- that those addicted to drugs are just too weak-willed to quit drug use on their own. But the moral weakness notion itself flies in the face of all scientific evidence, and so it should be discarded.

It should be stressed, however, that to assert that drug addiction is a brain disease is by no means the same thing as saying that those addicted to drugs are not accountable for their actions, or that they are just unwitting, hapless victims of the harmful effects that use of addictive drugs has on their brains, and in every facet of their lives.

Just as their behavior at the outset was pivotal in putting them on a collision course with compulsive drug use, their behavior after becoming addicted is just as critical if they are to be effectively treated and to recover.

At minimum, they have to adhere to their drug treatment regimen. But this can pose an enormous challenge. The changes in their brain that turned them into compulsive users make it a daunting enough task to control their actions and complete treatment. Making it even more difficult is the fact that their craving becomes more heightened and irresistible whenever they are exposed to any situation that triggers a memory of the euphoric experience of drug use. Little wonder, then, that most compulsive drug users can't quit on their own, even if they want to (for instance, at most only 7 percent of those who try in any one year to quit smoking cigarettes on their own actually succeed). This

is why it is essential that they enter a drug treatment program, even if they don't want to at the outset.

Clearly, a host of biological and behavioral factors conspires to trigger the oops phenomenon in drug addiction. So the widely held sentiment that drug addiction has to be explained from either the standpoint of biology or the standpoint of behavior, and never the twain shall meet, is terribly flawed. Biological and behavioral explanations of drug abuse must be given equal weight and integrated with each other if we are to gain an in-depth understanding of the root causes of drug addiction and then develop more effective treatments. Modern science has shown us that we reduce one explanation to the other -- the behavioral to the biological, or vice versa - at our own peril. We have to recognize that brain disease stemming from drug use cannot and should not be artificially isolated from its behavioral components, as well as its larger social components. They all are critical pieces of the puzzle that interact with and impact on one another at every turn.

A wealth of scientific evidence, by the way, makes it clear that rarely if ever are any forms of brain disease only biological in nature. To the contrary, such brain diseases as stroke, Alzheimer's, Parkinson's, schizophrenia, and clinical depression all have their behavioral and social dimensions. What is unique about the type of brain disease that results from drug abuse is that it starts out as voluntary behavior. But once continued use of an addictive drug brings about structural and functional changes in the brain that cause compulsive use, the disease-ravaged brain of a drug user closely resembles that of people with other kinds of brain diseases.

It's also important to bear in mind that we now see addiction as a chronic, virtually life-long illness for many people. And relapse is a common phenomenon in all forms of chronic illness -- from asthma and diabetes, to hypertension and addiction. The goals of successive treatments, as with other chronic illnesses, are to manage the illness and increase the intervals between relapses, until there are no more.

An increasing body of scientific evidence makes the compelling case that the most effective treatment programs for overcoming drug addiction incorporate an array of approaches -- from medications, to behavior therapies, to social services and rehabilitation. The National Institute on Drug Abuse recently published ***Principles of Effective Drug Addiction Treatment***, which features many of the most promising drug treatment programs to date. As this booklet explains, the programs with the most successful track records treat the *whole* individual. Their treatment strategies place just as much emphasis on the unique social and behavioral aspects of drug addiction treatment and recovery as on the biological aspects. By doing so, they better enable those who have abused drugs to surmount the unexpected consequences of drug use and once again lead fruitful lives.

The National Institute on Drug Abuse (NIDA) is part of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services.
http://www.drugabuse.gov/Published_Articles/Oops.html

*Part Two of Three – Curriculum (continued)*
**Chapter 5 - Depression in Adolescents**

## Definition and Overview

While depression is generally regarded as an "adult" illness, it is becoming alarmingly prevalent among adolescents. An estimated 8 percent of young people now suffer from clinical depression, and that number grows every year. Depression has a devastating and debilitating impact on families, who are all too frequently torn apart by its effects. The good news is that depression is one of the most treatable mental disorders – and in many cases it can be entirely preventable.

Depression affects a young person's emotions, thoughts, and actions. It exists across a continuum (Beasley & Beardslee, 1998). On one end are the inevitable and normal "ups and downs" in an adolescent's moods. Transient sadness in response to stress is considered to be a normal mood variation, and the healthy adolescent will typically "bounce back" from stress within a few days. Moving toward the middle of this continuum, an adolescent's sad or depressed mood becomes more concerning when it is accompanied by more persistent signs of impaired functioning such as: disturbances in sleep, appetite, energy level, or ability to concentrate, decrease in self-esteem, diminished ability to experience joy from normally pleasurable activities, and/or frequent crying, irritability, agitation, or apathy. Evidence of mild impairments in schoolwork, family functioning or peer relationships may become apparent to either the parent or the adolescent. This level of depression occurs typically in response to an environmental stressor (e.g., death, marital discord, family physical illness, sexual abuse, school problem, etc.). When an adolescent's depressed mood and functional impairment persist, and especially if there is evidence of suicidal thoughts, we have moved to the other end of the spectrum where depression becomes a disorder.

Clinical depression is a biological illness that involves abnormal functioning of the brain's chemicals. An episode of depression can result from a challenging life situation, stressful event, developmental problem, or, in some cases, no apparent precipitating event. Adolescents suffering from clinical depression cannot simply "get over it." The symptoms persist often months and even years. They may even worsen after the perceived stressful event has resolved. Clinical depression often runs in families, which suggests that its origins may be both genetic (inherited) as well as learned. It can be accompanied by – and even aggravated by – other illnesses (e.g., substance abuse, learning disabilities, attention deficit hyperactivity disorder, and anxiety). (Adolescent Mental Health Curriculum 2003; Beasley & Beardslee, 1998).

## Goals and Objective

✓ *Goal 1*

This module is meant to provide an understanding of depression to middle and high school students. The emphasis is on providing factual information within a context

that will seem familiar and understandable to students via case examples, role-plays, and other activities. The main activity for this module is divided into four sections: 1) the continuum from stress to depression, 2) symptoms of depression, 3) suicide, and 4) treatment. There are supplemental sections that may be used in conjunction with the main activity to provide more in-depth information and stimulate discussion.

✓ *Goal 2*

This module is meant to provide education and guidance for school professionals. The following sections are outlined for teachers, counselors, nurses, and administrative staff: 1) identifying symptoms of depression, 2) understanding risk factors for depression, 3) conducting a brief assessment of a teen's risk for harming him or herself, and 4) how to provide help within the school and how to facilitate referrals to outside agencies.

✓ *Objective*

This module will help both students and school staff to be able to identify symptoms of depression, understand how clinical depression is different from temporary sad mood, and how to obtain treatment. Students and school staff will gain an understanding of the risk factors of suicide as well as how to initiate a conversation about depression and suicide with someone they feel might be at risk.

**Prior to Activities: Determine Level of Safety**

Due to the sensitive nature of the information contained in these modules, we recommend that an assessment of the level of safety be conducted within the group of students that will participate in the presentations. By safety, we refer to the level of comfort, confidentiality, and closeness students may feel among each other and with the presenter. For specifics, please see Chapter 2 in this manual entitled *Assessing Class Safety to Determine Curriculum Level*.

Once the presenter has identified which level to use with the group of students, he or she will find in each of the modules specific activities to be used according to the level of safety. (i.e., Level 1 activities are used with Level 1 safety level).

For questions regarding the safety of individual students, please refer to Appendices 5A - 5C in this chapter.

## Level 1 Activities

✓ *Activity A: Factual Information About Depression and Suicide*

Estimated time: 45 to 60 minutes. The activity in Level 1 is strictly factual in nature. These facts will provide students with a beginning understanding of depression, including information about suicide, and set the stage for future activities. Information included in this section can be used to respond to particular student questions, may be used to initiate conversation, or may be used as to assess student knowledge about the topic (Adolescent Mental Health Curriculum, 2003; U.S. Public Health Service, 2001; Gould et al., 2003).

There are two components to this activity: (A-1) a didactic presentation of the definition and factual information associated with depression in adolescents and (A-2) an open-ended format where discussion is encouraged by the presenter.

*(A-1) Didactic Presentation*

*Presenter: Introduce self; mention purpose of presentation and overview of topics to be covered. In the section below are included the overview of topic, as well as symptoms and causes of depression.*

Overview of Topic

While depression is generally regarded as an "adult" illness, it is becoming alarmingly prevalent among adolescents. An estimated 8 percent of young people now suffer from clinical depression and that number grows every year. Depression robs people of the pleasure they experience in life and has a devastating and debilitating impact on families. The good news is that depression is one of the most treatable mental disorders – and in many cases it is entirely preventable.

Symptoms of Depression

Depression affects a young person's emotions, thoughts, and actions. It exists across a continuum. On one end are the inevitable and normal "ups and downs" in an adolescent's moods. Transient sadness in response to stress is considered to be a normal mood variation, and the healthy adolescent will typically "bounce back" from stress within a few days. Moving toward the middle of this continuum, an adolescent's sad or depressed mood becomes more concerning when it is accompanied by more persistent signs of impaired functioning such as: disturbances in sleep, appetite, energy level, or ability to concentrate, decrease in self-esteem, diminished ability to experience joy from normally pleasurable activities, and/or frequent crying, irritability, agitation, or apathy. Evidence of mild impairments in schoolwork, family functioning or peer relationships may become apparent to either the parent or the adolescent. This level of depression occurs typically in response to an environmental stressor (e.g., death, marital discord, family physical illness, sexual abuse, school problem, etc.). When an adolescent's depressed mood and functional impairment persist, or if there is evidence of suicidal thoughts, we have moved to the other end of the spectrum where depression becomes a disorder.

Causes of Depression

Clinical depression is a biological illness that involves abnormal functioning of the brain's chemicals. An episode of depression can result from a challenging life situation, stressful event, developmental problem, or, in some cases, no apparent precipitating event. Adolescents suffering from clinical depression cannot simply "get over it." The symptoms persist often months and even years. They may even worsen after the perceived stressful event has resolved. Clinical depression often runs in families, which suggests that its origins may be both genetic (inherited) as well as learned. It can be accompanied by – and even aggravated by – other illnesses (e.g., substance abuse, learning disabilities, attention deficit hyperactivity disorder, and anxiety). (Beasley & Beardslee, 1998).

Facts about Depression (Health in Action, 2002)

- Only 20% of all cases of childhood depression are recognized and diagnosed.
- Peak years of onset of depression: 16-24 years old.
- Between 10-15% of children and adolescents have some symptoms of depression at any given time.
- Prior to puberty, boys and girls are equally likely to have depression. But, after age 15, girls and women are twice as likely as boys and men to have depression.
- Between 20 and 40% of children with depression will relapse within 2 years; 70% of children relapse by adulthood.
- On average, an episode of major clinical depression in children and adolescents lasts 7 to 9 months.
- Approximately two thirds of children and adolescents with major depressive disorder also suffer from another mental disorder.
- 24%-40% of Americans with mood disorders also have substance abuse disorders.
- In the United States, only one-third of people with depression receive treatment.

Facts about Suicide (Health in Action, 2002)

- Every 17 minutes a life is lost to suicide. Every day 86 Americans take their own life and over 1,500 attempt suicide.
- Suicide is now the eighth leading cause of deaths in Americans.
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease, combined.

- Each year, one in five teenagers in the US seriously considers suicide, 5-8% attempt it, representing nearly 1 million teens, and approximately 1,600 teens die by suicide.

- Suicide was the third leading cause of death among 10-19 year olds in the US in 2000.

- Suicides after puberty are more common than before puberty. This probably relates to two significant risk factors that become more prevalent in adolescence: depression and exposure to drugs and alcohol.

- Suicide attempts are more common in females in the US, but completed suicide is more common among males (five times more 15-19 year old boys commit suicide compared to girls).

- Research suggests that self-identified gay, lesbian, or bisexual youth are at higher risk for suicide than their heterosexual peers.

*(A-2) Open-ended Format*
*Questions to Guide Discussion and Possible Presenter Responses*

1. By a show of hands, were most of you familiar with the definition of depression?

   *Presenter: Encourage discussion about any level of exposure to the topic of depression.*

2. Was there anything in the definition or description of symptoms associated with depression that was new information for you? If so, what?

   *Presenter: Encourage students to discuss any misconceptions or wrong information they may have had that was challenged by this factual information.*

3. Were you familiar with the causes of depression? What was your understanding of the causes of depression prior to this presentation?

   *Presenter: Encourage students to discuss any misconceptions or wrong information they may have had that was challenged by this factual information.*

4. Were you surprised by any of the facts presented today?

   *Presenter: Understanding what most "surprised" students will provide a window into understanding in what information they are most interested. Keep record of questions so they may be addressed in future meetings with the students.*

5. Were you worried by any of the information presented? If so, what?

*Presenter: The answers students share to this question might provide a window into their concerns about themselves or loved ones. Often, when symptoms of depression, or certain facts are shared, students may "self-diagnose." It will be important to reassure students that everyone will have one or two of these symptoms at any given time, but it is the continuity, severity, and amount that makes the difference between regular stress and clinical depression. It will be important to have time available to meet with students individually should they continue to express worries or concerns.*

6. If this new information has made you wonder if someone you know might be suffering from depression, how would you approach him or her about it?

   *Presenter: We do not encourage giving specific advice to students about how to do this. However, it would be appropriate to guide students in identifying professionals or resources to help them (e.g., school nurse, guidance counselor, school psychologist or social worker, member of clergy, family doctor). The primary message to students should be not to feel solely responsible for helping someone who is depressed. Depression is a serious medical condition and requires professional attention.*

7. If you are worried that someone you know is at risk for suicide, what should you do?

   *Presenter: As with question #6, the presenter's role is to facilitate student contact with helping professionals. Students should not feel alone, burdened by, or responsible for anyone else's safety.*

8. Are there any further questions; is there a particular topic related to depression and suicide you would like to learn more about?

   *Presenter: You may wish to ask this question verbally, or provide students with index cards where they may share their questions anonymously. It has been our experience that students feel more comfortable sharing their questions and concerns in writing.*

**Level 2 Activities**

Level 2 begins by providing the same factual information and discussion as described above in Level 1 activities. However, Level 2 moves beyond facts to introduce the topic of depression within the context of a continuum.

✓ *Activity A: Factual Information About Depression and Suicide*
Estimated time: 45 to 60 minutes. See Level 1 Activities above for details.

✓ *Activity B: Adolescent Mood Continuum*
Estimated time: 45 minutes to one hour. In this activity, the student learns the mood continuum. At one end of the spectrum is stress with symptoms commonly experienced by many adolescents, while on the other end is clinical depression. The differences between stress and clinical depression are highlighted. Suicide is discussed, as well as the impact of depression and suicide on the family, and finally, treatment options are discussed. If time allows, a supplemental activity (Activity C) may be included. The supplemental activity is designed to promote further student discussion**.**

*Presenter: Introduce self; mention purpose of presentation and overview of topics to be covered. Below you will find each section to be discussed in this activity.*

<u>Mood Continuum</u>
Range of mood – from a little sad or stressed moving across to very sad and unable to change mood (expand by providing examples) – *draw continuum on the board*

First, let us spend a bit of time talking about the stress side of the continuum.

1. Ask the class: What does it mean to be stressed?
   *Any positive or negative change that requires adaptation.*

2. What are some sources of stress?
   *(environment, physiological state, relationships, work/school, emotional well-being, lifestyle changes)*

3. How do you know when you are experiencing stress? What are some signs?
   *(pain, tension, nerves, fatigue, appetite or sleep change, sadness, guilt, irritability, loneliness)*

All these symptoms are normally associated with stress, and when the stressful factor gets better, your mood typically improves and you feel more relaxed - back to your "normal self."

But there are times when people experience some of those same symptoms we talked about in relation to stress, but they are more significant and last much longer. That's when we move to this side (*point on the board*) of the continuum into depression.

Depression – General Information

Depression is a psychological illness, and there are many possible causes for it. Some include reaction to extreme and prolonged stress, and some include biology (this means that at times it may run in families, and that sometimes, the chemicals in the brain are affected). People who suffer from depression are **not** "crazy."

- Depression is more than just feeling sad; when people suffer from depression, they feel they cannot get "over it" or beyond their feelings of sadness on their own.

- Depression can also be associated with other problems, such as anxiety, and substance abuse. People who have chronic illnesses are also vulnerable to depression.

- When we discussed that depression can start in response to a serious event, it is important to note that even once the stressful event is over, the feelings of sadness can persist. Sometimes, depression occurs without a clear reason why.

- Among adolescents, about 1 in 5 teenagers will experience one episode of depression. Some people will experience more than one episode during their lifetimes. Getting help early can prevent a more serious depression and can lead to a better outcome. We will talk about ways of receiving help a bit later on.

Presentation of Depression

Question to class: *If you had to determine whether someone seemed depressed to you, what would you look for? What signs?*

- Unpleasant mood: sadness, irritability, anger, tearfulness

- Feelings: boredom, guilty, worthless, hopeless, fatigued

- Behaviors: getting in trouble at home, school, or with the law, using drugs, sleeping more/less than usual, eating more/less than usual, not hanging out with your friends anymore, failing in school – *emphasize how depression may present differently in adolescents in more of a "risk-taking" or acting out fashion, with boredom, change in behavior, poor decision making as prominent symptoms – may lead adults to misunderstand behavior as laziness or oppositionality*

- Thoughts: pessimism, forgetting positive qualities, low self-esteem

At any one point, people will likely experience some symptoms of depression. For example, if you are going through a stressful period, you might feel fatigued, your sleeping habits may change, or you may be irritable. This is normal, and these symptoms will likely go away once your stressful situation is over.

Let's talk about ways to determine whether the symptoms someone is experiencing are either part of a temporary stressful situation, or whether they are indicative of clinical depression (Beasley & Beardslee, 1998).

- Symptom severity (intensity, duration, suicidal ideation)
- Functioning (across family, school, peers, health)
- Burden of suffering (depth of distress, anguish, difficulty coping)
- High level of self-hatred
- Running away from home
- Significant decrease in ability to concentrate, notably lower school performance
- Extremely high irritability, boredom, hypersomnia

Misdiagnosis

Another important component in determining whether one suffers from clinical depression is physical health. There are several physical conditions that can mimic the presentation of depression, and therefore, a full medical examination is always recommended (Beasley & Beardslee, 1998).

- Mononucleosis
- Hypothyroidism
- Anemia
- Nutritional deficiencies

Suicide

Significant feelings of depression may lead to thoughts of suicide. In some cases, people feel so badly that they think about harming themselves.

- Risk factors for suicide include: family history of suicide, recent losses, social isolation, drug/alcohol abuse, exposure to violence, trauma (e.g., physical or sexual abuse).
- Warning signs of suicidal ideation: preoccupation with death related topics, suicidal talk, behavior changes, giving away special things, taking excessive risks, increased drug/alcohol use, decreased interest in usual activities, increased isolation, getting weapons

Myths About Suicide

- *Myth:* Not talking about suicide is better, as talking about it will only put ideas in people's head

*Truth:* It is important to ask someone if they have ever thought about hurting him or herself. Often, people who are suicidal do not have someone they can talk to about how badly they feel. Opening a line of communication can be helpful and can introduce different ways of dealing with their pain.

- *Myth*: When people talk about suicide, they are only doing it to get attention – they won't really go through with it.

  *Truth*: When someone talks about suicide, it is very important to always take it seriously. The person needs to find help and this should be given to them in a non-judgmental manner.

- *Myth:* If a person has made a suicidal gesture but did not complete a suicide, they will not try it again.

  *Truth:* A person is more at risk for completing suicide if they have prior attempts.

- *Myth:* If someone tells you they will commit suicide, but you have to keep it a secret, you are betraying them if you tell someone.

  *Truth:* You will not be betraying someone if you alert a parent, teacher, counselor, friend, or professional about their intent to commit suicide. Breaking their confidentiality is much more important in order to help them remain safe.

<u>Cultural Differences</u>
What does your culture believe about suicide? How would the family of someone who committed suicide be viewed? (*To the presenter: McGoldrick et al, 1996 may be used as a reference guide.)*

<u>Impact on Family and Friends</u>
It is very important to understand that people who experience depression are not to blame for feeling that way, nor are the parents or friends.

- Depression typically affects other people around the person because his interactions are different and difficult to understand.

- Support to family and friends is very important

- Cultural differences/implications

- Has anyone in your family ever experienced depression? If so, how did it affect the family as a unit, and how did it impact you as an individual?

<u>Getting Help/Treatment</u>
Depression is a highly treatable illness. Psychotherapy and medications have been shown to be effective treatments. Usually, psychotherapy is tried first. If the person

does not improve, or if the person is so depressed that he or she is thinking about harming himself or herself, then medication is also used.

- Counseling can help focus on changing thinking, problems in relationships, and can help the person develop better ways to deal with stress.

- Group therapy can sometimes be helpful as well, as you are able to interact with others and know that you are not alone in the illness

- School interventions

- Family therapy

What You Can Do in the School:
If you have identified any change in mood or behavior in yourself, or if simply you don't feel right, there are many people who are willing to help. For example, within the school, you can contact a teacher, a nurse, or your guidance counselor. They are willing to listen and to find help for you in a safe and confidential manner. People within the school setting will help you find counseling, if that is something you will need.

Sometimes, you might notice these symptoms in a friend, and perhaps that friend has not identified the symptoms in him or herself. Do not feel like you are betraying them if you speak to a teacher, nurse, or counselor about your concerns. Remember, identifying and treating the depression early helps make the outcome better. Therefore, you are helping your friend. Also remember that he or she might react in an angry fashion with you as a result of the depressed thinking. Helping your friends is not shameful or "telling on them."

Supplemental Activity to Promote Discussion
Following is an activity designed to promote discussion and increase learning in students. While a lecture format can be informative, discussion and class participation have been shown to increase learning and facilitate questions. This activity may be conducted as a group project.

- ✓ Divide the classroom into smaller groups of students, and ask each one to complete the chart and questions found below. The class may then come together again and discuss each group's responses.

✓ *Activity C: Differences in Depression*
Estimated time: 30 to 45 minutes.

*Presenter: How does depression look and feel in boys versus girls? Is there a difference? If so, explain. Does it look and feel different in children/teenagers versus adults? If so, how?*

| | Feelings | Thought/Cognition | Behaviors |
|---|---|---|---|
| Boys | | | |
| Girls | | | |
| Children | | | |
| Teenagers | | | |
| Adults | | | |
| Latino Families | | | |
| Asian Families | | | |
| African American Families | | | |
| Caucasian Families | | | |
| Native American Families | | | |
| Middle Eastern Families | | | |

- In your culture and in your family, would it be acceptable to talk about depression? How do you think family members or people in your community would react if you disclosed being depressed? McGoldrick et al., 1996 can be referenced for further information regarding family and mental health issues within different cultural groups.

- Brainstorm about possible reactions

- Does it feel safe enough to talk about depression in school? With your friends? In your church?

- Do you feel that adults will respect your confidentiality? How about your parents? Guidance counselors? Teachers? Therapist? Pastor/Priest/Minister? Family friend?

**Level 3 Activities**

This last level contains a range of information from didactic to personal discussion. It includes the activities in levels 1 and 2, and adds 3 additional activities to consider based on students' personal experiences. This level continues the open-ended format where the presenter encourages discussion.

✓ *Activity A: Factual Information About Depression and Suicide*
Estimated time: 45 to 60 minutes. See Level 1 Activities above for details.

✓ *Activity B: Adolescent Mood Continuum*
Estimated time: 45 minutes to 60 minutes. See Level 2 Activities above for details.

✓ *Activity C: Differences in Depression*
Estimated time: 30 to 45 minutes. See Level 2 Activities above for details. Optional.

✓ *Activity D: Assumptions About Depression.*
Estimated time: 30 to 45 minutes.

Questions

- What is your definition of depression?
- What are some general assumptions about people who suffer from depression?
- What are some societal obstacles that prevent us from talking about depression?
- If someone asked you if you go to therapy, what would you say? Why?
- What do you think people would assume about you if they knew you went to therapy?

Case Examples

*Share with the class the following two vignettes:*

- Vignette D-1: Michael is a 17-year-old senior in high school. He has an older brother, and two younger sisters. He is one of the top athletes in his school and is number three in his class. Michael goes to parties with his friends during the weekend, likes to work on his father's motorcycle, and is getting ready for college. Generally, he tries to stay out of trouble and is considered a role model for other students in his class.
- Vignette D-2: Jason is a 16-year-old junior in high school. He has changed schools twice in the last four years, and is currently having a hard time in his new school. He likes to go out partying during the weekend, and likes to experiment with drugs and alcohol. He is considered a "rebel" in his class, and rumors about him include that he is depressed, that one of his best friends committed suicide, and that his parents are "crazy."

*Ask the class:* What assumptions would you make about each of these boys? What would you guess about their personalities? Do you like or dislike them? Why?

✓ *Activity E: Role Plays*

Estimated time: 30 to 45 minutes. This activity encourages discussion via role-plays. Students should discuss their experiences during the role-play, as well as the reasoning behind their responses.

- "Sarah, I need to talk to you. I have been thinking of giving up. If I talk to you about how I'm feeling, will you promise not to tell anyone? I know you are a good friend and I can trust you. This is why I have chosen to talk to you. I can trust you, right?"

- "I want to die. I don't feel that I have anything to live for anymore. I have some pills and I plan to take them tonight. I guess I am telling you because I consider you a close friend and wanted to say good-bye to you. Swear you won't tell anyone. If you do, you will ruin everything. You know how miserable I am and that I hate living this life. I really need you to support me with my plan. Ok?"

✓ *Activity F: Student Testimonials*

Estimated time: 30 to 45 minutes. If a student self-identifies as having experienced depression and would like to volunteer sharing a personal experience he or she may do so with the support of the presenter. Alternatively, a panel of students may wish to share personal experiences of their interactions with loved ones or friends who have suffered from depression.

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**The following appendices are provided as guidance for school professionals regarding students at risk from suicide.**

## Appendix 5-A: Questions to Guide Safety Assessment[6]

The questions listed in this appendix are designed as a guide to determine the course of action needed with a student who is at risk. The information gathered will help in determining whether the student is in imminent danger and will need to be immediately transported to an emergency room (at a facility with an adolescent psychiatric unit, if possible) or whether in-school evaluation can take place.

*Step 1: Guidelines for Person Evaluating the Student.*

The following questions relate to different risk factors for suicide. School personnel may wish to use them as a guideline for the kind of information that needs to be gathered during the assessment. These are questions school staff may ask themselves when thinking about whether a student is at-risk.

- Has the student unintentionally gained or lost a significant amount of weight in the last month?
- Has the student reported any changes in sleeping habits (e.g., sleeping too much or too little)?
- Does the student appear sad or withdrawn?
- Does the student sound despondent?
- Has anyone else reported that the student is despondent or sounding hopeless?
- Does the student seem extremely angry or hostile?
- Has the student recently experienced a significant loss?
- Has the student reported any recent suicide among friends or family?
- Has the student reported any history of suicide in the family? If so, does the family talk about it or is it a secret?
- Is the student approaching an anniversary of a family death or suicide?
- Is the student about the same age or under similar circumstances as the family member who committed suicide?

[6] Lukas, S. (1993). *Where to Start and What to Ask*. Norton, NY. (p.126).

- Has the student reported to you a previous suicide attempt?
- Has the student made any comments, joking or otherwise, suggesting that death would be preferable to life?
- Has anyone else reported that the student has talked about killing herself or himself?
- Has anyone found a note, poem, or printed literature involving death or suicide that was written or belongs to the student?
- Does the student report having given away any possessions?
- Does the student have a history of impulsivity, poor judgment, or antisocial behavior?
- Does the student have a history of recurrent depression, intense anxiety, or panic attacks?
- Does the student have a history of substance abuse?
- Is the student frequently involved in death defying or high-risk behaviors?
- Is there a current crisis in the student's life (e.g., school failure or suspension)?

*Step 2: Questions That Can Be Asked Directly to Students.*

- You seem upset, just how badly *are* you feeling?
- When you feel badly, do you ever have any thoughts about hurting yourself?
- Do you ever wish you were dead?
- When you wish you were dead, do you ever think about killing yourself?

*Step 3: Gather Specific Information.*

If the answer is "yes" to any of the questions in step 2, please proceed to the following:

- When did you start having these thoughts?
- What was happening when you started thinking about hurting yourself?

- How often are you having these thoughts?
- Are you able to stop these thoughts once you start having them?
- When you think about killing yourself, do you think a lot about it?
- Do these thoughts upset you, or make you feel better?
- What do you think would happen if you tried to kill yourself?
- Who do you think would try to prevent your suicide?
- Have you told anyone that you're thinking of killing yourself?
- What do you imagine death would be like?
- When you have thoughts of killing yourself, how do you imagine doing it?
- When you imagine it, do you complete the suicide? If not, who or what stops you?
- Do you imagine writing a suicide note?
- Have you actually written a suicide note?
- Do you have access to anything that you could use to harm or kill yourself (e.g., knives, guns, pills)
- When you feel this way, do you talk to anyone about it? If so, is that person a comfort?

*Step 4: Determine Level of Care Needed*

Once the student evaluation is complete, the assessor may use the following guidelines to determine level of care needed:

✓ If Suicidal Ideation is Expressed
- Passive suicidal ideation: This refers to instances when students may have passing thoughts of death, wonder what it might be like if they were dead, but have no active suicide plan, and indicate they would not actually harm themselves. They are able to communicate with adults or friends about their sadness, and are able to promise to speak to someone immediately should they feel like thoughts about harming themselves are becoming stronger. In this instance, parents should be contacted immediately. If the student is already in the care of a therapist, written (or verbal) permission to contact the clinician

should be requested, and a call should be placed to consult with the clinician about the student's immediate safety. A decision to allow a student to leave school with any indication of suicidal ideation should not be made alone. We encourage school staff to make collaborative decisions, including the school nurse, mental health practitioners who consult with the school and parents/caretakers in the decision making process.

- Active suicidal ideation: This refers to instances when students are actively considering suicide. They have a plan, or at least have considered what they would use to harm themselves. Additionally, students may seem reticent and distant, and are not able to express any level of safety. When a student endorses active suicidal ideation, it is important to seek help immediately. First, parents should be notified, and then the student should be transported to the nearest emergency room (at a facility with an adolescent or child psychiatric unit if possible) for further evaluation. If a parent is not able to reach the school immediately, or the student seems in great danger to himself or to others, 911 should be contacted to ensure the student's safety during transport and to ensure that the student is able to reach the emergency room. Students should never be sent alone to the emergency room. School personnel should not accompany the student to the emergency room due to liability reasons.

✓ If Suicidal Ideation Is Not Expressed

- If a student does not endorse either passive or active suicidal ideation, he or she does not require immediate evaluation or transport to an emergency room. However, it will be important to assess what sources of distress are present for the student. Anxiety, problems with attention or activity, panic attacks, or peer problems might be present. Therefore, continued monitoring and follow-up would be appropriate. Parents should be informed of these concerns, and recommendations may be made for outpatient services.

## Appendix 5-B: Sample Form for Student Evaluation Notes

The following is a sample form for documenting the assessment of an individual student as contained in Appendix 5-A. Conducting a risk assessment requires that you carefully document the information produced during the process, the findings and recommendations for follow-up. We urge you to consult with health care professionals associated with your program regarding any questions.

Date: _____

Student Name: _____

Homeroom/Teacher: _____

Student Age: _____

Person conducting evaluation: _____

Parents Contacted? Date: _____

Evaluation Notes

Reason for evaluation:

_____
_____
_____
_____
_____

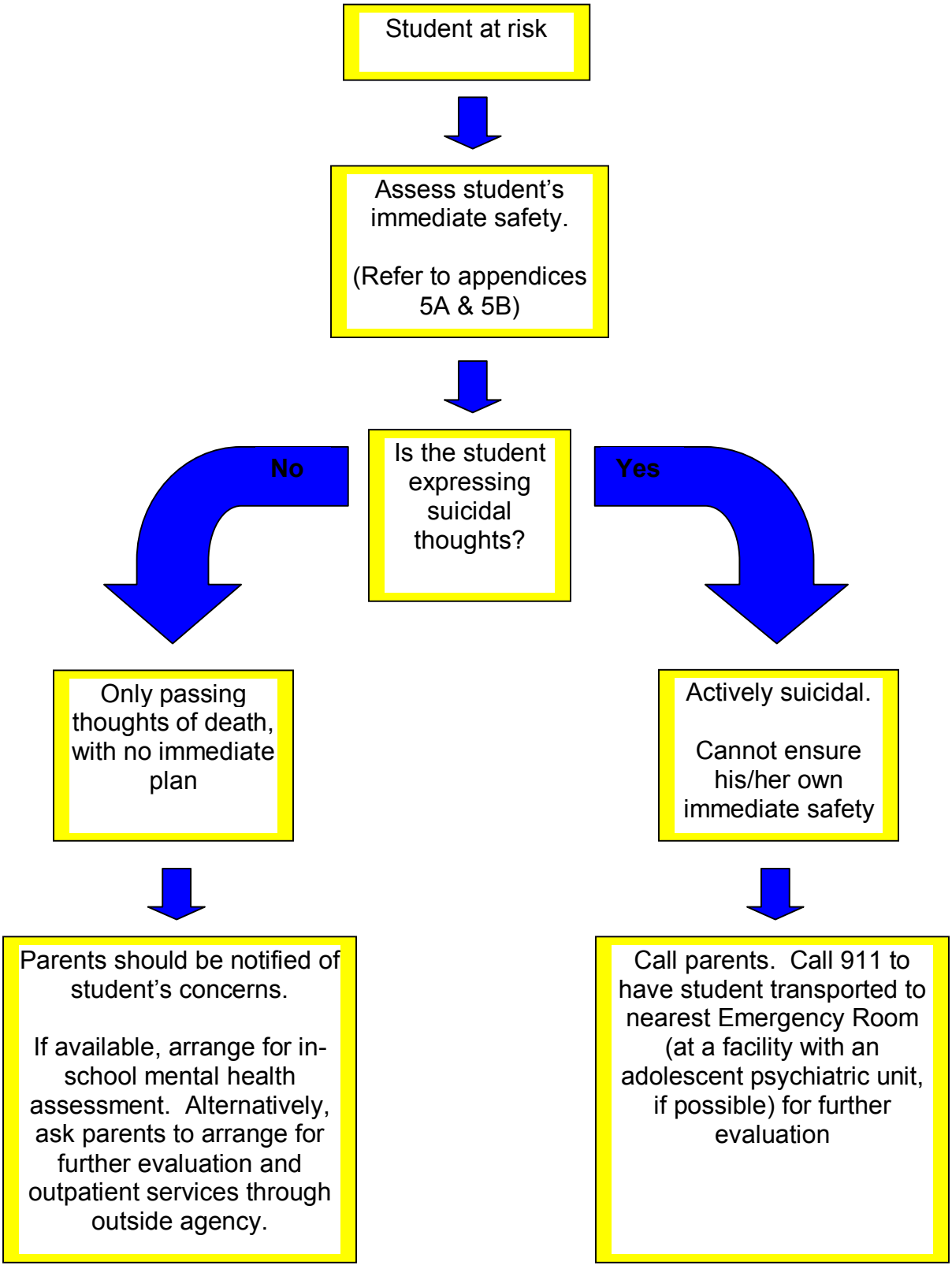
Evaluation findings:

_____
_____
_____
_____
_____

Outcome/follow-up:

_____
_____
_____
_____

**Appendix 5-C: Assessment Decision Tree**



*Part Three of Three – Evaluation and Conclusions*

# Chapter 6 - Evaluating Mental Health Programs in Schools

## Evaluation is an Integral Part of Prevention

The principles that guide this mental health and wellness curriculum are also the ones that direct our evaluation efforts. The curriculum is designed to prevent problems in adolescents before more formal intervention and treatment becomes necessary.

Evaluation is an ongoing and integral part of prevention, rather than a discrete assessment that occurs at one point in time. Curriculum evaluation should aim to identify *what works*, while simultaneously encouraging a collaborative dialogue among students, school staff, parents and mental health consultants on *how it works* to prevent problems and promote wellness in students.

As stated in the first chapter, the *Adolescent Mental Health & Wellness Curriculum* is a universal preventive intervention designed to reduce risks and enhance strengths in school children. It is *universal* because it applies to all students, not just those who have been identified as needing special help. While the responses of individual students may vary from disabling disorders to transient problems to amazing resilience, all teens face serious emotional and psychological challenges as they grow to adulthood. A great deal of their behavior, thoughts and feelings are normal and natural aspects of this major developmental transition. It is a *preventive intervention* tool, designed to work with adolescents in the face of these major developmental challenges before their behavior escalates to the point of needing treatment. The curriculum targets aspects of risk as well as protective factors through the provision of important information and support to teens and the key adults involved with them.

It is well understood that multiple risks can lead to specific emotional and behavioral problems such as depression. For this reason, this curriculum must be assessed regarding its impact on both specific problem areas, (i.e. substance abuse, depression, or stress), and generic risks (i.e., impulsivity or social isolation). Its influence on protective factors that can prevent more critical outcomes is a third area of focus. Using a combination of knowledge-based and group interactive approaches, the curriculum is designed to raise awareness, increase knowledge, promote social-emotional skills, enhance interactions and relationships with peers and other important adults, and shore up school capacity to include mental health and wellness as a fundamental aspect of educational programming. We believe evaluation should try to capture process and change in all of these areas.

As a program that promotes positive change in individuals as well as across school and home settings, the multiple voices and perspectives of children, parents, teachers and staff on *what works* should be captured through a mix of formats. Both qualitative (i.e., open-ended questions, interviews, or focus groups) and quantitative (i.e., surveys, rating scales, or grades) assessments can be used to measure the impact

of the curriculum. It is important to consider the critical role that family, peer and school cultures can play in the process of implementing a mental health and wellness curriculum. These points of view should be used to determine how to improve and adapt the curriculum to meet the particular needs of your school.

**What Works In School-Based Preventive Interventions?**

Evidence has shown that effective school-based preventions reduce problems and disorders as well as promote processes that protect against risk (Durlak & Wells, 1998; Greenberg, Domitrovich, & Bumbarger, 2001). There are several essential principles that emerge from prevention research findings that have served as the foundation for the design of this curriculum. Most findings reviewed in the literature are based on prevention programs that were structured around a specific research design, with the goal of obtaining outcomes or results related to reducing a targeted problem behavior (e.g., smoking or fighting).

The following key elements of effective school-based preventive interventions have been identified:

- **Multi-year ongoing programs provide enduring benefits, while short-term programs have limited benefits**. Building the curriculum into your school program over several years would offer more benefits than offering a one-time "quick-fix" program. You may want to reflect on what this means for the feasibility of using the curriculum in your school. For example, do you have the resources to sustain the whole curriculum or just part of it as an ongoing program over a longer period of time?

- **The earlier prevention services are started, the better the prevention effects**. This point may help you to reflect on where your efforts should be directed and with whom. For example, do you want to offer the program to 9$^{th}$ graders as they begin to negotiate the challenges of adolescent development in high school, or to 12$^{th}$ graders as they begin their transition to adulthood? What are the opportunities and benefits of each of these approaches? What are the costs of one over the other – of targeting the older kids or the younger ones?

- **Prevention works best when it targets risk and protective factors rather than specific problem behaviors.** Although the curriculum is organized around important mental health problems, the activities presented in each module are designed to enhance protective factors that will help adolescents make healthier choices and feel more in control of their lives. These skills include such things as reflecting on and making sense of their experiences, identifying their needs, and expressing their concerns.

- **Combined emphases on changing child behaviors, teacher and family behaviors, and home-school relationships are more effective than a child-only approach.** The curriculum hopes to increase awareness, encourage

reflection and ultimately change how your students, their families and your staff think about and engage issues of mental health and wellness. Bridging school and home, this ecological focus on the relational context of adolescents' lives acknowledges the essential role these relationships play in your students' lives. Strengthening of these relationships – going it together rather than alone – is one of the primary mechanisms underlying how the curriculum works to promote health and wellness.

- **No single program can prevent multiple high-risk behaviors in a community. Effective prevention programs offer collaborative, coordinated strategies and programs.** How does this tool build upon and connect to other strategies you are already using – as well as ones you may start to use? You may want to identify other programs that already exist in your school or in your community that may enhance your prevention efforts when offered in concert with the curriculum.

- **School partnerships with community providers and organizations will help to sustain prevention efforts.** This is related to the above point. Partnerships with community providers will increase your resources, enable you to provide additional services that may not be available at your school, and build networks or prevention and treatment options in your community.

Taken together, these research-supported lessons serve as a useful guide for the philosophy and structure of this curriculum. Hopefully, they also provide you with an outline for thinking through the implementation of the curriculum, and the evaluation of your overall efforts to support the emotional health and well being of your school community. This curriculum has been developed based on an integrated knowledge base of lessons drawn from program-specific research as well as our combined years of clinical practice in school and treatment settings at both McLean Hospital and Children's Hospital Boston.

## Pilot Evaluations of the Adolescent Mental Health and Wellness Curriculum

We have begun the process of introducing the curriculum modules to schools in the Boston metropolitan area. Along the way, we have utilized selected evaluation strategies to determine whether the modules are *safe, feasible and effective*. Just which strategies to employ depend upon general factors such as school readiness as well as more specific factors including the extent and nature of our involvement with a particular school. These issues affect how evaluation is conducted, just as they have an impact upon service delivery – interventions and their assessment are most successful when grounded in a working relationship between ourselves and a school characterized by trust, common understandings and goals, and mutual respect.

Most likely due to ongoing concerns about the rate of teenage suicide, many of the schools with which we have partnered have expressed interest in psycho-educational presentations on depression for students, parents, and staff. These requests led to the development and refinement of the depression module included in this curriculum. What follows is a description of how this module was used in two very different school settings in the Boston area, the evaluation process that accompanied it, and our initial findings from that evaluation.

In the fall of 2003, we offered the depression module to eighth and tenth grade students at a large Boston public school that serves students in grades 7 through 12. Our rationale for this implementation strategy came out of a combination of our discussions with school staff, experience working with students in this school (and others), and principles of effective prevention, which show that earlier intervention works better. Specifically, we targeted students in this age range to catch them earlier in the school year at two particularly challenging points of transition -- early adolescence and the beginning of high school -- with the goal of helping them to learn how to recognize risks for depression along the mood continuum (e.g., from stress to mood or behavior symptoms), strengthen their capacity to identify these risks in themselves or others, and get appropriate help if needed.

A clinician from Children's Hospital Neighborhood Partnerships had been in this school for over two years providing individual and consultation services. As a result, the facilitation of the depression workshops was incorporated into an existing structure for mental health service delivery. Since the facilitators had already established trusting relationships with both staff and students through this partnership, they were able to assess the emotional safety level in the school and the classrooms where they would be presenting the curriculum in a whole-class group format.[7] Based on their assessment of a moderate level of confidentiality and comfort among students and staff, they decided to start the groups with "Level Two" activities, which included psychoeducation, discussion and more interactive role-plays. Because of the already established relationships between the presenters and school staff, feasibility had been similarly assessed over time through classroom observations and discussions with staff. The

[7] This assessment was done informally at the time, but from their informal assessment strategies came the Class Emotional Safety Assessment provided for you in Chapter 2 of this manual.

module was folded into the curriculum of a health class and offered to all sections for one class period. A total of six classes participated in the groups; the remaining classes opted out due to scheduling difficulties. About half of the classes that participated requested a follow-up session to continue interactive role-plays.

Upon completion of the groups, the 132 students who participated provided feedback about the safety, feasibility and effectiveness of the group by answering the following questions (also listed in appendix 6-A):

1. Was the information presented relevant to your experience as a teenager?

2. Did you feel comfortable sharing personal information in class and that the information shared remained confidential?

3. Did you feel the presenters were knowledgeable about depression?

4. Did you feel that the presenters addressed your questions effectively?

5. Did you feel that the presenters promoted class discussion effectively?

6. Did you feel your understanding of mental health issues improved from this presentation?

7. Would you recommend that others participate in this kind of group?

Students rated each of the above questions on a scale from 1 ("not at all") to 5 ("yes, definitely"). On average, for all seven questions, students rated their experience as either 4's or 5's – that is, all participants found the presentations somewhat to very relevant, safe and effective. In fact, 75% of the responses given were either a 4 or a 5 – a very high level of agreement. The average response for each question ranged from a low of 3.5 to a high of 4.5. The highest ratings were given in response to Question 4, where 90% of the students felt the presenters addressed their questions effectively. The lowest ratings overall were in response to Question 2, where only 46% of students felt positively about sharing personal information in class, highlighting the importance of establishing a safe environment for the presentation of sensitive material. On the remainder of the questions, between 72% and 85% of the responses received were 4's and 5's.

In sum, these results suggest that students find the material interesting and useful, and the activities engaging and not overly threatening, all of which makes it more likely that students will retain the information in a way that may influence their behavior in positive ways. Furthermore, the positive responses to questions related to participating in groups on mental health issues demonstrate students' receptivity to the inclusion of these topics within the school curriculum.

In the winter of 2004, the depression module was presented to 22 eighth graders at a small private school in the Boston area serving students in grades 7-12. Unlike the school setting described above, presenters at this school were not providing other services and did not have well-established relationships with school staff and students. The module was presented during a health and development class, with three sessions offered over the period of a week to the same 22 students. Again, the rationale for offering the depression module to eighth graders was consistent with what we described above: to take an early intervention approach by educating students about the signs and symptoms of depression. Due to feasibility issues (mainly, the structure of the course in which the module was presented), a decision was made by the school to target half of the eighth grade class in the winter and to present the module to the remaining half in the spring.

Unlike the first setting, a classroom safety assessment was conducted in this setting because of the presenters' lack of knowledge about school and class dynamics. As discussed in an earlier section of this curriculum, the safety assessment asks students to rate on a 3-point scale how comfortable or concerned they feel about the following areas:

1. Comfort with sharing personal information with classmates and the presenter.

2. Confidentiality of personal information kept by classmates and presenter.

3. Concerns about possible negative consequences of sharing personal information with classmates and presenter.

4. Respect for differences by classmates and the presenter.

On average, across these four safety areas, all participating students indicated that they had a moderate level of safety and were ready to start with level two activities. However, a closer look at the assessment revealed some important distinctions made by the students that are very relevant to how the module would be presented. Students indicated that they would have a high level of comfort sharing personal information, and that their classmates and the presenter would respect differences. But they reported feeling only moderately safe when it came to the specifics of sharing information, e.g. confidentiality and negative consequences.

Based on this information, their experience and feedback from using the module in other schools, the presenters decided to modify the presentation format to engage students right away in interactive activities, as a way to present potentially sensitive information on the first day of the three-day presentation and to leave discussion for later. However, in feedback received after this first day, staff and students indicated that they would feel more comfortable learning in a more didactic format. In response to this feedback from staff, presenters shifted to focus on more psychoeducational aspects of the depression module.

For this evaluation, we decided that it would be important not only to understand whether the module was safe, feasible and effective for students, but to also determine how the shifting of the formats had effected students' engagement. At the end of the week at the completion of the module, students were asked to rate how comfortable they felt and how much they learned. In addition, they were also asked to rate how effective they felt the format of the presentation was on the three different days. All students who took part in the groups completed the ratings. Interestingly, the majority of the students indicated that they felt more satisfied with a question and answer format than with interactive activities and dialogue. This experience illustrates the importance of using evaluation and feedback to help in matching both the level of activity to use and the format in which information is delivered to the readiness and safety level of students and staff. Given the moderate level of safety assessed at the beginning of the week, students' less positive response to the more interactive and emotionally charged activities makes sense.

While we are enthusiastic about these initial results from our pilot efforts, we recognize that there are limitations to these findings: these represent relatively small numbers of students and only two school sites. A primary objective of our institutional collaboration is to pilot the modules more broadly in various schools with a wide variety of students, and evaluate them comprehensively. In addition to the questions presented above, we are also exploring other issues related to effectiveness, including presenter characteristics. For example, does it make a difference to students in terms of comfort and engagement to have a known figure – classroom teacher, school counselor – conduct the modules, or is it preferable to have an outside presenter? What is the optimal skill level and preparation for conducting these modules – and what is realistic to expect school personnel to do on their own? Such information will help us as we develop professional training tools, conferences and support materials to assist school personnel in implementing the curriculum.

## The Evaluation Cycle in Your School

To date, we have incorporated assessments of the modules into our work as we have developed and refined them through our ongoing consultation relationships with independent and public schools. As you consider using the curriculum (or any part of it) in your school, we encourage you to incorporate some kind of evaluation or assessment procedure into that process. The most important reason for evaluating your use of the curriculum is to answer three key questions:

- Is it *safe* for my students?
- Is it *feasible* for my school?
- Is it an *effective* way to help our community to deal with mental health issues?

To support this effort, we offer a description of the steps you may want to take in conducting your evaluation – what we call "*the evaluation cycle*." As mentioned before, evaluation is built into the curriculum. If you have begun to implement the curriculum by assessing your needs and readiness, you have started your evaluation! Listed below are the recommended steps that are usually taken in a comprehensive evaluation.

1. Conduct a needs assessment to determine where you would like to focus your prevention efforts. Engage all constituencies, survey students, staff and parents to determine awareness, prevalence, cultural attitudes, current strategies and policies, new directions and resources. (More on conducting a needs assessment can be found in the first chapter of this curriculum.)

2. Define objectives related to your needs. This is an iterative process of questioning and exploring, identifying and prioritizing areas on which to focus. A larger goal you may want to consider as you engage in this process is how to make students' social and emotional learning a more central part of your educational program,

3. Determine readiness and feasibility for implementation of curriculum groups in your school. This involves determining what resources you already have in place that can be committed to this project (e.g., staff, time, space), as well as areas of need (e.g., student support services, referral sources), which may lead you to partner with outside agencies for additional resources and support. In this process of figuring out how you will implement the curriculum, you will have many choices to make about who does what and how it will be done. Here are just a few of the many questions you may face as you engage in this process: Who should obtain consent from parents? Should groups be provided to all targeted students during the same period of time or will you stagger the groups across several months? Who will run the groups: the student support coordinator, the health teacher or the classroom teacher, or some combination? Or would it be better to have them facilitated by a clinician from a community agency? At what time will the groups be held - during lunch, after school, or…?

4. Create and maintain a "map" of services provided to your students, as well as a narrative record. This is an important part of keeping track of both the story of how your groups unfolded, and to accurately describe the amount (or "dosage") of prevention services provided. This description can be brief and succinct, but should be specific; for example, "We conducted a needs and readiness assessment, followed by the formation of a weekly group based on the depression module, levels 2 and 3, which ran for 8 weeks and was provided to all 9th graders." If you have a *rationale* for providing the curriculum to a certain group of students, you should make it clear. For example, "9th graders were chosen for this group because the transition to high school can be a particularly stressful time and prevention efforts can begin earlier rather than waiting for problems to emerge."

5. Identify the level of safety in class, and among staff and parents. As described above, the adults involved need to feel safe and comfortable so they can create an environment in which students feel the same. What are the potential benefits and negative consequences for your students? In fact, if you decided to assess class safety using the assessment provided in the first part of this manual to determine the appropriate curriculum level for your students, you have already taken some of the necessary steps towards this goal. The safety assessment should limit negative consequences because it enables you to identify the intensity and amount of information to present to students. If there were negative consequences, were they minor – and were they "worth it" in terms of the benefits? For example, some students may at times feel uncomfortable talking about personal experiences in the group. And what were the benefits? "Students felt more supported and less alone knowing that other kids had struggled with similar issues."

6. Assess the effects of the groups on students using multiple formats and informants. If possible, plan to identify both short-term as well as long-term effects. There are many different ways to know if your goals have been met – in other words, *if the curriculum has been effective*. You may want to assess if risks (such as impulsivity) have been reduced, if protective factors have been enhanced (such as connection to school, improved educational outcomes) and/or if wellness has been promoted (improved communication, decrease in outside of school referrals). These indicators of effective prevention are generally the opposite of the risks and problem behaviors that influenced your decision to use this tool in your school. They are the objectives or "performance" indicators that grow out of the needs you first identified at the beginning of this process. For example, if you determined from your needs assessment that elevated levels of stress among your students was related to an increase in disciplinary problems in your school, you might want to see if disciplinary problems were reduced over the period from before you offered the stress module (a *pre- or baseline assessment*) to the period following the completion of the module (a *post-assessment*).
    - *Satisfaction* is another important indicator of effectiveness, particularly with adolescents. To understand if an instructional strategy like this one is effective, it is crucial to determine how engaged students felt in the curriculum group activities and discussion. We know that students are apt to absorb more if they

feel that the material presented to them is relevant to both their thinking and emotional selves. An example survey titled Student Evaluation of the Depression Module is provided as Appendix 6-A at the end of this section.

- Comparing groups of students who participated in the curriculum presentations to those who did not may also give you some sense of how things are working. Depending on your focus, you may look at whether students who chose to participate in groups were faring better in their efforts to learn. In addition, you may want to ask other people in students' lives, like their parents and teachers and even peers, if they have improved in important areas of their lives following participation in a curriculum group. This kind of assessment strategy requires a very high level of safety in the environment, where people feel a shared sense of responsibility and commitment to helping others. Careful consideration of confidentiality must be addressed in using this approach.

7. Discuss lessons learned and challenges faced in all stages of implementing the curriculum and review the impact the curriculum has made on students and on your school.

8. Make adaptations to the implementation process, the curriculum activities, and the evaluation methods, based on the information generated by Step 7.

9. Implement the revised approach. The evaluation cycle – really, the cycle of assessing needs, implementing an approach to meet the need, and assessing the progress toward accomplishing the goal – begins again.

We recognize that you may not want to tackle the whole thing right away. You should focus on the piece that makes the most sense to you, has the most direct relevance to your immediate and long-term goals, and that will provide you with the information you most want to learn.

You may already have in place measures that can be used to answer your questions: attendance rates, disciplinary referral data, student support referrals, tests scores and grades. In fact, we encourage you to use methods and information that you already have in place rather than imposing new measures that will take additional time and investment from people and systems under stress. It is more likely that the evaluation questions you ask will be answered as a result!

## Conclusion

As in all of the chapters of this manual, we have aimed to provide you with a theoretical framework and practical tools to help you meet your specific goals related to the mental health and wellness of your students and the overall operation of your school. Quality evaluation, like quality treatment, not only addresses the immediate issues in front of you but also helps you to prepare more effectively for the future. Our main recommendation to you about evaluation is: *You can do it*. Define a clear goal for your work; ask one or two focused questions about whether and how that goal has been achieved; and use the answers to advance you toward that goal. Remember that evaluation is a cycle of gathering feedback and using that information to make your work even better. As educators, as professionals invested in the growth and successful development of your students, this is a process that serves us all well.

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## Appendix 6-A: Student Evaluation of the Depression Module

*Please rate the following questions using the following markers:*
*1 – strongly disagree*
*2 – disagree somewhat*
*3 – neither agree nor disagree*
*4 – agree somewhat*
*5 – strongly agree*

1. The topics discussed in the presentations were relevant to my experience as an adolescent. 1 2 3 4 5

2. I was able to express my opinions without fear of judgment or break in confidentiality.
   1 2 3 4 5

3. I learned how to identify symptoms of depression, as well as how to obtain help if I identify any of those symptoms in myself or in others.
   1 2 3 4 5

4. The group leaders were able to address questions raised in the class effectively.
   1 2 3 4 5

5. The presentation raised issues that promoted helpful discussion and interactions among students.
   1 2 3 4 5

6. The presentation helped raise my understanding of mental health and wellness, as well as how they play a role in the school setting.
   1 2 3 4 5

7. I would recommend this presentation to other students in this school.
   1 2 3 4 5

Additional Comments (optional):

## Appendix 6-B: Your Evaluation of *An Adolescent Mental Health & Wellness Curriculum*

We appreciate your interest in our Adolescent Mental Health & Wellness Curriculum. At the beginning of this manual, we set our goal to develop a starter kit for school leaders containing information directed at promoting wellness and resiliency in the adolescents in their schools. We want this material to be a helpful guide for educators to run a preventive mental health program either with or without outside mental health expertise.

To accomplish this goal we welcome your comments and suggestions. We would appreciate receiving the following evaluation form after you have reviewed and/or used any chapter of our curriculum. Your comments will remain confidential; no personal identifying information of either individuals or schools will be available to anyone outside of our working group. We strongly believe that improvement is contingent upon feedback from those who are actually in the school.

David Ray DeMaso, M.D.
Joseph Gold, MD

## Appendix 6-B: *Adolescent Mental Health & Wellness Curriculum* Evaluation Form

***Please choose one response for each item below and write your comments on the reverse side of this page.***

**1.** Person completing this form is (*check one*):
☐ Teacher ☐ Counselor ☐ Head Master/Principal
☐ Nurse ☐ Mental Health Professional ☐ Other (Specify_____)

**2.** ☐ School (Name _____) or (Describe _____)

*Please check one box for each of the following:* ***(1 = poor, 5= excellent)***

**3.** The overall usefulness of the *Adolescent Mental Health & Wellness Curriculum* 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐

**4.** The relevance of the *AMHW Curriculum* to your students was 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐
(***1 = not at all, 5 = very well***)

**5.** How well did the *AMHW Curriculum* meet the stated goal? 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐
*"To develop a starter kit for school leaders containing information directed at promoting wellness and resiliency in the adolescents in their school."*

**6.** The *Adolescent Mental Health & Wellness Curriculum* chapters were: ***(1 = poor, 5 = excellent)***

- *Using the Adolescent Mental Health & Wellness Curriculum in Your School* 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐
- *Assessing Class Safety to Determine Curriculum Level* 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐
- *Stress - Causes, Consequences and Management* 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐
- *Substance Use, Abuse, and Dependence* 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐
- *Depression in Adolescents* 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐
- *Evaluation and Conclusions* 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐

(***1 = not at all, 5 = absolutely***)

**7.** The *Adolescent Mental Health & Wellness Curriculum* requires the involvement of an onsite mental health professional to ensure its feasibility and safety. 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐

**8.** Please briefly describe your overall impression of *An Adolescent Mental Health & Wellness Curriculum:*
(_____)

**9.** We would also very much appreciate your longer comments on the modules used in our curriculum. Please indicate on the reverse side of this page how each module could be improved.

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***Thank you for completing this form. Please return to:***
Children's Hospital Neighborhood Partnership, Attention: Caroline Watts Ed.D., Dept. of Psychiatry, Children's Hospital Boston, 120 Brookline Avenue, Lower Level, Boston, MA 02215