

SAVE SOMEBUDDY: A TRAUMA-INFORMED PROGRAM TO PROMOTE
EMOTIONAL REGULATION, ENCOURAGE A SENSE OF COMMUNITY, AND
PREVENT SUICIDE AMONG YOUTH IN A SCHOOL SETTING: A PILOT STUDY

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ABSTRACT

SAVE SOMEBUDDY is a global initiative to simplify brain science into ordinary actions (Van der Kolk, 2014). Students are taught to “save yourself and help a buddy” by practicing program tools through a community focused buddy system intended to inspire a trauma-sensitive classroom and school environment. An ability to see through the eyes of others is imperative to understanding trauma. Therefore, survivors are potentially the best resource for sustainable solutions. The program addresses the roots of conflict: self-sabotage, traumatic ordeal, and suicide (SOS), while placing responsibility for these concerns in the hands of the people. To accomplish this objective, adult mentors from the community were paired with youth and adult students with a similar background and culture. For example, African refugee adults paired with African refugee students. This approach crossed cultural barriers and created a strong sense of community. Six outcomes were measured (improved communication, self-awareness, coping skills, positive self-perception, forming a trusting relationship with a peer, and experiencing a safe and supportive trauma-informed classroom). Six of the seven measures used indicated an improvement with the intervention. Statistical significance was shown for increased grit, health, and resiliency associated with improved communication, self-awareness, coping skills, and positive self-perception. There was also statistical significance for satisfaction for life related to improved positive self-perception, forming a trusting relationship with a peer, and experiencing a safe and supportive trauma-informed classroom. The study was designed to examine the effectiveness of simple evidence-informed tools taught to students by adult community mentors with the clear intention to break the cycle of conflict and transform the lives of a new generation.

TABLE OF CONTENTS

ABSTRACT	ii
ACKNOWLEDGMENTS	iv
INTRODUCTION	1
METHODS	16
RESULTS	43
DISCUSSION	48
CONCLUSION	52
REFERENCES	54
APPENDIX	63

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SAVE SOMEBUDDY: A Trauma-Informed Program to Promote Emotional Regulation,
Encourage a Sense of Community, and Prevent Suicide
Among Youth in a School Setting: A Pilot Study

INTRODUCTION

"I spent an hour with Laughter
We chatted all the way
But I barely remember a single thing
From what she had to say

I then spent an hour with Sorrow
And ne'er a word said she
But, O, the things I learned the day
That Sorrow walked with me"
- Anonymous

Human history has taught that conflict begets trauma and trauma begets conflict. This cycle has played out repeatedly in families, communities, and nations. Sorrow and her sisters, abandonment and neglect, and brothers tragedy and cruelty, are born of trauma. They are the fruits of conflict within the self and with others. Toxic stress from traumatic experiences wreaks havoc on the body and mind and is manifested through modification of gene expression. These influences on the genome transform how an organism or human body function with regard to health or pathology. These changes are dynamic and epigenetics is the study of these alterations. Because the epigenome is dynamic, it is also responsible for the positive health changes that arise from post-traumatic growth (Van der Kolk, 2014). A broader view of these genomic changes suggests that these “ghosts in the nursery” influence and affect the entire human-family genome (Fraiberg, Adelson, & Shapiro, 1975).

Even among families where the love bonds are stable and strong, the intruders from the parental past may break through the magic circle in an unguarded moment, and a parent and his child may find themselves reenacting a moment or a scene from another time with another set of characters (Fraiberg et al., 1975, p. 387).

Fraiberg et al. (1975) were among the first to explore how troublesome familial ghosts “take up residence and conduct the rehearsal of the family tragedy from a tattered script.” They discovered from a child development perspective that “the baby in these families is burdened by the oppressive past of his parents from the moment he enters the world.” This leaves humanity in a quandary, to determine whether one can choose to be either a creator or creature of circumstance (Maugham, 1947). Benjamin Disraeli, the only British prime minister to have been of Jewish birth, in an attempt to redirect his nations’ tumultuous histories, reflected the sentiment, “Man is not the creature of circumstances, circumstances are the creatures of men. We are free agents, and man is more powerful than matter.”

When granted the power that comes from being a creator, one is then compelled to consider the words of Abraham Lincoln, who laid a foundation for triumph over the entrenched conflict and intergenerational trauma of slaves and their captors, with the challenge, “Nearly all men can stand adversity, but if you want to test a man’s character, give him power.” Thus, we shall explore how Sorrow’s gift of resilience is power that can strengthen character and change the plight of future generations, through simple tools developed and tempered by the lived experience of our ancestors, transcending circumstance and revealing that “history is not destiny” (Fraiberg et al., 1975).

This idea has been demonstrated by champions of non-violence like Nelson Mandela and Paul Kagame by empowering ordinary people to accomplish extraordinary things. They promoted freedom and established peace, but peace is not just the absence of war. Ascension to freedom is grasped when one is released from trauma and its aftermath. Liberation of mind and body is an inherent right. Resolving pervasive

intergenerational trauma is not the sole responsibility of educators, government agencies, or mental health practitioners, but rather must be addressed as a social justice issue (Button, 2016). This responsibility can be placed in the hands of the people by simplifying brain science into ordinary actions (Van der Kolk, 2014). “For to be free is not merely to cast off one’s chains, but to live in a way that respects and enhances the freedom of others” (Nelson Mandela).

Trauma is a major risk factor for self-harm, intimate partner violence, and suicide (SAMHSA, 2019; Feletti et al., 1998). The problem is exacerbated when retributive anger (Nussbaum, 1998), or revenge, doesn’t allow one to move on by creating a vicious cycle of more revenge, often glorified in popular media. The 1994 Rwandan genocide, where an estimated 800,000 Tutsis were killed in just 100 days, was fueled by the politics of revenge: hatred, division, and separation. Tutsi military leader and politician, Paul Kagame, led the Rwandan Patriot Front that overthrew fanatic Hutu forces, ending the genocide. When he was elected president of Rwanda, even though he had lost many of his own family members, he began a nationwide reconciliation project reversing previous political manipulation and propaganda.

Kagame focused on building community, based on understanding and forgiveness to heal the wounds of genocide, teaching his people that irrespective of their differences they could work together for peace. He and his staff visited citizens in their homes to discuss how they could have hope for the future, by understanding that blame doesn’t help, and to confront the situation proactively. Kagame taught that justice and revenge are different. He proclaimed, “Revenge may be justified, but it is not justice.” Because of his insight, Rwanda has not returned to violence.

The ability to resolve trauma and its aftermath through post-traumatic growth is crucial for individual health and society as a whole. Not to resolve toxic stress only leads to destruction of self and a society. Many studies evaluating the dramatic rise in school-based violence, self-harm, and suicide suggest that adverse traumatizing childhood experiences contribute to lasting health, educational, and social problems throughout the lifespan (Feletti et al., 1998). Prevalent societal decline calls for an urgent solution to benefit the social and emotional welfare of the next generation by curbing the enduring effects of toxic stress and intergenerational trauma passed on through epigenetics. There have been relatively few programs implemented among school age children to educate them on how chronic stress and the emotional reactivity to these experiences can affect them (Phifer & Hull, 2016; Dorado et al., 2016). Research suggests that implementing a trauma-informed approach in schools may have social, emotional, and educational benefits for students (Howard, 2018). Furthermore, emotional self-regulation and social support may reduce violence toward self and others (Howard, 2018).

Relatedly, while no single cause has been determined, suicide most often occurs when there is a convergence of toxic stress with poor emotional and physical health sowing an experience of despair and hopelessness (Van der Kolk, 1989; Van der Kolk 2014). Self-harm can be a precursor to suicide (Van der Kolk, Perry, & Herman, 1991) that is often expressed in the form of self-sabotage and addiction (Fisher, Roget, Sage, & Sage, 2009), the slow death of the soul. A simple and replicable solution to address the destructive repercussions of trauma is imperative. The World Health Organization (WHO) states that humanity is facing a worldwide epidemic nearing 800,000 deaths by suicide annually, one death every 40 seconds (WHO, 2019; Vijayakumar, 2015;

Vijayakumar, Nagaraj, Pirkis, & Whiteford, 2005). Suicide is the second leading cause of death globally among people 15-29 years of age (WHO, 2016). Research indicates 20 attempts for every adult who takes their own life, at an annual rate of almost 16 million attempts internationally (WHO, 2019; Vijayakumar, 2015) and 50–120 million people are significantly affected by the attempted suicide or suicide of an associate or loved one (Vijayakumar, 2015). Architects of genocide are becoming obsolete. Rather than killing each other, we are killing ourselves.

Groundbreaking research suggests that the aftermath of conflict, among nations and in the home, has been passed on to children who have never experienced the horrors of war through their parents' DNA (Yehuda et al., 2014). Children of survivors of the Jewish Holocaust and 9/11 terrorist attacks, who had not experienced the same levels of stress, show biomarkers similar to their parents, indicating high levels of stress hormones such as cortisol and have a higher risk of developing anxiety, depression, and post-traumatic stress (Yehuda et al., 2014). Fortunately, there is hope for children who have survived horrific experiences (Perry & Szalavitz, 2017; Kerig & Wainryb, 2014) as effective and evidence-based methods can be implemented to prevent suicide and suicide attempts with individuals and at all population levels (WHO, 2019).

Nelson Mandela encouraged the philosophy of ubuntu, a Nguni Bantu term meaning “humanity” often translated as “I am because we are.” A sense of community shatters the destructive confines of “us versus them.” A half-century of collaborative research on trauma has revealed the key in changing lives, beyond all treatment modalities, is one person genuinely caring about another (Van der Kolk, 2014). These steps toward self-actualization are explored through Maslow's Hierarchy of Needs

(Maslow, 1943). Physiology is at the base, transcending upward toward higher levels of self-awareness and the world around us. Trauma breaks connection with self.

Relationship with self heals trauma (Van der Kolk, 2014). Thus, love is the emotional air we breathe. Love of self and for others is as vital as food and shelter (Suomi, 2007).

Trauma lights the limbic system, the emotional engine of the brain, on fire that can induce a heightened state of fight, flight or freeze (Van der Kolk, 2014; Van der Kolk, Perry, & Herman, 1991). In order for people affected by trauma to fully integrate into a society and have a grounded sense of themselves, alleviating the effects of trauma must be addressed to attain these hierarchical needs. Van der Kolk (2014) states:

As long as we continue to live in denial and treat only trauma while ignoring its origins, we are bound to fail. In today's world your zip code, even more than your genetic code, determines whether you will lead a safe and healthy life. People's incomes, family structure, housing, employment, and educational opportunities affect not only their risk of developing traumatic stress, but also their access to effective help to address it. Poverty, unemployment, inferior schools, social isolations, widespread availability of guns, and substandard housing all are breeding grounds for trauma. Trauma breeds further trauma. Hurt people hurt other people. (Van der Kolk, 2014)

In the 2017 docuseries "The Story of Us" Morgan Freeman (Freeman et al., 2018) affirms, "There is nothing we can do that can't be done with love." Case studies from our beginning, illustrate that polarization of different camps creating divisive tribal nationalism through religion, race, and gender identity, is fuel for cultural conflict and a precursor to war, where poor and young die to line the pockets of rich men. When a nation's citizens are successfully manipulated to turn on each other the nation can be easily overpowered (Hutchison, Nyks, Scott, Chomsky, PF Pictures (Firm), & FilmRise (Firm), 2015). Humanity is continually duped into taking the bait, but we can bridge the gap of separation. "People need personal experience with the other, so the story of us can also include them" (Bill Clinton). Rather than asking, "What is wrong

with you?” we begin asking, “What happened to you?” (Van der Kolk, 2014). People can then bind the social contract that has been broken by our leaders when they teach each other “correct principles and they (learn to) govern themselves” (Joseph Smith). We can then become the miracle that can save our world by reversing the damage we have inflicted on societies and ourselves.

“The quality of mercy is not strained. It droppeth as the gentle rain from heaven upon the place beneath” (Shakespeare). Each person has the ability to be merciful by seeing the brokenness in the world and do what they can to repair it. To shift such perspective, kindness and mercy are necessary ingredients and are more powerful than hostility and aggression to create effective change. Subtle and profound influence is felt through patient, gentle conversation (Resick, Monson, & Chard, 2017), guiding us to our common humanity and creating a movement where the people are the light and lead the way for others. When we shift our identity to accept ourselves, for who we are, rather than what we have, and include the other (Ellis & Bernard, 2006) as part of our allegiance to an entity greater than ourselves (e.g. God, Source, Love, Creator, etc.) we rise to a higher purpose of being as an individual and society, and shed destructive ideology that has commonly driven conflict. This new identity can be created most directly and efficiently within the family and school systems (Ellis & Bernard, 2006), where the upcoming generations spend most of their time. With repetition and reinforcement, children can learn to cultivate a culture based on kindness, while discovering the importance and beauty of connection with others, simply by “paying kindness forward” (Hammond, 1916). When we change perspective from “us vs. them” that drives isolation, to “all of us together”, we can then discover how much we have in common with our

(perceived) enemy. Mahatma Gandhi encouraged this objective when he said, “An eye for an eye makes the whole world blind.”

Northern Ireland has experienced such blindness for over 700 years. It was this tumultuous history that inspired the SAVE SOMEBUDDY (SSB) project. Through the Oxford Consortium for Human Rights in Northern Ireland, the author participated in interviewing combatants, politicians, human rights advocates, militarized police, journalists, and mental health practitioners who all experienced “The Troubles” and were working toward long-term reconciliation. While the Good Friday Agreement (1998) intended to end the centuries-old conflict, it did not subdue the tension simmering under the surface and that continues to exist today (Mac Ginty, Muldoon, & Ferguson, 2007). This tension can be attributed to intergenerational conflict and subsequent trauma that has been passed on through Irish families for centuries (Van der Kolk, 2014). Given the longevity of societal trauma, is not surprising that Northern Ireland has high rates of alcoholism and drug addiction as well as sexual exploitation of children (Montgomery-Devlin, 2008). Recognition that a significant number of children were suffering from the effects of perpetual conflict, a reconciliation process was implemented and relied on the school system to help youth become more comfortable with diversity (Gallagher, 2016) and no longer see their “enemy” as different than themselves.

The Division of Violence Protection at the Centers for Disease Control and Prevention (CDC) conducted a landmark study, the Adverse Childhood Experiences, with over 17,000 participants from Kaiser Permanente (Feletti et al., 1998). As previously mentioned, the study found that adverse childhood experiences (ACEs) are a significant risk factor for long-term chronic disease and substance use disorders throughout a

person's lifespan, potentially leading to and early death (*Figure 1*).

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

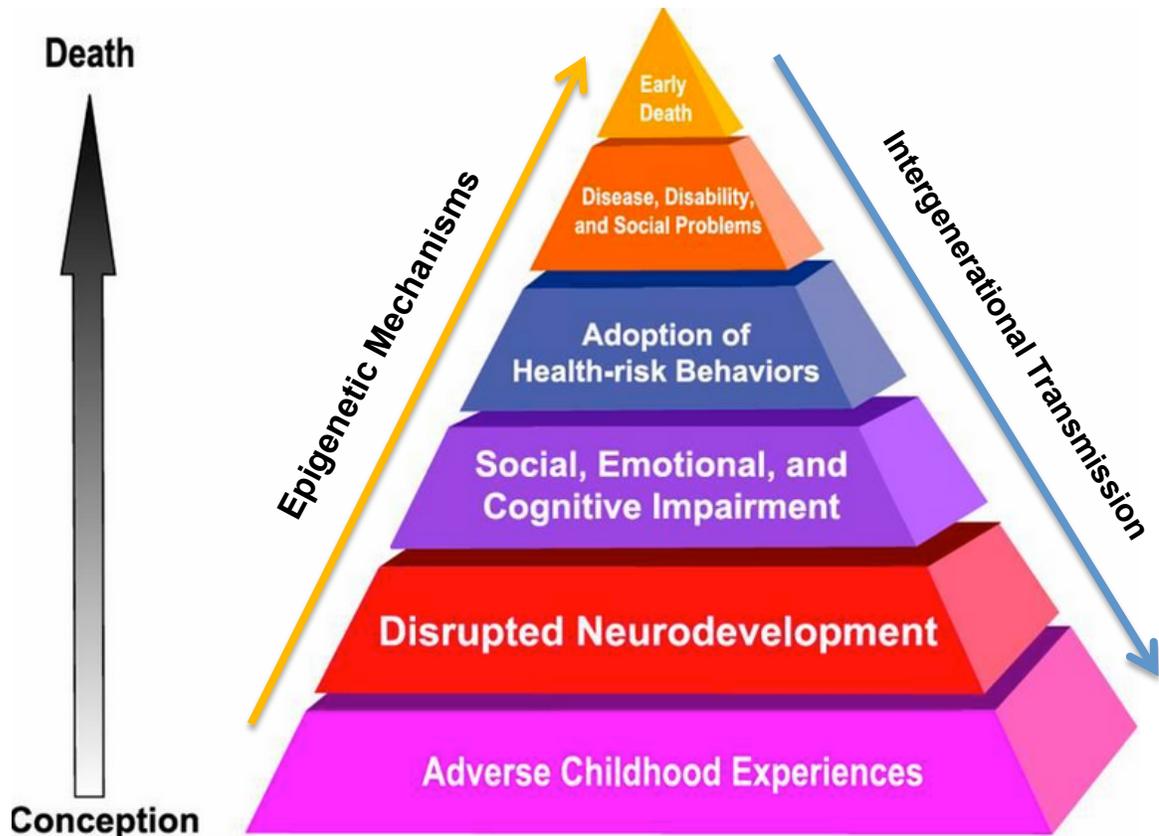


Figure 1. Adverse Childhood Experience (ACEs) Pyramid: progression of physical, emotional, and functional decline over the lifespan. Graphic courtesy of Robert Anda, MD.

The degree of childhood adversity has been shown to be directly correlated to emotional, physical and productivity challenges in adulthood. However, many people who have suffered from ACEs have altered the course of their trajectory because of support from individuals within their community (e.g. specific family members, friends, teachers, clergy, etc.) who helped them see themselves differently and shift perspective.

ACEs research has documented clear and unsettling statistics that correlate the dosage of ACEs and adult-onset of medical and mental health diagnoses, which is only

recently being recognized by medical providers (Burke, 2019). The ten adverse experiences segregate into three main categories: neglect, abandonment, and abuse. Each of the ten items identified as having occurred determines a person's ACE score. The higher the ACE score, the exponentially higher the risk for long-term health conditions and decline in function. For instance, a male child with an ACE score of 6 > has a 4600% increased likelihood for IV drug use compared to a male child with an ACE score of 0. This may suggest that heroin and other forms of addiction may be used for the relief of anguish dating back to ACEs, as it may have become the best coping mechanism that an individual can find (Feletti, et al., 1998).

Pediatrician and California Surgeon General, Nadine Burke-Harris (2019) is leading the medical community toward a trauma-informed approach to caring for children (Burke, (2019) exemplified in her clinic, the Center for Youth Wellness. She has noted that "ACEs affect 34.8 million children across socioeconomic lines, puts them at higher risk for health, behavioral, and learning problems" (Burke, 2019; Child and Adolescent Health Measurement Initiative, 2013). Research has now well established that toxic stress caused by ACEs affects brain development by changing the expression of a child's DNA, which interacts with the immune and hormonal systems.

ACEs research shows that two out of three individuals (67%) had one or more ACEs and 13% had four or more ACEs. Strikingly, a shorter life expectancy by 20 years is associated with a high ACEs score that is untreated. Common diseases across the lifetime are linked to children exposed to ACEs and are most recognized in adulthood. Some examples of adult statistics include:

- More likely to experience seven of the ten leading causes of death.
- Three times the risk of heart disease or lung cancer.

- A score of 6 > is at risk for 700 times more likely to experience addiction to alcohol.
- A score of 6 > is 1200 times more likely to die by suicide.

Early intervention is crucial to halt the transmission of trauma and increase sustainable health among individuals and communities (CDC, 2015; Feletti et al., 1998).

Many studies evaluating the dramatic rise in school-based violence, self-harm, and suicide suggest that ACEs contribute to long-term health, educational, and social problems throughout the life. However, there have been relatively few programs implemented among school age children to educate them on how chronic stress and the emotional reactivity to these experiences can affect them (Phifer & Hull, 2016; Dorado et al., 2016). Much of the research is primarily qualitative (Phifer & Hull, 2016). There is a need for more research with clearly defined variables utilizing tools that are evidence-based or evidence-informed. This study was designed to meet this objective.

Research suggests that implementing a trauma-informed approach in schools may have social, emotional, and educational benefits for students (Howard, 2018) and that emotional self-regulation and social support may reduce violence toward self or others (Howard, 2018). Further evaluation of the relationship between learning trauma-informed skills and hypothesized improvement in academic performance is necessary. Such studies may better identify how these learned skills may be generalizable to non-academic settings and be potentially beneficial for curbing the long-term effects of toxic stress on intergenerational trauma.

The SSB study is designed to evaluate the effectiveness of teaching a trauma-informed program to students based on changes in academic performance and social-

emotional skills. The SSB program houses simplified tools that are based upon validated and well-recognized methods in the public domain, including Rational Emotive Behavioral Therapy, Cognitive Behavioral Therapy, Thought Field Therapy, and suicide prevention planning (Ellis & Bernard, 2006; Resick, Monson, Chard, 2017; Van der Kolk, 2014; Connolly & Sakai, 2011; Bryan, Mintz, Clemans, Leeson, Burch, Williams, Maney, & Rudd, 2017; Bryan & Rudd, 2015). SSB is designed to deliver a curriculum based on the combination of simplified tools over a specific time frame (6 hours of instruction including pre and post assessment). The design includes delivery by community members (non-licensed mental health practitioners). SSB is anticipated to have a positive impact on the identified outcomes.

Research Aims

The aim of the research was to examine the effectiveness of social-emotional learning activities through trauma-informed skills taught in a school setting. The goals included improvement in overall performance scores, sufficient mastery of coping skills to support emotional regulation, reframing negative thoughts with positive self-perceptions, and building connection with a chosen “buddy”. (A buddy is defined as a student who agreed to offer social and emotional support in line with SSB goals.) This is an inclusive study design, where no students are isolated from participating due to personal conditions. All students had the same opportunity to participate in SSB that included an online self-assessment and exposure to easy-to-use learning activities/tools. Providing each student with a unique identifier that was associated with the student ID protected the confidentiality of the student. The researchers were blinded to the link between the student ID and the unique identifier.

The purpose of this study was to strengthen self-awareness, promote emotional regulation, create a trauma-sensitive community within a school setting, and prevent suicide among youth and their peers. Secondary aims of the study were to teach adult mentors from the community how to teach youth to practice emotional regulation, mindfulness, and sensitivity to the needs of others by saving yourself and helping a buddy. These objectives were accomplished by teaching simple emotional regulation and cognitive tools to adult community mentors who are lay people without mental health credentials. The mentors taught these tools to students (youth and adults) who may or may not have endured ACEs. The students then practiced the tools with a buddy. The mentor participants and select student participants each answered questions to determine if they have learned the skills, can teach the skills, and can apply the principles.

SSB draws from two disciplines: psychology and strategic communication and was influenced by the fields of human rights, political science, instructional design, and business process management. *Figure 2* illustrates the six objectives that were measured:

- 1) Improvement in Communication and Self-Awareness - The focus on psychology tests whether there is a measurable difference in an ability to communicate openly with self and others through self-awareness. These skills may impact school performance prior to learning the method, based on comparing performance from the previous school year and the current school year in which the information is received.
- 2) Improvement in Coping Skills - Students learned three simple evidence-informed tools that target behaviors and beliefs associated with self-sabotage (harm), traumatic response, and suicide prevention. Collectively, these coping skills teach how to reframe negative thoughts, breathing and self-soothing techniques to learn emotional regulation, and how to be a friend to create a supportive community.
- 3) Improvement in Positive Self-Perception - The component

provides education about basic concepts regarding how exposure to traumatic stress can change perception, beliefs about self, and emotional response in reaction to trauma and adversity. These skills are designed to help students focus on learning and achieving life goals. 4) Form a Trusting Relationship with a Peer - Students were introduced to the concept of community building by learning how to safely reach out to support and be supported by a buddy by practicing the tools during the educational sessions.

5) Experience a Safe and Supportive Trauma-Informed School – Adult members of the community were trained on trauma-informed practices. Their role was two-fold and included: a) inspire community involvement of participants in the study and b) support students in creating a student-directed trauma-informed school community.

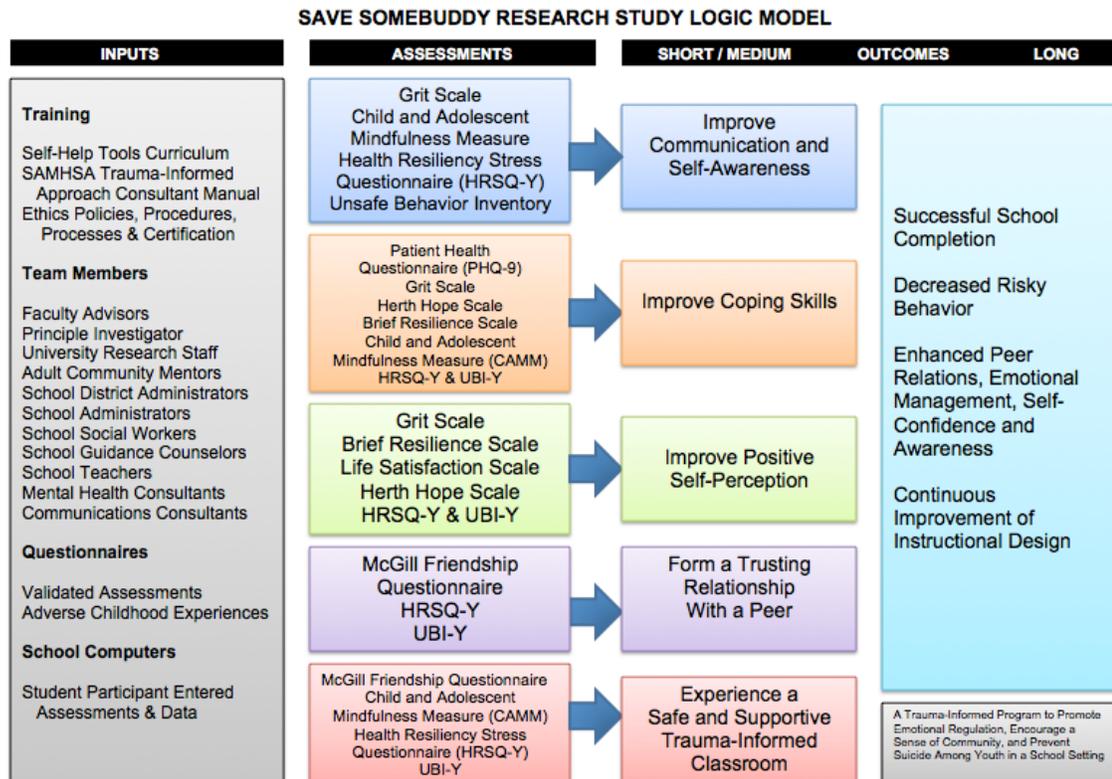


Figure 2. Study Logic Model: inputs, assessments, and potential outcomes.

6) Continuous Improvement of Instructional Design – Evaluation of the instructional design methods used to teach the aforementioned skills and tools, to determine the best implementation of the program from a human factors perspective.

Figure 3 is provided below to illustrate the training flow of mentors, students, teachers, and administrators to demonstrate a full community effort to support students in learning and integrating the tools in their everyday life. The program was designed to demonstrate the viability of non-clinical community-citizens learning and implementing a trauma-informed skills curriculum to students within their community. A secondary intent was for the adult-mentors to exemplify to the youth-students the concept of one

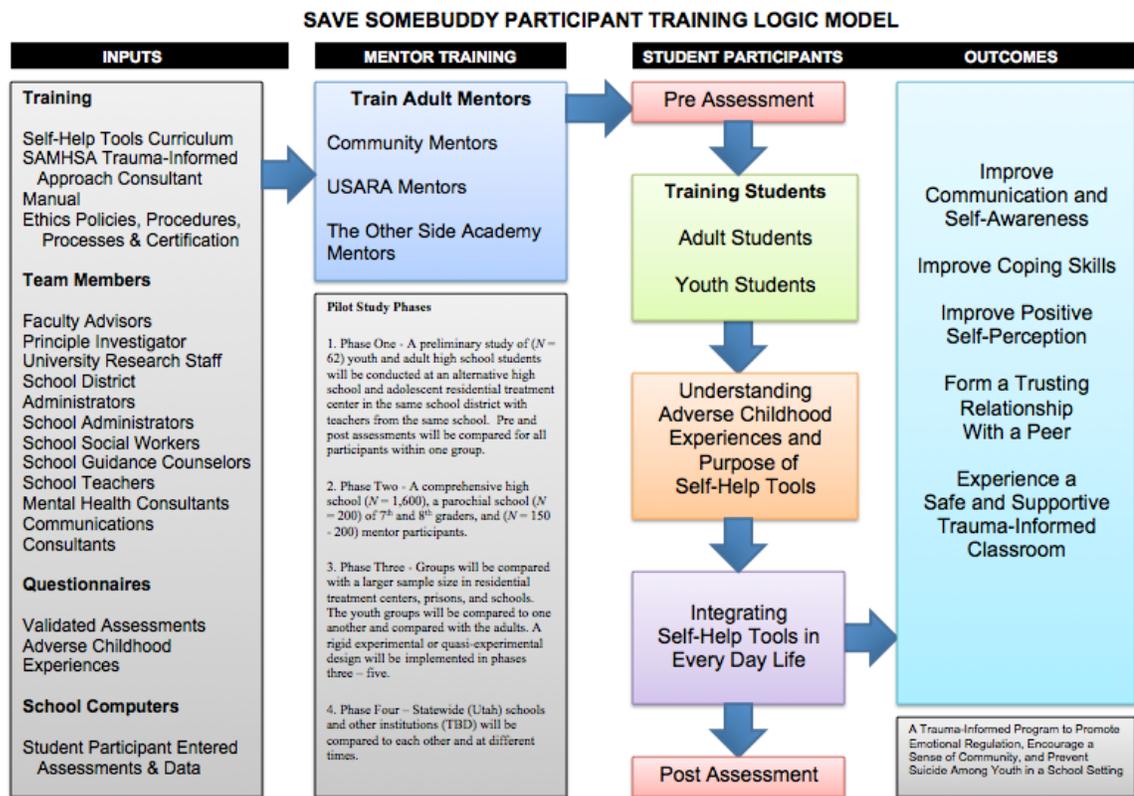


Figure 3. Study Logic Model, which illustrates the study phases, training timeline and flow for mentors, students, teachers, and administrators with potential outcomes.

person helping one person and “paying it forward”, which can effect positive change in a community’s culture and ideology.

METHODS

Participants

The preliminary participant sample, which was the target population for this thesis, consisted of 76 youth and adult students enrolled in an alternative high school. Twelve of the alternative high school students ages 15 - 18 years old lived in a residential drug treatment facility under the jurisdiction of the local school district. There are an estimated 91% of youth that are treated in the facility who have experienced trauma in childhood, including some participants who were actively homeless youth. All students were enrolled and attended schools in an urban area. There were 13 adult community mentors, 21 years of age or older that assisted the students. One mentor in training (age 20) assisted the Principal Investigator (PI).

The eligible target population for this pilot study was high school students 9th-12th grade, who provided written assent/consent, and had signed parental/guardian consent. The curriculum was delivered during advisory periods to avoid interference with academic demands.

Community mentor participants were pre-screened to determine if they would be able to effectively learn and teach students the SSB curriculum. The school teachers, staff, and administrators were not involved in research. Teachers were required to remain in the classroom for the duration of the mentors delivering the SSB curriculum with the intent to maintain and/or bridge a sense of safety for the students.

Alternative High School Students

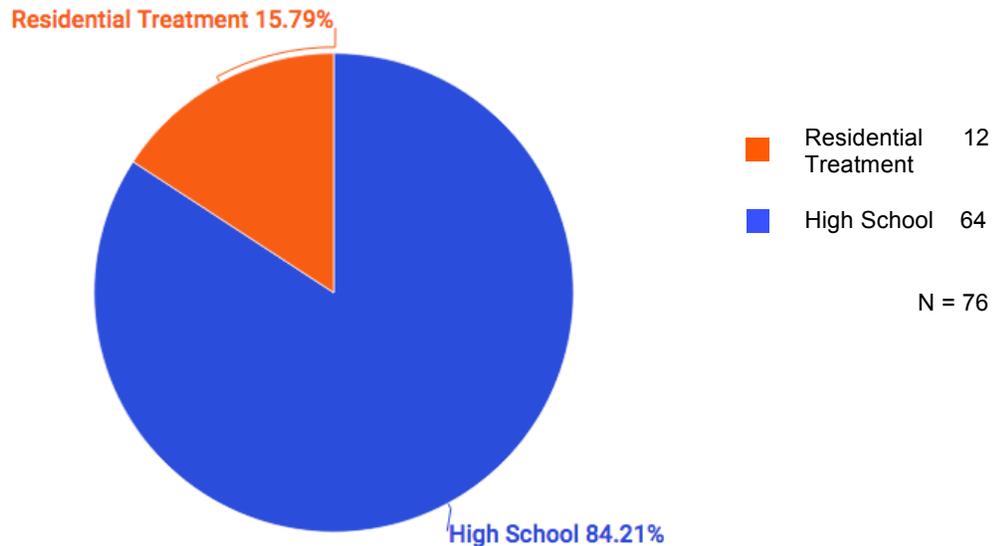


Figure 4. Pie chart illustrating the number of students being served by the alternative high school that were living in a residential addiction treatment center and the number of students living at home who were attending school on campus.

Inclusion Criteria

Youth Student Participants:

1. 14 to 18 years of age (primary group) and 10 - 13 years of age (future sub-group)
2. Enrolled at the designated high school/facility.
3. Students referred by their neighborhood school for a range of behavioral circumstances which, teachers and administrators agreed, made traditional classroom learning settings too disruptive for classmates.
4. A proportion of students (changes every academic year) were referred for daily instruction from juvenile probation systems.
5. Ethnic backgrounds were principally Hispanic and Caucasian.
6. Family status was predominantly low socioeconomic status.

Adult Student Participants (> 18 years):

1. Provided written consent attending high school to earn their high school diploma or GED.
2. Included immigrants and refugees.

Community Mentor Participants:

1. Adults 21 years of age or older.
2. Have graduated from high school.
3. Not professionally licensed/credentialed in the mental health field.
4. Living within the Wasatch Front (Utah).
5. Commitment to traveling to the high school (study location) on a weekly basis.
6. Report no criminal background involving violence of a minor.
7. Have prior experience working with adolescents and indicate they are comfortable working with them.
8. Available for weekly curriculum trainings in person or by conference call
9. Available to train students in a supervised classroom and introduce the study curriculum, materials, and tools.
10. Have clear communication skills.
11. Able to respect the supervising assigned teacher in the classroom setting.
12. Consent to participate in the study as a mentor.
13. Sign required forms and adhere to the IRB, School District, and school policies and procedures.
14. Fulfill CITI certification requirements.
15. Can teach and respect the ethnic background of any student or teacher

16. Demonstrate respect for the rules and curriculum set forth by the PI and advisors.

USARA and The Other Side Academy Mentor Participants:

Utah Support Advocates for Recovery Awareness (USARA) and The Other Side Academy mentors, are adults (age 21 and older) already actively volunteering in other community projects. These participants have a history of addiction, are in long-term recovery (> 12 months), and may or may not have a past criminal history related to addiction (no offenses involving minors or violence). These mentors attended all the mentor trainings, including that on ethics, and adhered to all rules governing the project, including having direct line-of-sight supervision by the teacher in the classroom. All mentors entered and exited the building together and followed the school's policy for visitor registration.

Vulnerable Participants

It was possible to conduct the study with other less vulnerable subjects. However, emotional challenges, negative self-perceptions, and traumatic history cross all social and economic strata of communities and are therefore not exclusive to children raised in low socioeconomic neighborhoods. Studying this population of students who have been enrolled in a center for struggling youth allowed the researchers to better understand how to generalize this program for children across all socioeconomic strata. The scientific merit of the study warrants the inclusion of subjects who may either be susceptible to pressure or who are already burdened.

Health-Resiliency-Stress Questionnaire for Youth (HRSQ-Y) (Addendum 1)

The Health-Resiliency-Stress Questionnaire for Youth (HRSQ-Y) provides a quick overview of a person's ability to tolerate and cope with stress in relationship to their health. It is an efficient, self-administered tool that can be completed in about five

minutes. It identifies and quantifies resiliency skills (strengths), tolerance to stress, and expanded ACEs. The data is collected anonymously. In keeping with widely accepted protocol for collecting ACEs scores on youth, the participant will only reports a total numerical score (#1-20). The participant was also given a separate card with their unique identifier stating “Please indicate if you need or want help with one or more of the items on the HRSQ-Y in Part D.” The card had a “Yes” and “No” to checkmark. For any card that indicates “Yes”, the unique identifier was reported to the teacher. The teacher was instructed to refer the student participant to the school counselor, as per school policy (Susan Wiet, 2019). The average HRSQ-Y risk value score was 4.29 for the students who completed the study, which is a moderate-severe risk category. All students were given the youth version of the questionnaire, whether youth or adults. The Youth version requires a total expanded-ACE score versus the adult version that requests specific identification of each experienced expanded-ACE. Therefore, the Youth version is considered less invasive. Utilizing the single instrument for both youth and adults also allowed for consistency across the sample.

Additional Consent Considerations - Individuals with Cognitive or Decisional Impairment or Mental Disability

Researchers were conducting the assessments in the student’s advisory class so there were naturally some students who may have cognitive impairment or mental disability. The research team was asked by the school district to include all students and did not want to exclude them because the tools were designed to be easily understood and integrated by people of all abilities and ages. This allowed for a more consistent assessment of the comprehension and application of the tools and the data to be generalized to a larger population. The simplicity and inclusive nature of the SSB

curriculum provided opportunity for all students to participate, including those with atypical development or learning styles. The pre and post assessments were made available to all participating students, including those with atypical development. A standardized script was read in class to attain student participant assent. A standardized process was implemented to attain parental consent. All students who participated in answering questionnaires on the computer or on paper had parental consent.

An adapted consent process was implemented for adolescents who legally could not consent for themselves. To ensure that student assent forms were signed, school staff reconciled the student ID numbers with the assent and parental consent forms.

Participant Support

The research team, including community mentors, were directed, trained, and supervised by a faculty advisor who is a child psychiatrist, an expert in adolescent trauma and addiction, and who agreed to provide additional psychological support. No need for psychiatric intervention arose during the study. The research team was also advised by an expert in neurobiology of learning and memory to provide additional guidance with design and implementation of the SSB program and to optimize positive hypothesized outcomes for the students. Additional resources to safeguard students against suicidal ideation or non-suicidal self-injury included referrals to the on-site school social worker and/or restorative justice coordinator that had access to resources and professional support if appropriate.

Study Design

Pre and post assessments were completed within one week before and after the program curriculum was introduced and completed. The assessments utilized

standardized scales to analyze dimensions of change. An analysis of variance statistical test was used (paired sample t-test). Activities and tools were taught and 26 randomly selected student participants as well as the community mentor participants completed a very brief questionnaire (on paper or electronically) after each session designed to assess comprehension of the subject matter. Researchers analyzed responses to determine the best way to implement the program in future studies. All data were treated confidentially and provided only to the PI using a unique identifier. There was no control group, as the school district required that all students have the opportunity to receive potentially valuable information unless their parent did not consent or they (students) chose not to assent/consent and opt out of the study. The study did not involve the use of a placebo. As previously stated, the length of the study was 6 hours of instruction to students by mentors. The original design of SSB was to be delivered across one to three months or one academic semester. Due to timing of the end of the academic year, the curriculum was delivered across a total of three weeks. In the future, school performance data may be extracted from end-of-year data the year prior to the study as well as end-of-year data after the school year in which the study occurred for comparison.

Study Format

Implementation of the intervention required a total of six hours, which occurred in one-hour sessions that were held two to three times per week over a period of three weeks. This number also includes the time necessary for students to complete pre and post-intervention assessments as well as any time necessary for additional instructions. The main focus of these sessions, however, was a basic introduction to ACEs and the three tools. The initial introduction to the material occurred in the context of a large

group discussion, after which students broke out into smaller groups of 10-15 students, which were directed by designated mentors. In future phases of the pilot, the large group discussion will be almost entirely eliminated, and the mentors themselves will be tasked with teaching the students in their assigned group, as well as practicing and implementing the tools with the students. In this format, students will only meet in large groups for an initial introduction to the study and to complete the requisite assessments.

Recruitment Methods

All student participants were eligible for inclusion. Prior to initiation of the study, students were asked to carry a written consent form home for their parent's consent. If the parent had questions, needed assistance with reading or required consent forms translated into Spanish, they were instructed to contact the principal investigator. For future studies, upon request, consent and assent forms will be translated into additional languages before they are sent home to parents. All students who obtained parental consent were administered the assent form in class. They were advised they could opt out at any time and spend the period in a separate classroom with other students who had chosen to opt out. The principal investigator administered the student participant consent/assent process. Effectively all students with signed parental consent and who assent to participate constitute the eligible population for the study.

Mentor participants were recruited by word of mouth via referrals through the principal investigator's friends, family, and colleagues who were interested in addressing trauma and how it affects the community. The principal investigator administered the mentor participant consent process. The mentors were contacted by phone, in person, and email. They could choose to participate in the study and refer

people they knew if they wished. The final selection of mentors were interviewed by phone or in person by the PI and/or advisor(s) and were selected based on the study criteria. The potential mentors were contacted twice. First as an initial contact and second for follow up and confirmation. The mentor participants then chose to consent to the study. After consent they were trained on an adapted curriculum developed by trauma experts convened at the request of the US Department of Health and Human Services, Substance Abuse Mental Health Administration (SAMHSA) as part of peer support training because peer support programs have been shown to be significantly positive (Addendum 2).

Consent Process

At the school's request, all students must be eligible for the study provided they have their parent/guardian's informed consent and they (students) assented to participate. Parents/guardians had one or two opportunities to consent or not consent to their child's participation. The first opportunity was at school registration, where they give their signature to indicate approval for student support programs. This is similar to the process used for suicide prevention activities, now ongoing across the state.

The second opportunity to consent or not consent was provided within one week before the study began. The consent form followed the IRB study protocol informed consent template. Forms for parental/guardian consent were hand carried home by students or emailed by the school to obtain their parent/guardian's consent. All students who obtained parental consent were administered the assent form in class. With the consent forms, the principal provided a letter introducing the study, its potential value to the student, and offer assurance that without parental consent, their student would not

participate. The principal's letter informed parents that, if they had questions, they should contact the PI by telephone or email. The school principal informed parents that he/she was available to take their calls as well, should they want to speak with him/her directly.

Training School Teachers and Administrators

The school teachers and administrators were trained by the PI on the trauma-informed curriculum used with mentors and students participating in the study. School personnel were also introduced to the tools and educational applications taught during the study. Before each module was introduced to the students, teachers received a copy and had an opportunity to discuss the module with the classroom's assigned community mentor participant. Teachers and administrators had an opportunity to review the Adverse Childhood Experiences (ACEs) questionnaire as part of their training so they were familiar with the types of trauma some children may have experienced. No data for the school teachers and administrators were gathered for the study as they were not participants of the study. They only assisted in facilitating the study location for the students and mentors who were participating.

Training Members of Community as Mentor Participants

Adult members of the community (age 21 and older) were trained in principles of trauma-informed care, using an adapted curriculum developed by trauma experts convened at the request of the US Department of Health and Human Services, Substance Abuse Mental Health Administration (SAMHSA). It is important to emphasize that the community mentors were not researchers they were only participants and were instructed to do exactly as directed under the supervision of the principal investigator and direction of the advisors.

The community mentors participating in the project were asked to complete the ACEs questionnaire. The purpose of this data collection was as follows:

1. To see how well people who have experienced varying levels of trauma can work together to make a difference in their community.
2. Better understand if learning and teaching trauma-informed tools increases their level of confidence and desire to share these tools with others.
3. Explore how common adverse childhood experiences are among those who volunteer to teach trauma-informed concepts.
4. Understand if they feel their experiences have helped them to develop more compassion, empathy, resilience, and a call to action.
5. Demonstrate that survivors of trauma may be a valuable untapped resource to support their community and positively impact the student participants, especially those who struggle from the effects of ACEs.

Community mentors were available for initial and ongoing meetings as appropriate with school and study administrators, were present at weekly training on procedures, policies, and curriculum material, worked collaboratively with classroom teachers, and assisted the PI in administering pre and post assessments according to PI's and advisors' direction.

Community mentor participants were identified as adults who care about the welfare of others. They reported having had no criminal record. The school did not require a criminal background check and child abuse clearance as long as the teacher was in the classroom directly supervising the mentor, as was the case in this study. If there were a change in policy the mentors adhered to the school and district requirements. They

were chosen to be mentor participants based on their interest and experience working to serve members of their community on a volunteer basis.

Community mentors were deliberately selected as lay people who do not have professional licensure in mental health, so as part of the study design, researchers could determine a lay person's ability to learn and teach the simple tools to other lay people and/or children. They were certified through the Collaborative Institutional Review Board Training Initiative (CITI) and mentored students in a classroom in the school. They were trained in trauma-informed care so they knew how to recognize someone who is struggling and avoid unintentionally causing harm by activities, policies, and practices that were insensitive to the needs of the students.

Community mentors were trained on the study curriculum and were under constant supervision of the classroom teachers, study administrators and/or school administration. The community mentor participants taught the curriculum and tools to the students that had parental consent and provided assent to participate in the study.

Before the study commenced the community mentor participants reviewed in detail the standardized student participant assessment tools, which were administered by the PI in a pre/post method for the study via computers provided by the facility/school. The mentors had reviewed the student participant assessments before the students were asked the questions so the mentors could understand what the students may experience and provided support when the students took the student participant pre and post assessments.

Community mentor participants were presented the first three modules on trauma and the brain and ACEs using a curriculum developed by trauma experts convened by

SAMHSA for this purpose, which has been adapted from a format that assumes the target audience are lay persons employed at health and human service organizations that treat victims of complex trauma including domestic violence shelter employees, social services agency staff, publicly funded community health center staff, and publicly funded mental health center staff. The intent of the study was to test whether these concepts work in a school setting among youth. Research project advisors who were licensed in mental health trained community mentors about boundaries and ethics (Addendum 3). The mentors also completed pre/post questionnaires (Addendum 4) and interim study evaluations (Addendum 5) to refine the study process as it progressed.

Supervision of Community Mentors

All mentors worked under the supervision of the assigned class teachers, school and district administrators, principal investigator, and a team of mental health professionals including: a child psychiatrist with expertise in trauma and substance use disorders and a neuroscientist with expertise in neurobiology of learning and memory. Some schools/facilities included a community psychologist with expertise in family dynamics, a school social worker, and a school guidance counselor.

Pre and Post Assessment of Standardized Tools

The assessment tools for both the students and mentors worked together to evaluate connection in times of vulnerability, understanding how trauma may have impacted emotional regulation, and how coping skills can improve mindfulness and help deal with stress. The student participant standardized assessments were not intended to ask specifically about children's understanding of trauma, but some understanding of trauma and its potential impact on emotional management is foundational to understanding the relevance of the coping skills they learned in a personal way. The

PI administered all assessments for the students and mentors.

The mentor participants completed pre and post assessments on paper and their information was made available to the PI and study administrators. Their information was kept strictly confidential. The PI administered an ACEs assessment for all mentors on paper to determine a mean score. A pre and post assessment determined the confidence of the mentors in the beginning and at the end of the study about their skills, how well they were able to learn and apply the concepts, and which learning style they felt was most useful for them. The students completed pre and post standardized assessments on paper and electronically via surveys made available through Google Forms. Future data collection process may assure anonymity via electronic devices, already available in the classroom for each student, through a software application developed by Research Triangle Institute (Youth Media Survey), previously used by schools to assure student confidentiality when answering health related surveys with a randomly generated number.

The students for the pilot study used a unique identification number only known to the administrators of the school/facility. The actual identity was contained within the assessment on paper and the school/facility's social work team gathered all responses under that assigned number. Neither mentors nor researchers had access to any identifying information attached to any responses. The school/facility's social work team worked with the students individually to answer any sensitive questions over the duration of the study, including being available in the social work office while students completed the Health-Resiliency-Stress Questionnaire for Youth (HRSQ-Y) ACEs expanded questionnaire. In this way, the school social work team was free to help students process

any feelings they may have regarding the questionnaire(s). Neither school personnel, researchers, nor mentors had access to students' answers to individual HRSQ-Y/ACEs questions; instead, they were provided a total score via the confidentiality process (unique identifier) for those students who chose to participate.

Structure of Curriculum

The introductory curriculum was created by a SAMHSA convened panel of trauma experts and has been implemented throughout the United States under the direction of the US Department of Health and Human Services. SAMHSA encourages adaptation of the curriculum for various populations. The researchers for this study modified this curriculum to make it easy to understand for children and members of the community who were providing support. The curriculum was used to teach a basic concept of trauma including how trauma affects the brain and adverse childhood experiences. The students also learned how to reframe negative thoughts into positive thoughts, calm themselves down when feeling upset, and how to support a friend when they are struggling or feeling sad.

The curriculum was taught in four modules (total of 6 hours) at consistent times per day for 60 minutes the same day(s) of the week over a two - three week period, depending on the school schedule. The pilot study student body ($N=76$) met together for introductory sessions and in small groups for discussions. Larger student bodies can be split into classrooms of ten to fifteen students each. The mentor participants taught the same group of student participants throughout the study. The PI acted as a substitute community mentor and was initially introduced to all of the classes. The PI filled in when a mentor was unavailable to facilitate their assigned activities. A session preceded the

study (prior to curriculum implementation and data collection) so students could begin to build trust with the teachers, mentors, and their peers. The study modules consisted of various teaching methods with an introduction to the program prior to the pre assessment and conclusion. The tools/activities were each taught in sessions of 60 minutes. This was followed by a brief questionnaire to select students and all mentors to assess comprehension. Research administrators collected and input the data for analysis.

Implementation of Self-Help Tools in Curriculum

The self-help tools listed below and implemented in the study (all under copyright law and used with permission or in public domain) have been used with military personnel, refugees, and people struggling with addiction to reframe harmful beliefs, calm physiology when symptoms of past trauma are re-experienced, and reach out to a support system when feeling despair. The structure of the training mirrors elements of National Center for Trauma-Informed Care (NCTIC) Trauma Curriculum Instructor's Guidance, SAMHSA's Trauma-Informed Approach: Key Assumptions and Principles (www.samhsa.gov/nctic/trauma-interventions). Research suggests a correlation between trauma and substance use disorders (Feletti, 1989; Feletti, 2004). Rather than reinventing the wheel, researchers hoped to learn more about the effectiveness and efficiency of combining proven methods into an integrated, trauma-informed program to best support struggling youth and other traumatized populations. The tools and information incorporated in the study curriculum included:

1. The Sabotage Cycle © www.savebuddy.org (Addendum 12)
2. Self-Help for Trauma Video & App ©

(Download video <https://youtu.be/Od5ql7hNP4w> or visit website

www.selfhelpfortrauma.org)

3. My3 App ©

(Download video <https://vimeo.com/97271796> or visit www.My3app.org)

4. Health-Resiliency Stress Questionnaire for Youth (HRSQ-Y) ©

5. National Center for Trauma-Informed Care Trauma Curriculum Instructor's

Guidance, Substance Abuse and Mental Health Services Administration Trauma-Informed Approach: Key Assumptions and Principles ©

Standardized Validated Assessments

Researchers conducted a series of validated assessments within the first two weeks of the study period. Students responded to standardized questionnaires on paper or on school computers, when available, and a teacher and/or facilitator was able to assist as needed. Within the software application, or on paper, the student was assigned a unique identifier (student ID) so the mentors or researchers could not link students' individual responses to their identity. This process helped to assure students of anonymity and reduce bias. The same series of assessment tools were administered post-program for analysis according to study objectives. Those students who did not assent to participate or whose parents did not consent to have their child participate did not participate in the assessment processes, but were involved in other class activities. On the days students were assessed they came to their normal advisory class and were provided with the following description:

“Today we are going to take you to the computer lab (or in class computer, tablet or paper) and ask you to answer some questions on the computer (tablet or paper). All of your answers are anonymous and kept confidential. Instead of your name, your responses are linked to your student identification number rather than your name so the mentors and

researchers do not know your identity. Your teacher will give you your student identification number if you do not remember it. The questions are designed to help researchers create better trauma-informed communities. You may choose not to participate. If you choose not to participate an alternative activity will be provided for you during this time.”

In the computer lab (or classroom), the mentor advised students: “Enter your student identification number in place of your name. This will keep your identity anonymous for the mentors and researchers. Only you and the school will know that this number links to you. Your name will not be available to anyone that looks at the data you enter. Feel free to answer the questions honestly. There are no right or wrong answers. Your grades will not be affected by the answers you give. You will also not be graded on your level of participation. Are there any questions?”

Students then entered their responses to the following validated questionnaires on the computer in two separate 30-60 minute sessions. These questionnaires measured the six primary objectives of the study that have been shown to be related to decreased school violence and improved school performance. The researchers hypothesized that each of these measures may show an improvement in a) school performance, b) coping skills, c) positive self-perception, d) form a trusting relationship with a peer, e) experience a safe and supportive trauma-informed school, and over time will assess f) fidelity of instructional design.

Study procedures, assessments, and outcomes were laid out visually in the Research Study Logic Model (*Figure 2*). As many of the assessments address more than one outcome it was expected that the most concise and effective assessments be used in future pilot study phases so participants do not experience fatigue and the efficiency of

data collection improves. All of the potential assessments considered were outlined for review and approval from the Institutional Review Board (IRB) Committee.

Assessments Used for Pilot Research

1. 8-Item Grit Scale - Child Adapted Version 4 (Addendum 6)

The 8-Item Grit Scale is designed to measure one of two traits that are known to predict achievement: grit and self-control. Grit is the tendency to be persistent when pursuing and sustaining interest and effort when working to achieve long-term goals (Duckworth et al., 2007). Note from the author: “These scales were originally designed to assess individual differences rather than subtle within-individual changes in behavior over time. Thus, it’s uncertain whether they are valid indicators of pre to post change as a consequence of interventions” (Duckworth, 2018). Can be found online at www.angeladuckworth.com/research. Therefore, additional measures were added to the study to account for this potential shortfall.

2. Brief Multidimensional Students Life Satisfaction Scale (BMSLSS – PTPB: Youth) (Addendum 7)

The Brief Multidimensional Students’ Life Satisfaction Scale can be completed by children between the ages of 8 and 18 years and is designed to better understand children’s satisfaction of life to include five primary domains: family, friends, school, living environment, and self (Scott Huebner, PhD).

3. Child & Adolescent Mindfulness Measurement (CAMM) (Addendum 8)

Research suggests that programs based in mindfulness for adolescents have positive effects on psychological well-being and brain function. The Child and Adolescent Mindfulness Measurement has been determined to be a valid and dependable

measure for mindfulness for both boys and girls (Kuby et al., 2015). It is designed as a self-report measure for children and adolescents (Greco, Baer, & Smith, 2011) incorporating ten statements that describe a lack of mindfulness.

4. Domain-Specific Impulsivity Scale for Children (DSIS-C) (Addendum 9)

The Domain-Specific Impulsivity Scale for Children aims to show that impulsive behaviors vary systematically by domain and has been measured among middle school students with ethnically and socioeconomically diverse backgrounds (Tsukayama, Duckworth, & Kim, 2013).

5. McGill Friendship Questionnaire (MFQ-RA) (Addendum 10)

The McGill Friendship Questionnaire is a 16-item questionnaire measuring how participants feel about a particular friend/friendship. A 9-point scale measures positive statements regarding friendship. Answers vary from "very much disagree" to "very much agree" (Mendelson & Aboud, 1999; Mendelson & Aboud, 1997).

6. Patient Health Questionnaire Depression Screening - Adolescents (PHQ-9-A)

(Kroenke, Spitzer, & Williams, 2001) (Addendum 11)

<https://www.mdcalc.com/phq-9-patient-health-questionnaire-9>

The Patient Health Questionnaire 9 measures depression severity by degree.

Advice

Final diagnosis should be made with clinical interview and mental status examination including assessment of patient's level of distress and functional impairment.

PHQ-9 Adolescent Management Summary

Score Depression Severity Comments

0-4 Minimal or none Monitor; may or may not require treatment

5-9	Mild	Use clinical judgment (symptom duration, functional
10-14	Moderate	impairment) to determine necessity of treatment
15-19	Moderately severe	Warrants active treatment with psychotherapy,
20-27	Severe	medications, or combination

Critical Actions

1. Referral to an on site school social worker and mental health professional.
2. Perform suicide risk assessment in patients who respond positively to item 9
"Thoughts that you would be better off dead or of hurting yourself in some way."
3. Rule out bipolar disorder, normal bereavement, and medical disorders causing depression. This sequence of data collection and student-input responses to validated assessments and standardized questionnaires were repeated at the completion of the program.

7. Health-Resiliency-Stress Questionnaire for Youth (HRSQ-Y)

The Health-Resiliency-Stress Questionnaire for Youth provides a quick overview of a person's ability to tolerate and cope with stress in relationship to their health. It is an efficient, self-administered tool that can be completed in about 4-5 minutes. It identifies and quantifies resiliency skills (strengths), tolerance to stress, and expanded Adverse Childhood Experiences (ACEs). The data is collected anonymously. In keeping with widely accepted protocol for collecting ACEs scores on youth, the participant only reports a total numerical score (#1-20). The participant is also given a separate card with their unique identifier stating "Please indicate if you need or want help with one or more of the items on the HRSQ-Y in Part D." The card has a "Yes" and "No" to checkmark. For any card that indicates "Yes", the unique identifier is reported to the teacher. The

teacher is instructed to refer the student-participant to the school counselor, as per school policy. This instrument is in pre-publication and is internally validated per communication with the author (Susan Wiet, MD).

The Unsafe Behavior Inventory for Youth (UBI-Y) may be utilized in future phases of the pilot study to determine longer-term outcomes. The UBI is designed to help children and the people working with them to know what is affecting their safety and whether the interventions and support they are receiving are helping to improve safety (Gabriella Grant, MA).

Medical or Psychological Resources

As previously stated, the research team and community mentors were all CITI certified and trained on trauma-informed care so they knew how to recognize someone who is struggling and avoid unintentionally causing harm by activities, policies, and practices that are insensitive to the needs of the students. The self-help tools taught to the students and the assessments are simple and non-invasive techniques designed to self-soothe, reframe negative thoughts, and be a supportive friend. These are not trauma therapies that could potentially trigger a negative psychological or physiological response, as determined by mental health clinicians who helped develop the program, and are adult/child psychiatrists as well as experts in adolescent trauma and addiction. The research team was directed and supervised by these experts who could provide additional psychological support if appropriate. Therefore, no adverse events due to the tools being taught were experienced or are expected.

The school had on-site social workers and school guidance counselors. All mentors were trained to defer to the classroom teachers if student participants needed

psychological resources. The teachers followed the standardized procedures for the student participants. Additional resources to safeguard students if they experienced suicidal ideation or non-suicidal self-injury included referral to the on site school social worker who had access to the following resources and professional support if appropriate. The monitoring entity met weekly to discuss potential events.

As previously mentioned, the research team and mentor participants were all CITI certified and were trained on trauma-informed care so they knew how to recognize someone who is struggling and could avoid unintentionally causing harm by activities, policies and practices that are insensitive to the needs of the students. The self-help tools taught to the students and the assessments are simple and non-invasive techniques designed to self-soothe, reframe negative thoughts, and be a supportive friend.

Study Procedures

Informed Consent:

The consent and assent processes were administered by the principal investigator. Effectively all students with signed parental consent and who assented to participate constituted the eligible population for the study. No legally authorized representatives were used. The consent and assent may be translated into to other languages as the study expands to additional cohorts.

Adult Student Consent and Youth Student Parental/Guardian Consent:

At the school's request, all students must be eligible for the study provided they have their parent/guardian's informed consent and they (students) assent or consent (if they are adults) to participate.

Parents/guardians had one or two opportunities to consent or not consent to their

child's participation. The first opportunity was in the fall at school registration, where parents provide their signature to indicate approval for student support programs. This is similar to the process used for suicide prevention activities now ongoing across the state. The second opportunity to consent or not consent was provided within one week before the study began. The consent form follows the IRB study protocol informed consent template.

The IRB approved study parental/guardian consent forms (hard copy on paper) were handed to the students by their advisory class teacher who asked the students to give the consent form to their parent/guardian to sign and to return the form the next day at school to their advisory class teacher. The students carried these forms home by hand and gave them to their parent/guardian to sign. The students then returned the signed forms to their advisory class teachers who kept track of the forms and determined that all of the students who were participating in the study in their class had a signed study parental/guardian consent form on file before the assessments were administered. There was no witness signature on the forms because of the setting for the study (a large high school). On the form, the parents were provided with the contact information for the PI, IRB, and school principal. Parents of students living at a residential treatment facility were either emailed the consent form and returned it via email or signed the consent when they came to visit.

With the consent forms, the principal provided a letter/phone call introducing the study, its potential value to the student, and offered assurance that without parental consent, their student would not participate. His/her letter informed parents that, if they had questions, they should contact the PI by telephone or email. The principal informed parents that he/she was available to take their calls as well, should they want to speak

with him/her directly.

Student Participants Assent:

All students who obtained parental consent or consented as adults were administered the assent form in class. The school teachers cross-referenced the student ID numbers, which were used as unique identifiers, with the consent forms. (Identifying information was not made available to the researchers). The students were advised they could opt out at any time and they could spend the class period in a separate classroom with other students who had chosen to opt out. The teacher and study class mentor obtained student assent in the students' advisory class on the same day the study assessments were conducted. The advisory class teachers collected assent forms and checked to see that all students' on their class role had assented or opted-out of the study prior to the pre-assessment being given. No data was collected on the students who opted out. Students were also provided a similar option to speak to the researchers in person at the school with a teacher or school administrator present, by phone, or email.

Community Mentor Participants Consent:

Recruitment of mentor participants was conducted by word of mouth via referrals and networking with the principal investigator's friends, family, and colleagues. These were individuals who are interested in addressing trauma and how it affects their community. They were contacted by phone and email. They could choose to participate in the study and refer people they knew if they wished. The final selection of mentors were interviewed by phone or in person by the PI and/or advisor(s) and were selected based on the study criteria.

The potential mentors were contacted twice. First as an initial contact and second

for follow up and confirmation. The mentor participants could then choose to consent to the study. Mentors were given consent forms in person at a briefing before the study began. After consent they were trained on an adapted curriculum developed by trauma experts convened at the request of the US Department of Health and Human Services, Substance Abuse Mental Health Administration (SAMHSA) as part of peer support training. As previously stated, peer support programs have been shown to be significantly positive. There was a one-week waiting period for consent from mentors before the study began. Similar language was provided in the Mentor Consent Form as described above to provide ample opportunity for mentors to speak to the principal investigator and other members of the research team, at any time, regarding questions or concerns.

Measures to Minimize the Possibility of Coercion or Undue Influence

Student Participants:

The students were free to opt out at any time. Researchers told the students that if they chose not to participate in the study or activities it would not affect their grades. They were not graded on their level of participation. So students could feel free of coercion and choose what was best for them. Another activity was provided by school administrators for students who did not want to participate or be assessed. The school administrators provided an alternate activity to help students who opted out to feel included socially and have their minds occupied. Students did not feel they had to participate because of boredom. School administrators reassigned students to a classroom without the program on the days the study was being conducted. (Addendum 13 - Student Assessment Information & Script) After the researchers read the class script, the students were encouraged to ask questions either in front of the class or individually. The assent

form also provided contact information for the students to speak to the researchers in person at the school under the supervision of their advisory teacher or school administrator, by phone, or email.

Mentor Participants:

Mentors were told that they could opt out at any time on the consent form, upon signing the consent form, and during training. They fully understood they had no obligation to participate in the study. Mentors were assigned to work in partnerships with the school teachers. There were enough mentors recruited to the study to support students if some mentors opted out. The mentors were given a week prior to the study to ask questions of the PI and/or advisors in person, by email, and individually.

Benefits to Participants

Participants were informed that the researchers could not promise any direct benefits to participants for taking part in the study. However, possible benefits for student participants included: increased feelings of self-worth, an ability to better cope with life stressors, increased feelings of validation and support from peers and their community, increased strength and resilience. Mentor participants may develop a skill set to communicate effectively with youth and other adults, be exposed to educational materials that are grounded in emotional regulation skills, and have team support and direct mentorship. There may also be societal benefits including increased compassion and understanding of trauma, learning evidence-informed tools to better support those who struggle with the effects of trauma, a better understanding of how to implement programs that are designed to see through the eyes of the people these programs are intended to help, reduce suicide attempts through community support, inspire

communities who care through a simple pay it forward buddy system, help average people take responsibility for the social and emotional struggles of family and members of the community, and provide the knowledge of how to best support them.

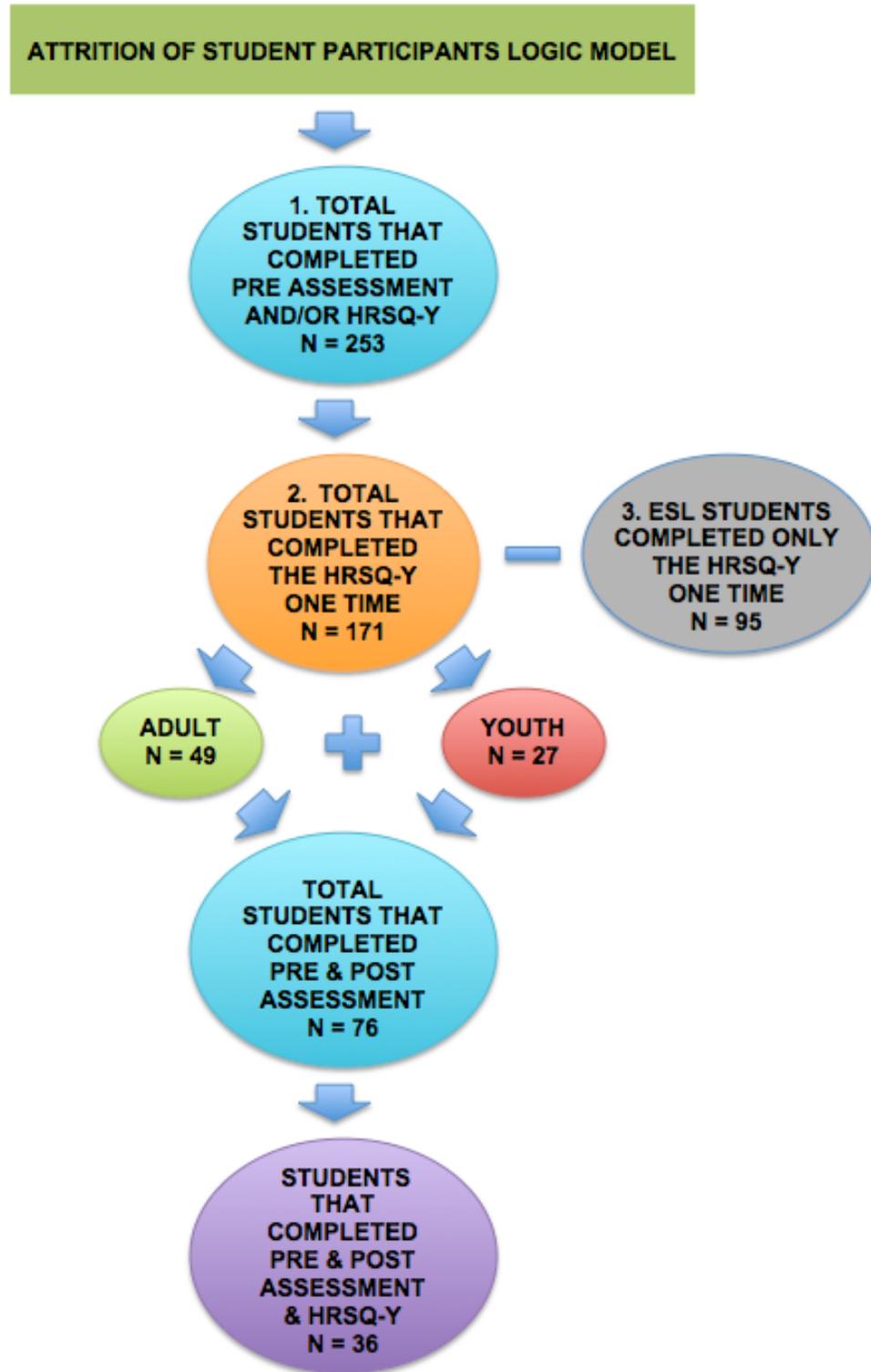
RESULTS

Community Response

Although anecdotal evidence obviously lacks the methodological rigor of the statistical findings detailed below, conversations with those involved in the program overwhelmingly viewed their participation as a positive experience. Individuals at both the district and school levels (i.e. treatment center administrators, teachers, and staff) reported a positive effect on the students based on their observations and interviews with the students. Some teachers expressed interested in becoming mentors in other schools or community programs. The high school and district administrators said they would recommend the SSB program to other schools and expressed a desire to continue the SSB program in the upcoming school year. One hundred percent of community mentors reported that being a study mentor participant was a meaningful, enjoyable, and growth-promoting experience and that they would volunteer to be a mentor again.

Sample Size and Measures

Figure 5 illustrates the attrition of student participants. This was a convenience sample and participation was contingent on enrollment in the class, parental consent or adult student consent to participate, youth student assent, and completion of both pre and post test questionnaires. The original sample consisted of 253 youth and adult students. The sample included immigrants and refugees representing every major ethnicity from South America, Eastern Europe, Africa, Asia, and the Middle East.



(Figure 5).

1. Six measures were included in pre and post assessments.
2. The HRSQ-Y (seventh measure) was administered separately to determine an average risk value score.
3. ESL students were exposed to the treatment, but were not included in data due to language barriers (potential confounding variable).

The pre and post assessment was comprised of six measures. The HRSQ-Y (the seventh measure) was employed separately to report findings without personal identifiers for those students who completed the questionnaire and to evaluate a mean risk value score ($M = 4.29$) that was moderate-severe. A total of 171 students completed the HRSQ-Y one time. Because language barriers might confound interpretation of results, English as a Second Language (ESL) students ($N = 95$) received instruction and participated in activities to learn the material like the English-speaking students, but were not included in the final research sample. ESL students were taught with the assistance of interpreters and ESL teachers.

In the final sample ($N = 76$) there were 49 adults and 27 youth including 36 males, 39 females, and one participant identifying as other ranging in age from 15 to 65 with a mean age ($M = 24.67$) and ($SD = 10.960$). Of the final sample, there were ($N = 36$) students that completed both the pre and post HRSQ-Y questionnaire, which was included independently in the statistical analysis because a second power analysis suggested a minimum sample size of only 26 was necessary to test for a difference between means at a significance level of 0.05 and a power of 0.95 and well above the threshold of 0.80 recommended by Cohen (1988). The HRSQ-Y was compared against itself like the other measures. The analyses were initially run in SPSS with supplementary analyses run in Stata that confirmed the results, showing statistically significant differences in mean pre and post intervention scores.

Statistical Analyses

Paired t-tests were used to determine differences between each pre and post data questionnaire that was used to assess the projected outcomes (improved coping,

self awareness, etc.). Researchers compared pre and post intervention survey results to determine improvement for each measured outcome separately. While two or more questionnaires were designed to measure each outcome, the questionnaires were evaluated separately so a more accurate significance level could be determined for each outcome.

Because the researchers tested significance of pre and post measure difference for each questionnaire, the significance level needed to be more conservative than .05 and was adjusted to approximate what would be determined at .05 divided by the seven measures (0.007) using a Bonferroni correction to calculate the alpha level because these were not all independent comparisons and there could be correlations among these variables. Therefore, a comparison of pre vs. post for each measure was utilized in the pilot study to determine the value of the variable with respect to effect.

A power analysis was completed in order to confirm that the final sample was large enough to detect statistically significant differences in pre and post intervention mean scores. Analyses using G*power (Faul et. al., 2017; Faul et al., 2009), and relying on the 0.80 standard established by Cohen (1988), confirmed that a relatively small sample size would not inhibit the use of paired samples t-tests for pre and post intervention comparisons.

A paired-samples t-test indicated that scores were significantly higher for the 8-Item Grit Scale, Satisfaction with Life (Y-BMSLSS), and HRSQ-Y ($p < 0.05$ for all three measures), and borderline statistical significance in mean pre and post intervention scores for the PHQ-9-A scale ($p < 0.5$) indicating a positive correlation and change over time for all six projected outcomes: improved communication and self awareness,

coping skills, positive self-perception, forming a trusting relationship with a peer, and experiencing a safe and supportive trauma-informed classroom.

(Table 1). Questionnaire Pre and Post Intervention Means and Paired t-test of Differences

Dependent Variable	Pretest Mean	Posttest Mean	Paired Sample t-test	df	Significance Level	Improvement
8-Item Grit	33.87	35.59	2.857	75	0.006*	YES
DSIS-C	22.05	20.32	-2.167	75	0.033	YES
Y-BMSLSS	27.63	30.42	2.783	75	0.007*	YES
CAMM	25.63	26.51	0.822	75	0.414	YES
PHQ-9-A	11.29	9.50	-2.428	75	0.018	YES
McGill FQ	151.29	149.53	-0.414	75	0.680	NO
HRSQ-Y	4.94	3.69	-3.910	35	0.000*	YES

*Significant at 0.05 using a Bonferroni correction for multiples comparisons and using 0.007 (0.05/7) as the significance level for 0.05.

Six of the seven measures showed an improvement with the intervention. The table indicates positive and negative scores because each measure was scored differently. For example, the 8-Item Grit Scale shows a positive score for increased grit. The DSIS-C measures impulsivity where scores decrease when there is improvement in impulsivity. The Y-BMSLSS measures satisfaction for life, which improves when satisfaction goes up. The CAMM measures improved (increased) mindfulness. The PHQ-9-A measures depression where the desired outcome is less depression. The HRSQ-Y is a health and resiliency measure where the risk value score will go down when there is improvement. The McGill FQ was the only measure that didn't show improvement. It is a friendship

measure that is intended go up, but the measure may be cumbersome and we surmise the questionnaire was not filled out accurately, likely due to the length of the survey and confusion with the questions.

The researchers found the instruments showing significant effect (8-Item Grit, Y-BMSLSS, HRSQ-Y, and PHQ-9-A) were most tailored to our research goals. Their simplicity made them usable and accessible for students with a range of English literacy, including ESL students. The researchers have field-tested these instruments and based on the population demographics for our study have found them to be efficient and easy to use. This pilot also, in effect, tested the accessibility of the instruments across students with a range of educational and language capabilities, and our experience suggests their value in subsequent studies of this model. We will potentially use versions translated into various languages moving forward.

Of the 13 mentor participants there were 2 males and 10 females ranging in age from 21 to 48 and one female mentor in training (age 20). There were no statistical analyses run for the mentors, as the primary focus of the study was to show differences in scores for the students with the support of adult mentors.

DISCUSSION

The two core features of SSB are the aims to empower survivors of trauma (save yourself) through emotional regulation and cultivate the ability to empathetically “pay forward” what is learned to the next person (help a buddy). These skills – empowerment and giving back - are essential elements for healing, through a process that can restore identity and exhume the core of conflict, the birthplace of traumatic experience. With a multi-disciplinary focus on identifying trauma and building resilience, it may be possible

to dramatically change the lives of the next generation, adding to the overall understanding and advancement of our human experience.

What may set SSB apart from other school-based trauma-informed programs is the combined effort of empowerment and giving back. The synergistic interface of these skills likely affects two related neurobiological pathways: the hypothalamic pituitary-adrenal axis (HPA) and reward system. The latter is well known as a powerful reinforcement pathway to ensure that we repeat a beneficial behavior (Baumeister, Lightman, & PARIANTE, 2014; NIDA, 2019). For example, feeling better about how we view our ability to make positive changes for ourselves is typically experienced as something good and positive. When we are then able to assist another person, the interaction is naturally positive and we receive another “hit” from the reward pathway, which embeds a very powerful reinforcement mechanism.

Implementation with sensitivity to cultural differences is key to the success of any trauma-informed approach as children and adults will have various reactions to the material being taught. Future researchers may consider strategically pairing mentors with students from their own community to minimize cross-cultural barriers (i.e. refugee adult mentors with refugee students, LGBTQ adult mentors with LGBTQ students, etc.).

The risks of this study were minimal. The students were asked to think about and share their feelings with their class mentor about what they were learning. The students were not asked to share personal information with their teacher, class, or mentors. If a student felt upset by the experience, the student could tell the teacher and he/she would tell the student or parent/guardian about resources available to help. There were no costs or compensation given to the participants from participation in the research. The

investment of time supports the activities outlined in their school classwork. The only cost is the opportunity cost of what the teachers and students would have done otherwise.

Piloting the program will help researchers better understand how to address variables and individual differences. Another important consideration for SSB is educating the family, which would likely normalize conversation within the household and reinforce the tools being taught so the “ghosts in the nursery” (Fraiberg et al., 1975) can be put to rest and “move toward the light” of healing.

Considerations

The SSB study is positioned for future research in fall 2019 in two comprehensive high schools, each located in different school districts. Combined student bodies would provide 4,300 potential student participants. Notably, one of the schools was specifically pursued due to an unprecedented number of student deaths by suicide in 2017-2018. Additional sites will include a charter school for the performing arts (300 student participants) and a parochial school (200 participants). A tangent organization serving 250 mothers struggling with addiction and their children have requested to participate. Additional districts, schools, medical/health, religious, and community-based organizations have expressed interest to implement SSB. These sites will likely be included in additional study phases. Such expansion will be fruitful for examining the scalability of SSB. The timing of potential expansion is ripe, as some Utah government agencies are investing in trauma-informed practices that can mitigate the trans-generational effect of trauma on poverty.

More research is needed to duplicate findings, pilot, and refine the delivery and data collection of the SSB program. Should the same robust results remain, widespread implementation could possibly effect generational healing from the effects of trauma by

increasing resilience. Therefore, the positive effect of SSB as demonstrated by the substantive changes in the measures may be attributed to these neural pathways, hence leading to the robust statistical changes. Adding measures of biomarkers such as cortisol and/or oxytocin markers may be beneficial in future study of SSB.

While the study design did not allow an analysis of causality or rule out confounding variables, it did demonstrate a positive association based on improved performance in the six projected outcomes after the six-hour course of learning; a trend in the predicted and desired direction. A larger sample size, longer time span to integrate the tools, and adjustment in study design in future phases of the pilot will help to more clearly show an effect with a reduction in potential confounding variables.

Researchers examined within-student variability in the study and if there was improvement on the predicted outcomes (communication, self-awareness, coping skills, positive self-perception, forming a trusting relationship with a peer, experiencing a safe and supportive trauma-informed classroom). Throughout the study consideration was given about how to refine the following elements: instructional design, implementation, application of the self-help tools, and comprehension,. The study design and duration did not allow the researchers to measure these elements, which can be measured in later phases. In addition, between-student and between-mentor variability can be staggered within the schools in a later study. Between-school variability will also be assessed when the study is later repeated in future pilot phases.

The overall improvement across all of these measures is most likely an improvement of perception of self-efficacy such as grit. The study duration did not allow evaluation of concrete academic changes indicating these qualities such as grades over

time. What is interesting is that six of the measures exhibited that how one perceives oneself will typically lead to the outcome of behavior. As such, self-perception shapes behavior. Therefore, it will be invaluable in future studies to have the pre/post measured over a longer trajectory of time in combination with tangible academic measures. The McGill Friendship Questionnaire will likely not be included in future studies due to the difficulty of administering the measure, to simplify the measures used, and to focus on the most effective methods of gathering data that is meaningful for the research.

CONCLUSION

The fields of psychology and psychiatry frequently dive deeply into examining the psychoanalytical aftermath of trauma. For those who are traumatically wounded, often the brightness of hope seems dimmed – or even lost – and they are trapped in a cycle characterized by distress, intolerance, poor emotional regulation, and inability to form meaningful and lasting relationships. Isolation is often a result. SSB may create a bridge of positive social interface that circumvents the muddiness of trauma affect.

Leonardo da Vinci stated, “Simplicity is the ultimate sophistication.” Albert Einstein echoed, “If you can't explain it to a six year old you don't understand it yourself.” Following such advice, delivery of simple concepts to mitigate the complex and impairing effects from trauma is a core element of SSB. Simply learning that one has the ability to start reversing damage caused by trauma is empowering, as well as healing. This process builds grit, resilience, depth of character, and human understanding.

Resilience is born of sorrow, making the experience of trauma a valuable life lesson to encourage compassion, creativity, and commitment to others. SSB is an intervention that may potentially effect the remapping of complex neural pathways

through learning, applying, and teaching simple tools. Perhaps SSB can become a common household activity that assists with revitalization of healthy relationships with self, family, and community. Communication and emotional expression based on compassion and respect for self and others allows us to live to our highest potential as individuals and for all of humanity.

REFERENCES

- Baumeister D., Lightman S.L., & Pianta C.M. (2014) The Interface of Stress and the HPA Axis in Behavioural Phenotypes of Mental Illness. In: Pianta C., Lapiz-Bluhm M. (eds) Behavioral Neurobiology of Stress-related Disorders. Current Topics in Behavioral Neurosciences, vol. 18. Springer, Berlin, Heidelberg
- Burke, H. N. (2019). *The deepest well: Healing the long-term effects of childhood adversity*. Boston: Mariner Books.
- Button, M. E. (June 01, 2016). Suicide and Social Justice: Toward a Political Approach to Suicide. *Political Research Quarterly*, 69, 2, 270-280.
- Bryan, C. J., Rudd, M. D. (2015). Preventing suicide attempts in military settings. In C. J. Bryan, C. J. Bryan (Eds.), *Cognitive behavioral therapy for preventing suicide attempts: A guide to brief treatments across clinical settings* (pp. 110-128). New York, NY, US: Routledge/Taylor & Francis Group.
- Bryan, C. J., Mintz, J., Clemans, T. A., Leeson, B., Burch, T. S., Williams, S. R., Maney, E., & Rudd, M. D. (January 01, 2017). Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial. *Journal of Affective Disorders*, 212, 64-72.
- Centers for Disease Control and Prevention (2018). Retrieved from <https://www.cdc.gov>
- Child and Adolescent Health Measurement Initiative (2013). "Overview of Adverse Child and Family Experiences among US Children." Data Resource Center, supported by Cooperative Agreement 1-U59-MC06980-01 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Available at www.childhealthdata.org.

- Connolly, S., & Sakai, C. (January 01, 2011). Brief Trauma Intervention with Rwandan Genocide-Survivors Using Thought Field Therapy. *International Journal of Emergency Mental Health*, 13, 3, 161-172.
- Connolly, S.M., Roe-Sepowitz, D., Sakai, C.E., & Edwards, J. (2013). Utilizing community resources to treat PTSD: A randomized controlled study using Thought Field Therapy. *African Journal of Traumatic Stress*, 3(1), 24-32.
- Dorado, J. S., Martinez, M., McArthur, L. E., & Leibovitz, T. (2016). Healthy Environments and Response to Trauma in Schools (HEARTS): A whole-school, multi-level, prevention and intervention program for creating trauma-informed, safe and supportive schools. *School Mental Health*, 8(1), 163–176. <https://doi-org.ezproxy.lib.utah.edu/10.1007/s12310-016-9177-0>
- Duckworth, A., Peterson, C., Matthews, M., Kelly, D., & Carver, Charles S. (2007). Grit: Perseverance and Passion for Long-Term Goals. *Journal of Personality and Social Psychology*, 92(6), 1087-1101.
- Duckworth, A. (2018); www.angeladuckworth.com/research.
- Ellis, A., & Bernard, M. E. (2006). Rational emotive behavioral approaches to childhood disorders: Theory, practice and research. New York: Springer.
- Faul, F., Erdfelder, E., Lang, A.G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, 39, 175-191.
- Faul, F., Erdfelder, E., Buchner, A., & Lang, A.G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, 41, 1149-1160.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards,

- V., Koss, M. P., Marks, J. S. (1998). Relationship of Child Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Child Experiences (ACE) Study, *American Journal of Preventative Medicine* 14. No. 4; 1998: 253-65 doi:10.1016/S0749-3797(98)00017-8
- Fisher, G. L., Roget, N. A., Sage, P., & Sage, E. (2009). *Encyclopedia of substance abuse prevention, treatment, & recovery*. Los Angeles: Los Angeles: SAGE.
- Fraiberg, S., Adelson, E., & Shapiro, V. (June 01, 1975). Ghosts in the Nursery. *Journal of the American Academy of Child Psychiatry*, 14, 3, 387-421.
- Freeman, M., Georgalis, S., Kohan, T., In Moro, M., In Sagle, C. J., Bromfman, P., & National Geographic Society (U.S.). (2018). *The story of us: With Morgan Freeman*.
- Gallagher, T. (2016). Shared education in Northern Ireland: school collaboration in divided societies, *Oxford Review of Education*, 42:3, 362-375, DOI: 10.1080/03054985.2016.1184868
- Garland, A. F., Haine-Schlagel, R., Brookman-Frazee, L., Baker-Ericzen, M., Trask, E., & Fawley-King, K. (2013). Improving community-based mental health care for children: translating knowledge into action. *Administration And Policy In Mental Health*, 40(1), 6-22.
<https://doi-org.ezproxy.lib.utah.edu/10.1007/s10488-012-0450-8>
- Govindji, R., & Linley, P. A. (2007). Strengths use, self-concordance and well-being: Implications for strengths coaching and coaching psychologists. *International Coaching Psychology Review*, 2 (2), 1 43-153.
- Greco, L. A., Baer, R. A., & Smith, G. T. (2011). Assessing mindfulness in children and adolescents: Development and validation of the Child and Adolescent

Mindfulness Measure (CAMM). *Psychological Assessment*, 23(3), 606-614.

<http://dx.doi.org/10.1037/a0022819>

Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009).

Trauma-Informed Organizational Toolkit. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. Available at www.homeless.samhsa.gov and www.familyhomelessness.org.

Kerig, P., & Wainryb, Cecilia. (2014). *Trauma and resilience among former child soldiers around the world*.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, 16(9), 606–613. doi:10.1046/j.1525-1497.2001.016009606.x

Hammond, L. H. (1916). *In the garden of delight*. New York: Thomas Y. Crowell Co.

Haugan, G. (2013). Nurse-patient interaction is a resource for hope, meaning in life and self-transcendence in nursing home patients. *Scandinavian Journal of Caring Sciences*, Scandinavian Journal of Caring Sciences, 2013.

Herth, K. (1991). Development and refinement of an instrument to measure hope. *Scholarly Inquiry for Nursing Practice: An International Journal*, 5(1), 39-51.

Herth, K. (1992). Abbreviated instrument to measure hope: Development and psychometric evaluation. *Journal of Advanced Nursing*, 17, 1251-1259.

Howard, J. (2018). A Systemic Framework for Trauma-Informed Schooling: Complex but Necessary! *Journal of Aggression, Maltreatment & Trauma*, 1-21.

Huebner, E.S. (2001). *Manual for the Multidimensional Students' Life Satisfaction Scale*.

University of South Carolina, Department of Psychology. Columbia, SC.

Huebner, E. S., Laughlin, J. E., Ash C., & Gilman, R. (1998). *Further validation of the*

Multidimensional Students' Life Satisfaction Scale. *Journal of Psychological*

Assessment, 16, 118-134.

Huebner, E.S. (1991). *Initial development of the Students' Life Satisfaction Scale*. *School*

Psychology International, 12, 231-243.

Hutchison, P., Nyks, K., Scott, J. P., Chomsky, N., PF Pictures (Firm), & FilmRise

(Firm). (2015). *Requiem for the American dream: Noam Comsky and the*

principles of concentration of wealth and power.

Irgens, A., Dammen, T., Nysaeter, T. E., & Hoffart, A. (November 01, 2012). *Thought*

Field Therapy (TFT) as a Treatment for Anxiety Symptoms: A Randomized

Controlled Trial. *Explore*, 8, 6, 331-338.

Irgens, A. C., Hoffart, A., Borge, F.-M., Hoffart, A., Haaland, V. O., Nysaeter, T. E.,

Haaland, V. O., ... Dammen, T. (January 01, 2017). *Thought field therapy*

compared to cognitive behavioral therapy and wait-list for agoraphobia: A

randomized, controlled study with a 12-month follow-up. *Frontiers in*

Psychology, 8.

Kuby, A. K., McLean, N., & Allen, K. (2015). *Validation of the Child and Adolescent*

Mindfulness Measure (CAMM) with non-clinical adolescents. *Mindfulness*, 6(6),

1448-1455. <http://dx.doi.org/10.1007/s12671-015-0418-3>

Levenson, H., & Maher, Brendan A. (1973). *Multidimensional locus of control in*

psychiatric patients. *Journal of Consulting and Clinical Psychology*, 41(3), 397-

404.

- Lounsbury, J. W., Fisher, L. A., Levy, J. J., & Welsh, D. P. (2009). An investigation of character strengths in relation to the academic success of college students. *Individual Differences Research*, 7, 52-69.
- Maslow, A. H. (1943). *Theory of human motivation*. Originally published in *Psychological Review*, 50, 370-396.
- Maugham, W. S. (1961). *Creatures of circumstance*. London: W. Heinemann.
- MacGinty, R., Muldoon, O. T., & Ferguson, N. (February 01, 2007). No War, No Peace: Northern Ireland after the Agreement. *Political Psychology*, 28, 1, 1-11.
- Montgomery-Devlin, J. (January 01, 2008). The Sexual Exploitation of Children and Young People in Northern Ireland: Overview from the Barnardo's Beyond the Shadows Service. *Child Care in Practice*, 14, 4, 381-400.
- Mendelson, M. J., & Aboud, F. (1999). Measuring friendship quality in late adolescents and young adults: McGill friendship questionnaires. *Canadian Journal of Behavioural Science*, 31, 130-132.
- Mendelson, M. J., & Aboud, F. (1997). Measuring friendship quality in late adolescents and young adults: McGill friendship questionnaires. Unpublished manuscript.
- Montgomery-Devlin, J. (2008) The Sexual Exploitation of Children and Young People in Northern Ireland: Overview from the Barnardo's Beyond the Shadows Service, *Child Care in Practice*, 14:4, 381-400, DOI: 10.1080/13575270802268059.
- NIDA. (2016, February 11). Understanding Drug Abuse and Addiction: What Science Says. Retrieved from <https://www.drugabuse.gov/understanding-drug-abuse-addiction-what-science-says> on 2019, July 23

Nussbaum, N. (1997). Narratives of Hierarchy: Loving v. Virginia and the Literary Imagination. *Quinnipiac Law Review*, 17, 337-813.

Patient Health Questionnaire Depression Screening (PHQ-9)

<https://www.mdcalc.com/phq-9-patient-health-questionnaire-9>

Perry, B. D., & Szalavitz, M. (2017). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook : what traumatized children can teach us about loss, love, and healing.*

Phifer, L.W. & Hull, R. (2016). Helping Students Heal: Observations of trauma-informed practices in the schools. *School Mental Health* 8: 201.

<https://doi.org/10.1007/s12310-016-9183-2>

Phillips-Salimi, C. Haase, J. Kintner, E., Monahan, P., & Azzouz, F. (2007).

Psychometric Properties of the Herth Hope Index in Adolescents and Young Adults With Cancer. *Journal of nursing measurement*. 15. 3-23.

10.1891/106137407780851769.

Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive processing therapy for PTSD: A comprehensive manual*. New York, NY: Guilford Press.

Riemer, M., Athay, M. M., Bickman, L., Breda, C., Kelley, S. D., & Vides de Andrade, A. R. (2012). The Peabody Treatment Progress Battery: history and methods for developing a comprehensive measurement battery for youth mental health.

Administration And Policy In Mental Health, 39(1-2), 3-12. <https://doi-org.ezproxy.lib.utah.edu/10.1007/s10488-012-0404-1>

Robson, R. H., Robson, P. M., Ludwig, R., Mitabu, C., & Phillips, C. (January 01,

- 2016). Effectiveness of Thought Field Therapy Provided by Newly Instructed Community Workers to a Traumatized Population in Uganda: A Randomized Trial. *Current Research in Psychology*, 7, 1, 1-11.
- Substance Abuse and Mental Health Services (SAMHSA). (2019). Retrieved from <https://www.integration.samhsa.gov>
- Sapp, S. G., & Harrod, W. J. (1993). Reliability and Validity of a Brief Version of Levenson's Locus of Control Scale. *Psychological Reports*, 72(2), 539–550. <https://doi.org/10.2466/pr0.1993.72.2.539>
- Shakespeare, The Merchant of Venice, Act - IV, Scene 1
- Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back *International journal of behavioral medicine*, 15(3), 194-200.
- Suomi, S. J. (2007). 1A-2 Gene environment interactions and aggression in primates. *Early Human Development*, 83, 1.
- Tsukayama, E., Duckworth, A., & Kim, B. (2013). Domain-specific impulsivity in school-age children. *Developmental Science*, 16(6), 879-893.
- Van der Kolk, B. A., (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. New York: Viking.
- Van der Kolk, B. A., Perry, J. C., & Herman, J. L. (January 01, 1991). Childhood origins of self-destructive behavior. *The American Journal of Psychiatry*, 148, 12, 1665-71.
- Van der Kolk, B. A. (January 01, 1989). The compulsion to repeat the trauma. Re-enactment, revictimization, and masochism. *The Psychiatric Clinics of North America*, 12, 2, 389-411.

- Vijayakumar L., Nagaraj K., Pirkis J., Whiteford H. (2005). Suicide in developing countries (1): Frequency, distribution, and association with socioeconomic indicators. *Crisis*. 2005;26:104–11. [PubMed: 16276752].
- Vijayakumar, L. (2015). Suicide in women. *Indian Journal of Psychiatry*, 57(6), 233. Retrieved from <http://link.galegroup.com.ezproxy.lib.utah.edu/apps/doc/A431997888/HRCA?u=marriottlibrary&sid=HRCA&xid=d22fc28>
- World Health Organization. (2017) Retrieved from http://www.who.int/mental_health/prevention/suicide/suicideprevent/en
- World Health Organization. (2018). Suicide prevention (SUPRE) Retrieved from <http://www.who.int>
- Yehuda, R., & Lehrner, A. (October 01, 2018). Intergenerational transmission of trauma effects: putative role of epigenetic mechanisms. *World Psychiatry*, 17, 3, 243-257.

APPENDIX

ADDENDUM 1

Health-Resiliency Stress Questionnaire for Youth (HRSQ-Y)

(Wiet, 2016; Wiet, 2018)

Health-Resiliency-Stress Questionnaire for Youth (HRSQ-Y)

Study Participant Identifier: _____ Age: _____
 Teacher: _____ Date: _____
 Gender: Female Male Other

PART A

We each have our own ways to cope with difficult times and view ourselves.					
PLEASE CIRCLE THE ANSWER THAT SHOWS HOW TRUE EACH STATEMENT IS FOR YOU:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1) I tend to bounce back quickly after hard times.	1	2	3	4	5
2) I have a hard time making it through stressful events.	5	4	3	2	1
3) It does not take me long to recover from a stressful event.	1	2	3	4	5
4) It is hard for me to snap back when something bad happens.	5	4	3	2	1
5) I usually come through difficult times with little trouble.	1	2	3	4	5
6) I tend to take a long time to get over <u>set-backs</u> in my life.	5	4	3	2	1

PLEASE CIRCLE THE ANSWER THAT SHOWS HOW TRUE EACH STATEMENT IS FOR YOU:	Not true at all	Rarely true	Sometimes true	Often true	True nearly all the time
1) I am hopeful about life in general.	1	2	3	4	5
2) I feel loved and supported.	1	2	3	4	5
3) I ask for help when I need it.	1	2	3	4	5
4) I have healthy, trusting relationship(s).	1	2	3	4	5
5) I choose healthy activities to decrease stress.	1	2	3	4	5
6) I can find positive solutions to life's problems.	1	2	3	4	5
7) I like who I am.	1	2	3	4	5
8) I feel optimistic about my future.	1	2	3	4	5

PART B

We each have our own ways by which view ourselves and health.					
PLEASE CIRCLE THE ANSWER THAT FITS BEST:	Poor	Fair	Good	Very Good	Excellent
1) My overall physical health is...	1	2	3	4	5
2) My physical ability to do the tasks of everyday life is...	1	2	3	4	5
3) My ability to function when I have physical pain is...	1	2	3	4	5
4) My overall mental health is...	1	2	3	4	5
5) My ability to stay positive when I am not feeling well is...	1	2	3	4	5
6) My ability to function when I am feeling sad or blue is...	1	2	3	4	5

PART C

In your life, have you ever had any experience that was so <u>frightening, horrible, or upsetting</u> that, <i>in the past month</i> , you:			
1) Have had nightmares about it or thought about it when you did not want to?	Yes	No	Don't Know
2) Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No	Don't Know
3) Were constantly on guard, watchful, or easily startled?	Yes	No	Don't Know
4) Felt numb or detached from others, activities or your surroundings?	Yes	No	Don't Know

PART D

Please read each of the following questions.
Please DO provide your total score.
You DO NOT need to identify the specific question.

MY TOTAL SCORE IS:

1) Did you live with anyone who was depressed, mentally ill, OR suicidal?
2) Did you live with anyone who was a problem drinker or alcoholic?
3) Did you live with anyone who used illegal drugs OR who abused prescription medications?
4) Did you live with anyone who served time or was sentenced to serve time in a prison, jail, OR other correctional facility?
5) Were your parents separated, divorced, one parent never involved OR <u>lose</u> a parent to death or abandonment? (including foster or proctor care placement)
6) Did you often feel that you did not have enough to eat, had to wear dirty clothes, <u>had</u> no one to protect you?
7) Did you often feel that your parents were not able to care for you due to their own struggles?
8) Did you often feel that no one in your family loved you, thought that you were important or special?
9) Did you often feel that your family didn't look out for each other, feel close or support each other
10) In your home, did you ever see or hear domestic abuse (such as physical assaults or verbal threats)?
11) Were you often afraid to go home?
12) In your home, were you ever physically hurt, injured OR threatened by anyone? (Do not include light spanking)
13) In your home, did anyone do any of the following: swear at you, insult you, humiliate you, OR put you down?
14) Did anyone ever touch you inappropriately (sexually) OR watch you bathe/undress that made you feel uncomfortable, embarrassed, or ashamed?
15) Did anyone ever make you watch sexual acts (including pornography) OR try to make you touch them sexually?
16) Did anyone ever coerce OR force you into having sex?
17) Were you often bullied (e.g. about your race, sexuality, immigration, intellect, etc.) at school AND felt unprotected?
18) Were you or your family ever homeless?
19) Were you often afraid to be outside because of violence in your community?
20) Other trauma or abuse (e.g. medical trauma, incarceration, etc.) please write-in if comfortable):

Please indicate if you want or need help with addressing any of the items above.

YES NO

HRSQ-Y: I need help

Study Participant Identifier: _____

Please share if you need or want help with one or more of the items on the HRSQ in Part D.

Yes No

If you circle "Yes", your teacher will be notified and will refer you to your school or program counselor.

The researchers will not know who you are.

ADDENDUM 2**SAVE SOMEBUDDY Program Curriculum**

The SAVE SOMEBUDDY program curriculum can be accessed at the following website: www.savesomebuddy.org

ADDENDUM 3**Boundaries and Ethics Training Outline**

Ethics Definition: Deciding how to act for the good of the people served, the delivery of the project, the goal of the project, and the team interface.

- People served: kindness, social responsibility, public health, and human rights
- Boundaries
 1. No 1:1 contact with any youth
 2. If a youth approaches you and self-discloses, an appropriate response for this study is: “It sure sounds like you have something important to talk about. So, I am going to let your teacher know that you need to talk to someone who can help you out.”
 3. No self-disclosure or disclosure of others’ experiences
 4. No discussion of current events
 - HIPAA
 - Delivery of the project: trust, knowledge, and compliance with the law
 - Delivery of the curriculum
 - Maintaining objectivity
 - Goal of the project: knowledge, truth, accountability, trust
 - Honoring commitment

- Observations
- Team interface: trust, accountability, mutual respect, and fairness
- Group interaction
- Concerns or questions

ADDENDUM 4

Community Mentor Pre/Post Questionnaire

Mentors were asked to complete a pre and post questionnaire. The questions included:

On a scale from 1 -5 (1 = poor, 2= fair, 3 = average, 4 = excellent, 5 = outstanding), please indicate the value that best describes your answer.

1. I feel confident in presenting information to students in the classroom setting.
2. I feel competent with communication skills.
3. I feel this program is valuable for students to learn.
4. I feel I am contributing to improving the lives of others.
5. I feel compassion toward others.
6. I feel empathy for people who struggle mentally and emotionally.
7. I feel able to withstand or recover quickly from difficult conditions (because of my life experiences).
8. I feel a personal responsibility to make a difference for people in my community.
9. I feel able to actively teach my family and community tools that help with emotional regulation.

None of the following procedures are considered experimental. The mentors were non-clinical members of the community. Training and the delivery of information from trainings is simple and non-clinical. Mentors are analogous to peer support specialists,

which have been widely studied and have demonstrated very positive outcomes for shaping new behavior.

These procedures and subsequent trainings allowed for potential replication of the study process with future mentors in future schools. The idea is to create a viable trauma-informed school based curriculum with volunteer community support. As such, multiple supervisory layers were in place for the mentors, which were provided by the district, school, and study administrative team.

ADDENDUM 5

Community Mentor Interim Study Evaluations

Questions were asked about the mentor's experience after each training session.

The questions included:

1. Were the materials clearly defined? YES NO
2. Did you have adequate time to deliver the material in the classroom setting? YES NO
3. Did you perceive that students understood the material you presented? YES NO
4. Did you observe any problems that the material caused? YES NO
4. Did you enjoy delivering the material? YES NO
6. Did you learn new skills from the material? YES NO
7. Do you have any suggestions or feedback about this unit? YES NO

If yes, please provide specific thoughts:

ADDENDUM 6

8-Item Grit Scale - Child Adapted Version 4

(Duckworth et al., 2007)

Directions for taking the Grit Scale: Please respond to the following 8 items. Be honest – there are no right or wrong answers.

1. New ideas and projects sometimes distract me from previous ones.*
 - Very much like me
 - Mostly like me
 - Somewhat like me
 - Not much like me
 - Not like me at all

2. Setbacks (delays and obstacles) don't discourage me. I bounce back from disappointments faster than most people.
 - Very much like me
 - Mostly like me
 - Somewhat like me
 - Not much like me
 - Not like me at all

3. I have been obsessed with a certain idea or project for a short time but later lost interest.*
 - Very much like me
 - Mostly like me
 - Somewhat like me
 - Not much like me
 - Not like me at all

4. I am a hard worker.
 - Very much like me
 - Mostly like me
 - Somewhat like me
 - Not much like me
 - Not like me at all

5. I often set a goal but often pursue (follow) different one.*
 - Very much like me
 - Mostly like me
 - Somewhat like me
 - Not much like me
 - Not like me at all

6. I have difficulty maintaining (keeping) my focus on projects that take more than a few months to complete.*
 - Very much like me
 - Mostly like me

- Somewhat like me
- Not much like me
- Not like me at all

7. I finish whatever I begin.

- Very much like me
- Mostly like me
- Somewhat like me
- Not much like me
- Not like me at all

8. I am diligent (hard working and careful).

- Very much like me
- Mostly like me
- Somewhat like me
- Not much like me
- Not like me at all

ADDENDUM 7

Brief Multidimensional Students Life Satisfaction Scale (BMSLSS-PTPB: Youth)

(Huebner, 1991; Huebner, Laughlin, Ash & Gilman, 1998)

Please place an 'X' in the one box that best indicates how satisfied or dissatisfied you CURRENTLY are with each item below. There is no right or wrong answer.

	HOW SATISFIED OR DISSATISFIED ARE YOU WITH...	Very Dissatisfied	Somewhat Dissatisfied	Neither Satisfied Nor Dissatisfied	Somewhat Satisfied	Very Satisfied
1.	Your family life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Your friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Your school experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Where you live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Your life overall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDENDUM 8

Child and Adolescent Mindfulness Measurement (CAMM)

(Greco, Baer & Smith, 2011)

We want to know more about what you think, how you feel, and what you do. **Read each sentence. Then, circle the number that tells how often each sentence is true for you.**

	Never True	Rarely True	Sometimes True	Often True	Always True
1. I get upset with myself for having feelings that don't make sense.	0	1	2	3	4
2. At school, I walk from class to class without noticing what I'm doing.	0	1	2	3	4
3. I keep myself busy so I don't notice my thoughts or feelings.	0	1	2	3	4
4. I tell myself that I shouldn't feel the way I'm feeling.	0	1	2	3	4
5. I push away thoughts that I don't like.	0	1	2	3	4
6. It's hard for me to pay attention to only one thing at a time.	0	1	2	3	4
7. I get upset with myself for having certain thoughts.	0	1	2	3	4
8. I think about things that have happened in the past instead of thinking about things that are happening right now.	0	1	2	3	4
9. I think that some of my feelings are bad and that I shouldn't have them.	0	1	2	3	4
10. I stop myself from having feelings that I don't like.	0	1	2	3	4

ADDENDUM 9**Domain-Specific Impulsivity Scale for Children (DSIS-C)**

(Tsukayama, Duckworth & Kim, 2013)

Here are a number of statements that may or may not apply to you. For the most accurate score, when responding, think of how you compare to most people -- not just the people you know well, but most people in the world. There are no right or wrong answers, so just answer honestly. For the following statements, please indicate how often you did the following during the past school year:

1. I forgot something I needed for class.

- Almost never
- About once a month
- About 2-3 times per month
- About once a week
- At least once a day

2. I interrupted other students while they were talking.

- Almost never
- About once a month
- About 2-3 times per month
- About once a week
- At least once a day

3. I said something rude.

- Almost never
- About once a month
- About 2-3 times per month
- About once a week
- At least once a day

4. I couldn't find something because my desk, locker, or bedroom was messy.

- Almost never
- About once a month
- About 2-3 times per month
- About once a week
- At least once a day

5. I lost my temper at home or at school.

- Almost never
- About once a month

- About 2-3 times per month
 - About once a week
 - At least once a day
6. I did not remember what my teacher told me to do.
- Almost never
 - About once a month
 - About 2-3 times per month
 - About once a week
 - At least once a day
7. My mind wandered when I should have been listening.
- Almost never
 - About once a month
 - About 2-3 times per month
 - About once a week
 - At least once a day
8. I talked back to my teacher or parent when I was upset.
- Almost never
 - About once a month
 - About 2-3 times per month
 - About once a week
 - At least once a day

ADDENDUM 10

McGill Friendship Questionnaire - FF_i (MFQ-RA)

(Mendelson & Aboud, 1999; Mendelson & Aboud, 1997)

The items below concern the kind of friend your friend is to you. Imagine that the blank space in each item contains your friend's name. With him or her in mind, decide how often the item applies. On the scale directly to the right of each item circle the number that indicates how often your friend is or does what the item says. There are no right or wrong answers because adult friendships are very different from one another. Just describe your friend as he or she really is to you.

	Never	Rarely	Once in a While		Fairly Often	Always			
	0	1	2	3	4	5	6	7	8
1. ___ helps me when I need it.	0	1	2	3	4	5	6	7	8
2. ___ would make me feel comfortable in a new situation.	0	1	2	3	4	5	6	7	8
3. ___ is someone I can tell private things to.	0	1	2	3	4	5	6	7	8
4. ___ has good ideas about entertaining things to do.	0	1	2	3	4	5	6	7	8
5. ___ would want to stay my friend if we didn't see each other for a few months.	0	1	2	3	4	5	6	7	8
6. ___ makes me feel smart.	0	1	2	3	4	5	6	7	8
7. ___ makes me laugh.	0	1	2	3	4	5	6	7	8
8. ___ knows when I'm upset.	0	1	2	3	4	5	6	7	8
9. ___ helps me do things.	0	1	2	3	4	5	6	7	8
10. ___ points out things that I am good at.	0	1	2	3	4	5	6	7	8
11. ___ would be good to have around if I were frightened.	0	1	2	3	4	5	6	7	8
12. ___ would still want to be my friend even if we had a fight.	0	1	2	3	4	5	6	7	8
13. ___ lends me things that I need.	0	1	2	3	4	5	6	7	8
14. ___ would make me feel better if I were worried.	0	1	2	3	4	5	6	7	8
15. ___ is someone I can tell secrets to.	0	1	2	3	4	5	6	7	8
16. ___ would stay my friend even if other people criticized me.	0	1	2	3	4	5	6	7	8
17. ___ compliments me when I do something well.	0	1	2	3	4	5	6	7	8
18. ___ is exciting to talk to.	0	1	2	3	4	5	6	7	8
19. ___ makes me feel special.	0	1	2	3	4	5	6	7	8
20. ___ would stay my friend even if other people did not like me.	0	1	2	3	4	5	6	7	8
21. ___ knows when something bothers me.	0	1	2	3	4	5	6	7	8
22. ___ is exciting to be with.	0	1	2	3	4	5	6	7	8
23. ___ would make me feel calmer if I were nervous.	0	1	2	3	4	5	6	7	8
24. ___ helps me when I'm trying hard to finish something.	0	1	2	3	4	5	6	7	8
25. ___ makes me feel that I can do things well.	0	1	2	3	4	5	6	7	8
26. ___ would still want to stay my friend even if we argued.	0	1	2	3	4	5	6	7	8
27. ___ shows me how to do things better.	0	1	2	3	4	5	6	7	8
28. ___ is fun to sit and talk with.	0	1	2	3	4	5	6	7	8
29. ___ is easy to talk to about private things.	0	1	2	3	4	5	6	7	8
30. ___ makes me feel better when I'm upset.	0	1	2	3	4	5	6	7	8

ADDENDUM 11

Patient Health Questionnaire Depression Screening - Adolescents (PHQ-9-A)

(Kroenke, Spitzer, & Williams, 2001)

<https://www.mdcalc.com/phq-9-patient-health-questionnaire-9>

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

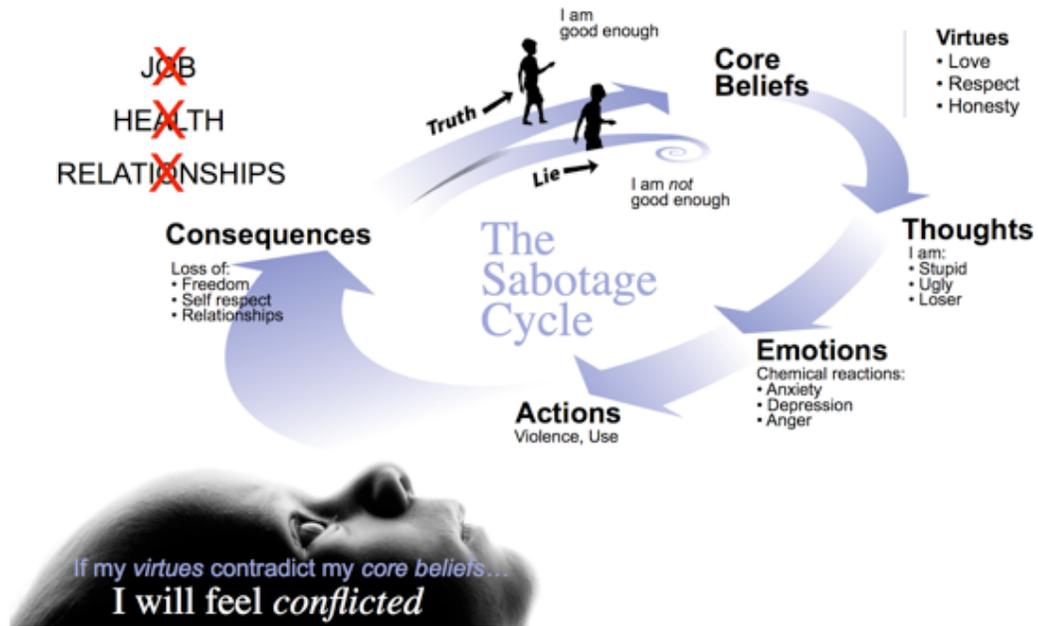
	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

ADDENDUM 12

The Sabotage Cycle

(Najarian, 2006; Najarian 2018)



When we are born we have no doubts about ourselves. We have experiences in our families that shape us. We either believe the truth or a lie about ourselves. This is called a core belief. If our core beliefs are true we will believe we are good enough. If our core beliefs are lies we will believe we are not good enough. Often we don't know our core beliefs exist. These core beliefs are the filters through which we interpret all of our experiences.

Our core beliefs create our thoughts. Our thoughts create our emotions. Our emotions are just biochemical. Depression and anxiety don't just happen to us. We create them through our thought process. Our emotions induce action. Our actions have consequences. As we experience our consequences, having lost our self-respect, freedom and relationships, we reinforce our core belief of not being good enough. This becomes cyclical.

When we believe we are not good enough we will subconsciously sabotage everything that is important to us in order to support the core belief because we don't believe we deserve those things. If our virtues are, for example, love, respect and honesty and we believe we are not good enough we will not be loving, respectful or honest with ourselves or others. When our virtues contradict our core belief we will experience inner conflict, like an angel and devil on your shoulders.

The only way to stop the cycle is to change the core belief. When we change our core belief everything changes. When our core belief is based on the truth The Sabotage Cycle transforms into The Success Cycle.

ADDENDUM 13**Student Assessment Information & Script**

We will conduct a series of validated assessments within the first two weeks of the study period. Students will respond to standardized questionnaires on school computers and a teacher and/or facilitator will be available to assist as needed. Within the software application, the student is assigned a unique identifier so that their individual responses cannot be linked to their identify. This process helps to assure students of anonymity and reduce bias. The same series of assessment tools will be administered post-program for analysis according to study objectives. Those students who do not consent to participate or whose parents do not consent to have their child participate will not participate in assessment processes but will be involved in class activities. On the days students will be assessed they will come to their normal advisory class and will be provided with the following description:

Script:

“Today we are going to take you to the computer lab and ask you to answer some questions on the computer. All of your answers on the computer are anonymous and kept confidential. Instead of your name, your responses will be linked to your student identification number rather than your name so the researchers do not know your identity. Your teacher will give you your student identification number if you do not remember it. The questions are designed to help researchers create better trauma-informed communities. You may choose not to participate. If you choose not to participate an alternative activity will be provided to you during this time.”

In the computer lab, the mentor/facilitator will advise students: “Enter your student identification number in place of your name. This will keep your identity

anonymous for the researchers. Only you and the school will know that this number links to you. Your name will not be available to anyone that looks at the data you enter. Feel free to answer the questions honestly. There are no right or wrong answers. Your grades will not be affected by the answers you give. You will also not be graded on your level of participation. Are there any questions?"

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