March 2024

The Cultural Relevance of the Well-Being Promotion Program

Gabrielle Francis
University of South Florida

The Cultural Relevance of the Well-Being Promotion Program

by

Gabrielle Francis

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
Department of Educational and Psychological Studies
College of Education
University of South Florida

Major Professor: Shannon Suldo Ph.D.
Sarah Fefer, Ph.D.
John Ferron, Ph.D.
Deidre Cobb-Roberts, Ph.D.

Date of Approval:
February 21, 2024

Keywords: positive psychology, cultural relevance, representativeness, intervention effectiveness, mixed methods, middle school

Acknowledgments

First I would like to express my gratitude to my dissertation chair, Dr. Shannon Suldo, for her support and guidance throughout the process of this dissertation. I would also like to express my gratitude to my dissertation committee members, Dr. John Ferron, Dr. Deirdre Cobb-Roberts and Dr. Sarah Fefer, for their expertise and thoughtful feedback which have been invaluable in forming this work. I am also grateful to the Institute of Educational Sciences (IES) for funding Project SOAR and thus enabling me to collect and analyze the data necessary for this dissertation. Additionally, I would like to thank Alexis Taylor, a fellow graduate student who served as the second coder for my qualitative data. I would not have been able to complete the qualitative section of my dissertation without her contribution and collaboration. There were also several people in my life who provide support and encouragement throughout my dissertation and who I would like to thank including my fiancé, Gio, my parents, siblings and friends. Lastly, to quote Snoop Dogg "I want to thank me for believing in me, I want to thank me for doing all this hard work. I want to thank me for having no days off. I want to thank me for never quitting."

Table of Contents

Table of Contents i

List of Tables v

Abstract vii

Chapter One: Introduction 1
- Statement of the Problem 1
- Purpose of Study 2
- Research Questions/Purposes 3
- Hypotheses 3
- Definition of Key Terms 5
  - Minoritized Student 5
  - Ethnic/Racial Group 6
  - Cultural Relevance 6
  - Representative Sample 6
  - Social Validity/Acceptability 7
  - Positive Psychology 7
  - Subjective Well-being 7
  - Significance of the Study 7

Chapter Two: Literature Review 9
- Best Practices in School Mental Health Services 10
  - Reimagined MTSS Framework 10
- Needs of Diverse Students in Mental Health 14
  - Reasons for Disparity in Mental Health Services 16
- Race in School-based Intervention Research 21
  - Representative Sampling 22
  - Reporting Racial Demographics and Effectiveness Across Race 24
- Impacts of Culturally Relevant Interventions 27
- Positive Psychology 32
  - Positive Psychology Interventions 34
  - Overview of the Well-Being Promotion Program 38

Chapter Three: Methods 43
- Participants 43
- Data Collection Procedure 48
- Intervention 52
  - The Well-Being Promotion Program 52

Leader Training in the WBPP 53
Measures 54
BMSLSS 54
SLSS 55
PANAS-C-10 55
TEI-SF 56
Student Exit Interview 57
Mental Health Provider Exit Interview 57
Coach Exit Interview 57
Data Analysis 58
Quantitative Data Analysis 58
Reliability 58
Research Question One 58
Research Question Two 59
Model Specification 60
Qualitative Analysis 61
Theoretical Orientation 61
Research Positionality 62
Research Question Three and Four 63
Ethical Considerations 65

Chapter Four: Results 66
Assignment to Racial/Ethnic Groups 66
Missing Data Analysis and Treatment 66
Creation of Composite Scores 67
Analysis of Consistency of Data with Assumptions 67
Descriptive Statistics 68
Research Question One 69
Chi Square Goodness of Fit Test 69
School One FL year 1 69
School Two MA Year 1 70
School Three MA Year 1 71
School Four FL Year 2 72
School Five FL year 2 72
School Six MA Year 2 73
School Seven MA year 2 74
School Eight MA Year 2 75
Research Question Two 76
Multilevel Modelling 77
Life Satisfaction 77
Positive Affect 78
Negative Affect 80
Research Question Three 81
Student Themes 84
Alignment with Culture 84
Cultural Efforts 89

Feelings of Acceptance 97
Advice for Interventionists 103
Research Question Four 107
SMHP Themes 110
Building and Maintaining Relationships 110
Building Safe Spaces 113
Cultural Efforts 116
Coach Themes 120
Building Safe Spaces 120
Discussions of Cultural Relevance 123
Needed Resources 126

Chapter Five: Discussion 130
Summary of Findings 130
Research Question One 130
Research Question Two 133
Research Question Three 135
Research Question Four 139
Implications for Practice 143
Contributions to the Literature 145
Limitations and Future Research 147
Conclusion 149

References 151

Appendix A: Active Parent Consent Letter 162

Appendix B: Recruitment Flyer 166

Appendix C: Passive Consent Form 169

Appendix D: Year 2 Student Recruitment 171

Appendix E: Procedures for Exit Interviews with Students 173

Appendix F: Procedures for Exit Interviews with Interventionists 176

Appendix G: Procedures for Exit Interviews with Coaches 180

Appendix H: Group Process Check-In 182

Appendix I: BMSLSS 184

Appendix J: SLSS 185

Appendix K: PANAS-C-10 186

Appendix L: Beliefs About WBPP Survey..187

List of Tables

Table 1 Racial Demographics Reported from NCES and Sample....44

Table 2 Demographic Features of Students in Intervention Condition of the RCT 45

Table 3 Students Chosen for Qualitative Analysis 47

Table 4 School Mental Health Providers Chosen for Qualitative Analysis....47

Table 5 Coaches Chosen for Qualitative Analysis....48

Table 6 Outline of WBPP Sessions....53

Table 7 Descriptive Statistics of Level 1 Predictor Variable 69

Table 8 School One Racial Demographics 70

Table 9 School Two Racial Demographics....71

Table 10 School Three Racial Demographics....71

Table 11 School Four Racial Demographics 72

Table 12 School Five Racial Demographics....73

Table 13 School Six Racial Demographics....74

Table 14 School Seven Racial Demographics 75

Table 15 School Eight Racial Demographics 76

Table 16 SLSS Fixed Effects from Initial Analysis....77

Table 17 SLSS Fixed Effects from Second Analysis 78

Table 18 SLSS Variance and Covariance 78

Table 19 Positive Affect Fixed Effects....79

Table 20 Positive Affect Variance and Covariance 80

Table 21 Negative Affect Fixed Effects from Initial Analysis 81

Table 22 Negative Affect Fixed Effects from Second Analysis 81

Table 23 Negative Affect Variance and Covariance 81

Table 24 Descriptions of Student Themes 83

Table 25 Coding Across Students 88

Table 26 Relatable and Unrelatable Activities Identified by Students 89

Table 27 Descriptions of School Mental Health Provider Themes 109

Table 28 Descriptions of Coach Themes 110

Table 29 Coding Across SMHPs 110

Table 30 Coding Across Coaches 110

Abstract

Schools are well-situated to be a primary setting to provide mental health services to youth. In fact, most minoritized students who receive mental health services do so through school (Ali et al., 2019). However, even school-based mental health services are not equitably accessed and provided for diverse populations of students, and minoritized students are less likely to have their mental health needs met in schools (Gudiño et al., 2009; Thomas et al., 2011). There are several reasons for the disparity in mental health services amongst students including the cultural relevance of interventions (Santiago-Rosario et al., 2021) and the early departure of minoritized students from treatment (Whitaker et al., 2018). In addition to these reasons, there are gaps in intervention research that aid in maintaining this disparity. Intervention studies have often failed to use representative samples and have also failed to analyse the effectiveness of interventions across racial/ethnic groups (Cipriano et al., 2022; Gaias et al., 2020; Sinclair et al., 2018). This means that diverse students may be receiving interventions that may be less effective for their unique needs (Castro-Olivo, 2017). The purpose of this research project was to address these gaps in the literature. This study focused on a school-based positive psychology intervention, the Well-Being Promotion Program, as delivered as a Tier 2 support in public middle schools. The dataset included qualitative and quantitative data from (a) 286 youth participating in the Well-Being Promotion Program during the 2021-2022 and 2022-2023 school years at eight middle schools in two states, (b) 45 school mental health providers who delivered the Well-Being Promotion Program to small groups of the youth participants, and (c) 6 research team members who provided coaching to the interventionists. This study examined the cultural

relevance of the intervention as perceived by the students; the participation of students in the intervention across racial/ethnic subgroups; the effectiveness of the intervention on youth mental health outcomes across racial/ethnic subgroups; and the strategies used by interventionists to increase the cultural relevance of the intervention. This study concluded that the study sample was partially representative of their larger school populations, and that students from different racial/ethnic groups respond similarly to the WBPP with regards to outcomes in life satisfaction and negative affect. However, Students who identify as Asian who have average scores at baseline, score higher in post intervention positive affect than their White counterparts who also have average scores at baseline. Lastly, the qualitative findings showed that students feel comfortable in their groups and also feel connected to their interventionists, however, the interventionists used a limited range of strategies to incorporate students' culture into intervention delivery.

Chapter One: Introduction

Statement of the Problem

Minoritized students are less likely to have their mental health needs met than their White counterparts, even in schools where mental health services are more accessible (Gudiño et al., 2009; Thomas et al., 2011). There are many different factors that affect this outcome, including the over-identification of Black students for disruptive behavior (Gregory et al., 2010), the early departure of minoritized students from mental health services (Whitaker et al., 2018), and cultural differences between minoritized students and their predominantly White mental health providers (Wang et al., 2020). Another factor affecting the provision of mental health services to minoritized youth is the interventions themselves. For an intervention to be culturally and contextually relevant the intervention's content (the manual and intervention activities), administration (methods and techniques used by the interventionist) and conduct (actions and manners of the interventionist) must address multiple cultural contexts (Huey & Polo, 2008).

However, most interventions are created for and tested with predominantly White populations. To address this issue, researchers need to attend to the issue of race. This can be done by reporting the race of samples in research articles, using racially representative samples, and intentionally examining interventions for their potential to reduce, maintain or increase inequities (Gaias et al. 2020). Reporting on the racial breakdown of a sample aids in generalization (Gaias et al. 2020), and doing so permits practitioners and researchers to determine if the intervention might be effective with their target population. Racially representative samples are a prevalent issue in research since samples are often predominantly White (Gaias et al. 2020). This limits generalizability and creates gaps in our

knowledge of minoritized groups. It is important to go beyond merely reporting on the representativeness of a sample; researchers must also analyze the data to determine if the intervention reduces racial inequities, maintains them, or increases them (Gaias et al. 2020).

According Gaias and colleagues (2020) systematic review of educational interventions, most empirical studies reported the racial demographics of their sample. However, in the studies that did report race/ethnicity, Black students were often over-represented in samples compared to the percentage of the school population that they actually account for. But few of these studies went beyond reporting demographics to analyzing outcomes by subgroups to determine the existence or not of disparities across races (Gaias et al. 2020). This shows that researchers are making efforts towards including Black students in their studies but does not address the overall issue of representative sampling for all minoritized students (e.g. Hispanic, Asian and Native American, Black, Pacific Islander individuals). This review reveals the need for more intervention studies that intentionally and specifically examine interventions to determine if they maintain, reduce or increase racial inequities. The purpose of this proposed dissertation was to examine the outcomes of a promising school-based positive psychology intervention— the Well-Being Promotion Project (WBPP; Suldo, 2016)— and analyze the outcomes of students who participate during two years (2021 – 2022 & 2022 – 2023) of a larger ongoing 5-year efficacy study to investigate its potential to reduce racial inequities. In addition, given the importance of the cultural relevance of the intervention itself, this study interviewed participants from minoritized groups to learn more about their perception of the cultural relevance of the WBPP, and interventionists and coaches on the strategies used to increase cultural relevance.

Purpose of Study

The purpose of this study was to address gaps that currently exist in the positive psychology research. There have been many studies that look at the effectiveness of positive

psychology interventions to increase subjective well-being but few have looked at the differential effectiveness across race. This study examined the WBPP on several different aspects. First, the study sample was examined for representativeness. Specifically, this study compared the racial groups of the school samples against the racial groups of the school populations to determine if the study sample was representative of the population. Second, it analysed the outcomes of subjective well-being across racial/ethnic subgroups. This analysis helped to illustrate whether there was differential effectiveness of the WBPP across race/ethnicity student group. Third, this study tried to gauge a better understanding of the students' perspectives on the cultural relevance of the WBPP. Lastly, this study gathered and examined data on how interventionists go about increasing the cultural relevance of the intervention as they implement it with their students.

Research Questions/Purposes

1. Are the racial/ethnic groups of the school samples representative of the racial/ethnic groups of the school populations?
2. Do students from different racial/ethnic subgroups respond similarly to the WBPP with regards to outcomes in subjective well-being (life satisfaction, negative affect and positive affect)?
3. In what ways is the WBPP perceived as culturally relevant by participants from minoritized groups? In what ways does the intervention align with the participants' cultures and in what ways does it not?
4. What do interventionists do to enhance the cultural relevance of the WBPP, as reported by interventionists, observed by coaches, and/or perceived by students?

Hypotheses

With regards to research question one, this author hypothesized that the proportion of racial/ethnic subgroups in the samples would not match the racial/ethnic subgroups of the

school populations. In the previous studies on the WBPP, 42% (Suldo et al., 2014) and 38% of students recruited to take part in the intervention ultimately received parent consent and also assented to be a part of the study (Roth et al., 2017). Though these percentages may be typical for a study required signed consent and assent for research activities in addition to intervention participation, they may not lead to samples that are representative of the school population. However, the extent to which there is a mismatch between the racial/ethnic subgroups of the sample compared to the school populations are to be seen.

With regards to the second research question this author hypothesized that different racial/ethnic subgroups would have similar outcomes in their subjective well-being. Previous studies examining the effectiveness of the WBPP showed an increase in life satisfaction (Roth et al., 2017; Suldo et al., 2014), an increase in protective factors (Lenz et al., 2020). Though these studies did not examined outcomes across racial/ethnic groups in a given study, the outcomes from these previous studies were derived from samples with a substantial range of representation of youth from minoritized groups, suggesting that the WBPP may have similar positive outcomes across race/ethnicity.

With regards to research question three this author hypothesized that the WBPP would be considered culturally relevant by participants and that it would align with participants' cultures. Previous research on mental health services showed that individuals perceive cultural alignment with their mental health provider as important and preferred to be matched with mental health providers who match their racial identity (Cabral & Smith, 2011; Wintersteen et al., 2005; Chang & Yoon, 2011). However, the interventionists in this study completed training on cultural humility and strategies to increase cultural relevance of the various intervention activities (see further description in methods section). In addition to this training they also engaged in weekly coaching sessions that focused on both session content as well as cultural humility and student engagement. The addition of this training and the

coaching sessions led the author to believe that the students would perceive the WBPP as culturally relevant.

With regards to research question four, the author hypothesized that the interventionists would have several strategies or methods that they used to enhance cultural relevance of the WBPP. Previous research showed that minoritized individuals may believe that White mental health providers are ignorant of their unique life experiences (Cabral & Smith, 2011; Chang & Yoon, 2011; Wintersteen et al., 2005) and that they cannot speak to White mental health providers about racial issues (Chang & Yoon, 2011), which indicated that White mental health providers may generally struggle with making treatment culturally relevant. However, the interventionists in this study completed training on cultural humility and strategies to increase the cultural relevance of the WBPP. Additionally, they also engaged in weekly coaching sessions where cultural relevance was one of the focuses of discussion. Because of these additions to the study, the author believed that the interventionists would have strategies that they used to increase cultural relevance, even though the research showed that this was not typically the case.

Definition of Key Terms

Minoritized Student

The term minority has typically been used to describe racial/ethnic groups like Black, Native American, Asian, Hispanic and multiracial individuals who represented a 'minor' percentage of the American population compared to White individuals. However, this term has been criticized for not fully representing the injustices experienced by these groups and the term 'minoritized' has replaced this term increasingly in literature (Gillborn, 2005; Harper, 2012; Shalabi, 2014). The term minoritized better represents the experiences of these groups of individuals who are discriminated against and marginalised by the dominant group for power.

The term minoritized student was used throughout this study to discuss students who are members of populations who typically experience discrimination, prejudice and disadvantages in the United States. In this study the term was primarily used to refer to racially minoritized students, i.e. students who belong to races that typically experience disadvantage in the United States including Black, Asian, Native American, Hispanic, and multiracial students.

Ethnic/Racial Group

Ethnic/racial group is a term that was used throughout this document and refers to the combination of cultural behaviors, customs, attitudes and language that are attributed to membership in a group (Neblett et al., 2012).

Cultural Relevance

Cultural relevance referred to the alignment of practices and activities to the culture of the students. The development of mental health interventions, including positive psychology interventions, have typically been based on Western and White perspectives which may not align with the cultures and experiences of diverse students (Gaias et al., 2020). Culturally relevant pedagogy calls for practices that incorporate and involve the customs, language and experiences of diverse students so they represented in the activities they are taking part in (Howard, 2001).

Representative Sample

In this study a representative sample refers to a smaller version of the entire population which retains the characteristics of the population (Grafstrom & Schelin, 2014). This study will specifically In particular examine the racial/ethnic groups of the schools samples compared to the overall school populations. One of the goals of this study is to assess the representativeness of the school sample with regards to racial/ethnic groups.

Social Validity/Acceptability

In this study, the terms social validity and acceptability were used interchangeably. The term social validity referred to the extent to which participants accept the procedures of the intervention which were created to change behaviour (Wolf, 1978). In this study treatment acceptability was associated with scores on a measure of acceptability completed immediately post-intervention.

Positive Psychology

Positive psychology is a term that referred to the study of enhancing happiness or subjective well-being (Seligman & Csikszentmihalyi, 2000).

Subjective Well-being

Subjective well-being is often considered synonymous with the word happiness (Suldo et al., 2016). Subjective well-being consist of three factor which includes positive affect, negative affect and life satisfaction (Diener, 200). Positive affect refers to experiencing pleasant emotions and moods, negative affect refers to experiencing unpleasant emotions and moods and life satisfaction refers to feeling satisfied with the different domains in your life (e.g. school, friend, home, neighborhood and family). Individuals who report high subjective well-being typically report high life satisfaction and positive affect, and low negative affect.

Significance of the Study

There are several gaps in both school-based mental health services and intervention research. Minoritized students have an increased need for mental health services when compared to their White peers. This increase is due to elevated risk factors that minoritized students are more likely to be exposed to (like poverty and racial discrimination) which then increases their likelihood of developing a mental health concerns (Larson et al., 2017; Pumariega et al., 2022). Minoritized students are also more likely to rely on school-based

mental health services than their White peers, however, even with this access their mental health needs are being left unmet (Ali et al., 2019; Gaias et al., 2020). Some of the reasons for this unmet need are the early departure of minoritized students from treatment (Whitaker et al., 2018) and the cultural differences between students and their mental health providers (Cabral & Smith, 2011; Chang & Yoon, 2011; Wintersteen et al., 2005). This study aimed to address this gap in school-based mental health provision by gaining the students' perspectives on the cultural relevance of a school-based positive psychology intervention (WBPP). This was significant because it would add to the limited literature on cultural relevance of school-based interventions and may lead to further studies in this area. Additionally, it was the first step in shedding lights in ways to consider adapting the WBPP for cultural relevance. By gaining a better understanding of the students' experiences with the intervention future researchers will be better able to create informed changes to the intervention, if needed.

There are also several gaps in intervention research that this study addressed. Current intervention research use samples that underrepresent minoritized populations and make limited attempts to recruit diverse populations (Cipriano et al., 2022; Gaias et al., 2020; Sinclair et al., 2018). Additionally, most studies examining the effectiveness of interventions fail to examine the differential effectiveness of interventions across race/ethnicity (Cipriano et al., 2022; Gaias et al., 2020). These gaps are significant for minoritized students because it means that they are not represented in the creation and validation of interventions that are used with them. This study aimed to address these gaps through using recruitment strategies to increase the recruitment of diverse students and by examining and comparing the outcomes of students across race/ethnicity. This was significant because it would add to the intervention research literature on positive psychology with a cultural lens, a lens that is currently missing in intervention research and sorely needed.

Chapter Two: Literature Review

School is a very important place for children and adolescents who spend the majority of their time within the walls of an educational institution. Schools also provide multiple services to children including education, healthcare and food. This is one of the reasons that schools are considered an appropriate setting to provide mental health services to children and adolescents. According to the 2020 National Survey of Drug Use and Health (NSDUH) about three million adolescents between the ages of 12-17 received mental health services in an educational setting in 2020. According to the same survey, approximately 432,000 Black students, 202,000 Asian-American students and 83,000 multiracial and 720,000 Hispanic or Latino students received school-based mental health services in 2020. Ali et al. (2019) found that approximately a third of adolescents who access mental health services solely depend on school-based mental health services. They also found that this was predominantly seen in students of low-income families and students of ethnic or racial minority groups (Ali et al., 2019). Thus schools serve as a means of increasing access to mental health services. However, even with these numbers, minoritized students are less likely to have their mental health needs met when compared to their White peers (Gudiño et al., 2009; Thomas et al., 2011). This chapter discusses this disparity through an exploration of current literature on mental health provision in schools, with a closer look at how to conceptualize and define mental health (i.e., using a dual-factor model) and the importance of tier two interventions. This chapter also examined the literature on the mental health needs of diverse students while exploring the disparity in mental health provisions and reasons for this phenomenon. The discussion in this chapter reviews the issues surrounding race in mental health intervention research as well as the impact of culturally relevant interventions on diverse students. Lastly,

this chapter provides an overview of positive psychology research and specifics on the positive psychology intervention that is the focus of this study, the Well-Being Promotion Program.

Best Practices in School Mental Health Services

The Multi-tiered Systems of Support (MTSS) is a framework used by schools to address academic, mental and behavioral concerns. There are several components of the MTSS framework. One of these components is making data-based decisions, which typically begins with using universal screening to identify the needs of the students and using progress monitoring throughout intervention implementation. Another key component of MTSS is the use of evidence-based practices which means the interventions that are used within the MTSS framework must be supported by research proving their effectiveness. The last key component is the use of tiered support. This tiered system is divided into three tiers. The first tier is universal in that all students receive these interventions which includes basic instruction and schoolwide interventions. The second tier is focused on providing services and supports for students who do not respond to the universal or tier one supports, and/or who demonstrate elevated levels of risk for problematic outcomes. This tier often involves providing interventions to students in small groups in a more targeted and focused way so that their needs are met. The last tier is tier three which is highly individualized and addresses the needs of a small subset of students who do not respond to either tier one or tier two supports, and/or demonstrated clinical levels of problems. In this tier students receive individualized care.

Reimagined MTSS Framework

That is a description of the basic MTSS framework, when the aim is to prevent and address psychological problems or mental illness. However, since its creation it has been revised or reimagined by researchers such as Doll et al. (2021). This reimagined version of

MTSS targets the complete mental health of students through the dual factor model. The dual factor model consists of two factors, one which focuses on problems—reducing the symptoms of mental disorders or psychopathology— and the other which focuses on wellness—enhancing subjective well-being (Doll et al., 2021). According to Diener (2000) subjective well-being consists of several components including "life satisfaction (global judgements of one's life), satisfaction of important domains (e.g. work satisfaction), positive affect (experiencing many positive emotions and moods) and low levels of negative affect (experiencing few unpleasant emotions and moods)" (pp. 34). The dual factor model is the integration of subjective well-being and psychopathology into one system, which defines complete mental health as both the absence of psychopathology as well as the presence of a positive level of subjective well-being (Greenspoon & Saklofske, 2001). Within the dual-factor system, students may fall into four different categories. They may present as vulnerable (low subjective well-being and low psychopathology), troubled (low subjective well-being and elevated psychopathology), symptomatic but content (average subjective well-being and elevated psychopathology) or complete mental health (low pathology and average subjective well-being).

In the traditional MTSS framework, the interventions used in the different tiers either increase mental health literacy or teach social, emotional and behavioral skills (Doll et al., 2021). The main aim of these interventions is to reduce the impact of psychopathology. Well-being is typically incorporated in these interventions, but increasing subjective well-being is not a major goal. The reimagined MTSS framework includes interventions that reduce the symptoms of psychopathology as well as interventions that enhance subjective well-being because in this framework, there are two goals, symptom reduction and enhancement of subjective well-being.

An empirical rational for using interventions intended to increase subjective well-being in addition to those intended to prevent/reduce psychopathology comes from earlier studies that establish psychopathology and subjective well-being are separable yet related constructs. For instance, Antaramian et al. (2010) investigated the value of assessing mental health using the dual-factor model as well as differences in school engagement across the groups using archival data. There were 764 student participants in this study, 54% were female while 46% were male. The participants were either in seventh grade (49%) or eight grade (51%) and were 30% Black, 64% Caucasian, 3% Asian, 1% Hispanic and 3% Other. Of this sample 21% received free or reduced-price lunch. The majority of the participants (67%) had average to high subjective well-being and low levels of internalizing and externalizing symptoms of psychopathology, thus comprising the positive mental health group. About 8% had low levels of psychopathology and low levels of subjective well-being and thus fell within the vulnerable group. About 17% of the participants had high subjective well-being and high psychopathology and were placed in the symptomatic but content group and 8% had high psychopathology and low subjective well-being and fell within the troubled group. The researchers found that the participants in the positive mental health group had the highest scores in school engagement and academic performance while the participants in the troubled group had the lowest scores in school engagement. An interesting finding in this study was that the symptomatic but content group had significantly higher engagement scores than the troubled group, which illustrates a positive association between average to high subjective well-being and academic engagement. Additionally, the study found that participants with average to high subjective well-being had more support from peers, parents and teachers than the groups with low subjective well-being. The results from this study show the importance of assessing subjective well-being alongside psychopathology. Low subjective well-being was associated with low academic performance and can be used as an

indicator of academic risk. This study also highlighted that promoting subjective well-being has potential benefits beyond improved well-being. The students with high subjective well-being and low psychopathology performed the best in the sample which shows that subjective well-being does have an impact on academics and thus should be promoted through school-based interventions.

Similar to Antaramian et al. (2010), Lyons et al. (2012) evaluated the usefulness of the dual factor model, however it incorporated a five month follow-up to examine the relationship between group membership and academic performance and engagement across time. At time one there were 1809 participants, 52% of whom were female and 48% male. Twenty-three percent of the participants were in eighth grade and 77% were in seventh grade; 23% received free or reduced lunch. Of this sample, 60% identified as Caucasian, 27% as Black, 3% as Asian American or Pacific Islander, 2% as Hispanic/Latino, 1% as Native American and 6% as Other. At time 2 there were 2727 participants, 87% of whom were seventh graders and 13% of whom were eighth graders. Lyons et al. (2012) found results similar to the Antaramian et al. (2010) study. There were significant differences among the four groups in the dual-factor model which supports the use of this model to differentiate students based on their levels of subjective well-being and psychopathology. Additionally, they found that students in the positive mental health group (low psychopathology and average to high subjective well-being) had the highest GPAs and school engagement. The positive mental health group also had significantly higher emotional engagement when compared to the vulnerable group (low psychopathology and low subjective well-being). In fact students in the vulnerable group showed a decline in their GPAs that was significantly faster than the positive mental health group. This study further supports both the usefulness of the dual-factor model as an appropriate framework for examining the complete mental

health of students as well as the importance of subjective well-being for academic performance and academic engagement.

Overall, the dual factor model has been shown to give a more complete look at the mental health of students than the traditional model that focuses solely on symptom reduction. It allows schools to identify vulnerable students who may remain overlooked in traditional mental health assessments due to their low levels of psychopathology, even as they experience low subjective well-being that is associated with academic risk. This information is especially relevant for mental health professionals employed in schools. These professionals include school social workers, school psychologists and school counsellors who, according to the National Survey of Drug Use and Health (NSDUH), served approximately two million students in 2020. With the use of the dual factor model to conceptualize the important components of mental health, and tier two interventions that target subjective well-being as well as those that target symptom reduction, school mental health professionals can help students to flourish in schools.

Needs of Diverse Students in Mental Health

The mental health of minoritized students needs to be a priority for schools. Minoritized students often experience more risk factors and fewer protective factors than their non-minoritized peers (Larson et al., 2017; Pumariega et al., 2022). This increase in risk factors is typically associated with the poverty and racism that many minoritized youth experience. Poverty has been associated with several risk factors including exposure to trauma, economic deprivation, increased family stress, family conflict and limited experiences of warmth and positive regard (Engle & Black, 2008). In addition to the negative impacts of poverty, minoritized students may also experience racism and discrimination, both of which have their own negative impacts on youth mental health. Seaton et al. (2008) reported that most Black and Caribbean American youth experience at least one incident of

discrimination a year. According to a systematic review completed by Priest et al. (2013), there is a strong relationship between racial discrimination and anxiety, depression, low self-esteem, low self-worth and decreased life satisfaction. Racism has also been associated with suicidal ideation in Black and Latinx youth (Madubata et al., 2019). Minoritized students have an increased need for mental health services than their White counterparts, however, these needs are not being met (Gaias et al., 2020).

One of the reasons for this unmet need is access to mental health services. There is a disparity in mental health provision for minoritized students. Wood et al. (2005) investigated age of entry into mental health services across race/ethnicity. The sample consisted of 1552 high risk youth with a mean age of 13.9. Sixty-six percent of the sample were male, 40% were Non-Hispanic White, 22% were Black, 7% were Asian/Pacific Islander and 31% were Latino. The researchers conducted interviews with the participants and their parents to assess their mental health needs and service use. They found that Non-Hispanic White students were more likely to receive school-based mental health and also to start receiving mental health services at an earlier age. The minoritized students were less likely to start mental health services before 11 compared to their White peers and were less likely to engage with school-based mental health services at all compared to their White peers. This study highlights the disparity in mental health provision between White students and minoritized students. Though minoritized students have increased needs for mental health services due to the increased exposure to risk factors, they are less likely to receive these services than their majority peers.

Garland et al. (2005) found similar results in their investigation of the use of mental health services in high risk youth who were in one or more of the following sectors of care in San Diego: child welfare, juvenile justice, alcohol and drug abuse, special education and/or mental health. This study had 1,256 participants between the ages of 16-18. The researchers

used a similar method to Wood et al. (2005) and interviewed the participants and their caregivers to measure the youth's usage of mental health services, their diagnoses, impairment, caregiver strain and parental depression. There was a generally high usage of mental health services within the sample, however White youth were still more likely to receive services. The study found that 79% of the Non-Hispanic White participants used mental health services while the percentages for the rest of the sample was 70% for Latino Americans, 64% for Blacks and 59% for Asian American/Pacific Islanders. The researchers also looked at the use of outpatient care, and found that Black and Asian American youth were significantly less likely to utilize this type of care compared to their White peers. Overall, this study supports the findings from the Wood et al. (2005) study and shows that there is a disparity in mental health services between White youth and minoritized youth. Additionally this study highlighted the fact that many minoritized youth do not use outpatient care which only emphasizes the need for effective and accessible school-based mental health services.

Reasons for Disparity in Mental Health Services

There are several reasons for this disparity in mental health services between White students and minoritized students. One of the reasons behind this is the overidentification of Black students for disruptive behaviour. Santiago-Rosario et al. (2021) investigated the racial disparity in school discipline and the influence that teacher expectations have on school discipline outcomes. The participants in this study were 33 elementary school teachers and 496 students. Of the student participants 48% were female and 52% were male. The racial breakdown of the students was 58% White, 17% Latinx, 10% Asian, 9% Black and 5% multiracial; 23% of the students were in special education, 15% were English Language Learners, and 43% experienced economic disadvantages. They found that Black students received significantly more office discipline referrals than their White counterparts. Black

students experienced the largest amount of disproportionality followed by students in special services programs, male students and students experiencing economic disadvantages. Teacher expectations were found to influence discipline referrals as well. If teachers hold high academic and behavioral expectations for students then the students are less likely to receive discipline referrals. There are racial disparities in school discipline which impacts the academics of minoritized students as well as their mental health (Girvan et al., 2017; Wolf & Kupchik, 2017 Minoritized students are more likely to be sent to the office for externalizing behaviors than their peers which reduces the amount of instruction time that they receive as well as the receipt of mental health services. It is difficult to conduct counseling or intervention groups with students who are frequently suspended from school.

Another reason for this disparity is the early departure of minoritized students from mental health services. Whitaker et al. (2018) investigated access and retention in school-based mental health services. The sample in this study included 2,205 students in middle and high school; 68% were female and 31% were male. Of this sample 21% were African-American, 19% were Asian/Pacific Islander, 33% were Caucasian, 11% were Hispanic/Latino, 15% were multiracial and 1% were American Indian. The results of this study show that access and retention are not the same across race/ethnicity. They found that Native Americans and multiracial students accessed mental health services at higher rates while Hispanic, Asian and White students accessed school-based mental health at significantly lower rates. However, once students were engaged with school-based mental health services males, Black students were more likely than their peers to leave the mental health services early. When looking at the concerns that lead to mental health services and retention, they found that internalizing issues, social or educational issues and trauma experiences were the concerns that were associated with greater retention. However, they found that students with externalizing behaviors typically only received one session of

counselling. Black and male students are more likely than their peers to leave school-based mental health services early. This contributes to the unmet mental health needs of minoritized students because these groups of students are exiting interventions before they can truly have positive impacts on their mental health. Though this study found that many groups of minoritized students initially engage with school-based mental health services, this initial engagement means little if they are not being retained.

Lastly, cultural differences between students and school-based mental health providers may also contribute to the disparity in school-based mental health provision and may also be the reason behind the early departure of minoritized students from mental health treatment. Wintersteen and colleagues (2005) examined the issue of retention of youth in treatment in a study of the impact of gender and racial matching on therapeutic alliance and retention in substance-abusing youths. The study sample included 600 youth with a mean age of 15.7, 61% of the sample were White, 32% were Black and 19% were girls. The authors matched participants based on gender and race so that the participants were either with a therapist who was of the same gender or a different gender and were White or a member of a minority group. With regards to therapeutic alliance they found that girls generally rated the alliance higher than boys, and patients in gender matched dyads rated their alliance higher. Racial matching did not have an effect on therapeutic alliance. With regards to treatment retention they found that gender matched dyads had greater treatment retention than those in gender mismatched dyads. However, racial matching seemed to have a greater impact on treatment retention. Only 55% of the patients in the racially mismatched dyad completed two thirds of the treatment, this is significant when compared to the 79% of patients in the racially matched dyads who completed two thirds of the treatment. The White therapists treating minoritized youths had the lowest retention rates of all the dyads. The authors had several hypothesizes for why racial matching had such an impact on retention including distrusts

from Black patients working with White therapists and discomfort from White therapists working with Black patients. Overall, this article helps add to the understanding one of the possible reasons for why minoritized students leave treatment early, cultural differences between the student and the therapist, which also happens to be a contributor to the mental health disparity.

Cabral and Smith (2011) conducted a meta-analysis on the research on racial/ethnic matching in therapy. They looked at three variables in racial/ethnic matching which included the client's preference for a therapist of their race/ethnicity, the clients' perceptions of their therapist, and therapeutic outcomes. They utilized 52 studies on preferences, 81 studies on perceptions and 53 studies on client outcomes. The researchers calculated the effect sizes of the three variables of interest and found that there was a moderately strong (d=0.63) client preference for racial/ethnic matching with therapists. With regards to the clients' perceptions of therapist there was a noted tendency for clients to perceive matched therapists more positively (d=0.32). However, there was very little difference in outcomes between clients with matched and unmatched therapists (d=0.09). These results show that clients typically prefer therapists of their own racial background and see these therapists in a more positive light than therapists that are of a different race/ethnicity to them, but such preferences may not link to effectiveness. Though this meta-analysis also found that racial/ethnic matching did not have a large effect on outcomes, the preferences and perceptions of clients do have an impact on initiation of mental health services and retention of clients. In schools, the mental health providers—school psychologists, school counsellors and school social workers—who are providing the tiered interventions are predominantly White (Cabral & Smith, 2011). The diverse students at schools may balk at the idea of working with someone who they believe is ignorant of the difficulties and experiences that are unique to their race/ethnicity.

Chang and Yoon (2011) conducted a qualitative study with 23 minority clients to investigate their perceptions of race during their therapy with White therapists. The sample included 13 females and 10 males, five of whom were Asian American, five Hispanic American, nine Black and four multiracial. The ages of the sample ranged from 19-55. Though this study was conducted with adults in outpatient mental health care it was included in this literature review because it provides a more nuanced look at the possible reasons behind a preference for race matching in therapy. Additionally, there were no similar qualitative studies conducted with youth clients and/or clients served in schools. The researchers used semi-structured interviews to gain information on the clients' perceptions of their therapist, the therapeutic relationship and the interventions that the clients deemed to be helpful. Most of the participants (19) viewed a race/ethnicity mismatch between therapist and client to be a barrier to developing a therapeutic relationship and 15 viewed racial/ethnic matching as a facilitator for a better therapeutic relationship. There was a subset of participants (9) believed that racial matching would pose a *barrier* to the therapeutic relationship due to issues like cultural stigmas and some participants did not believe that racial matching would have any impact on the therapeutic relationship. Most of the participants (16) also believed that their therapist could not understand their unique life experiences as a minoritized individual. A majority of the participants (14) reported that they did not talk with their therapist about certain racial/cultural issues that they were facing. However, some participants (7) viewed the mismatch between themselves and their therapist as a positive and saw the differences as an aid in building a relationship. Though most of the participants viewed racial/ethnic matching as important, there were other characteristics that they also valued which included compassion, caring, non-judgemental and open-mindedness. This study complements the meta-analysis completed by Cabral and Smith (2011) by providing a more nuanced look at the preferences and perceptions of minority clients. The

moderate preference that minoritized clients have for therapists of similar racial/ethnic backgrounds may be due to belief that White therapists will not be able to understand the experiences of a minoritized individual and the further belief that the client will not be able to discuss certain racial/ethnic experiences for fear of not being understood.

In sum, minoritized students often have increased needs for mental health services (Larson et al., 2017; Pumariega et al., 2022). They often experience more risk factors than their White peers, including poverty, discrimination, trauma, family stress and family conflict to name a few (Engle & Black, 2008; Priest et al., 2013; Seaton et al., 2008). However, minoritized students are less likely to have their mental health needs met than their White peers (Gaias et al., 2020; Garland et al., 2005; Wood et al., 2005). There is a disparity in mental health provision whereby White students are more likely to receive services than minoritized students and there are several reasons behind this disparity (Gaias et al., 2020; Garland et al., 2005; Wood et al., 2005). Some of the reasons covered in this discussion include the overidentification of minoritized students, especially Black students, for disruptive behaviors (Santiago-Rosario et al., 2021), the early departure of minoritized students from services (Whitaker et al., 2018) and the cultural differences between mental health providers and their clients, which is also connected to the early departure of minoritized students from treatement (Cabral & Smith, 2011; Chang & Yoon,2011; Wintersteen et al., 2005). There is clearly a need for more research into this area of providing mental health services for minoritized students.

Race in School-based Intervention Research

Minoritized students are less likely to receive the mental health services that they need when compared to their White counterparts and when they do receive these services they may be less responsive to their unique needs (Castro-Olivo, 2017). This is especially concerning given the increased needs of minoritized students due to their exposure to

multiple risk factors like poverty, discrimination and family conflict. Additionally, untreated mental health concerns can result in several negative outcomes including school dropout and increased likelihood of criminal behaviour (Wegmann et al., 2017). One way to address the disparity in mental health services between White students and minoritized students is to attend to race and ethnicity in education research, especially research on programs, practices and policies (Gaias et al., 2020). However, current educational research has been lacking in this regard for years. There are three specific areas that are especially concerning when examining school-based intervention research and minoritized students and these areas are representative sampling, reporting on racial demographics and analysing interventions for their effectiveness across race/ethnicity.

Representative Sampling

Sinclair et al. (2018) completed a systematic review of intervention research in special education across 12 education journals to examine the diversity of samples used in school-based intervention research. They looked at diversity across race/ethnicity, sexual orientation, disability and English Language Learner status and analysed 495 articles on interventions between 2000 and 2016. Though this article examined the intervention articles for sampling across the previously mentioned diversity criteria, for the purposes of this literature review we will focus on the racial demographic features of the samples featured in the articles. They found that 54.5% of the samples were White students, 26.4% were Black students, 12.8% were Latino/a, 2.2% were an ethnic minority, 1.3% were American Indian or Alaskan Native, 1.2% were Asian American, 0.7% were multiracial, 0.7% were unknown and 0.1% were Middle Eastern. However, 45.1% of the articles examined in this systematic review did not report the race and ethnicity of their samples. Compared to the national demographics for race and ethnicity the studies that reported race overrepresented some races (Black, American Indian or Alaska Native), underrepresented other races (Latino, White, Asian American,

multiracial) and only met the national percentage with American Indian or Alaska Native. The overrepresentation of Black students and American Indian or Alaska Native students may have been purposeful or may show a shift in focus towards sampling some minoritized populations. Though the underrepresentation of Asian American students and multiracial students should be noted as these are also minoritized populations that are seemingly not getting the same attention as Black and American Indian students are. Another interesting finding from this systematic study was the use of recruitment and retention strategies. A little more than half (56%) of the articles reported recruitment strategies and only 0.4% reported retention strategies. Of the recruitment and retention strategies, none included methods for recruiting and retaining minoritized students. One limitation of this systematic review is that it focused on students in special education not those receiving counselling or mental health services.

Pina et al. (2019) conducted an update on evidence-based psycho-social interventions for ethnic minority youth. They evaluated 65 studies on interventions from 2007 to 2018 and chose studies that reported the racial demographic features of their samples. They evaluated the studies based on representation and design and methods. The interventions investigated were placed into levels between one and five, where level one refers to a well-established intervention, level two is a probably efficacious intervention, level three is a possibly efficacious intervention, level four is considered an experimental intervention and level five is a questionable intervention. With regards to representation there was a criteria of at least 75% minority representation and this criteria was met by 27 studies for Hispanic/Latino youth, 19 studies for Black youth and one study for Asian American youth and 18 studies for multi-ethnic youth. With regards to analyses, 7 studies utilized subgroup analyses and 16 evaluated if race was a moderator. They identified four interventions as well-established for Hispanic/Latino and Black youth and eight interventions as probably or possibly efficacious.

However, one important point that the authors made in this article was the need for more representation of minoritized youth in samples and the need for more analyses on the impact of race on the effectiveness of treatment. This supports the findings from the Sinclair et al. (2018) study which also found that some minoritized populations are underrepresented in educational research.

Reporting Racial Demographics and Effectiveness Across Race

Gaias et al. (2020) conducted a similar systematic review of research on educational intervention research with students in elementary and middle school. However, their review investigate several aspects of educational research including 1) the prevalence of reporting race or ethnicity, 2) examining interventions for effectiveness across race and 3) having samples that are representative of the US population. The researchers only utilized studies that met the What Works Clearinghouse design standards and of the 785 intervention studies published between 2000 and 2020 that met these standards they randomly chose 96 studies. Additionally, they examined 210 meta-analyses on the effects of interventions. With regards to their first research question on reporting race/ethnicity they found that of the intervention studies 62.5% reported complete details on race/ethnicity, 10.4% reported partial details and 27.1% reported no details on race/ethnicity. Of the meta-analyses that they examined, 3.8% reported full details on race/ethnicity, 2.4% reported partial details on race/ethnicity and 93.8% reported no details on race/ethnicity. Their second research question asked about diverse racial groups being included and represented in educational intervention research. They found that while White students were included in 89.9% of the empirical studies and 84.6% of the meta-analyses that reported race, but were underrepresented in samples when compared to the U.S. public school attending population. Black students were included in 80% of the empirical studies and 84.6% of the meta-analyses that reported race and were overrepresented compared to the U.S. public school attending population. Hispanic/Latinx

students participated in 69.5% of the empirical studies and 53.8% of the meta-analyses that reported race or ethnicity and were underrepresented compared to the US public school attending population. Asian/Pacific Islander students were included in 32.9% of the empirical studies and 15.4% of the meta-analyses that reported race or ethnicity and were compared to the US public school attending population. Lastly, Native American students were included in 15.7% of the empirical studies and 23.1% of the meta-analyses that reported race or ethnicity and were also underrepresented compared to their US public school attending population. Lastly, they looked at the extent to which educational intervention research examines the effectiveness of interventions across race or ethnicity. Of the 96 empirical studies that they examined only 18 (18.8%) conducted analyses that could potentially inform on the effectiveness of the interventions for diverse students and of these 18 only 15 conducted sub-group analyses. Of 210 the meta-analyses, only 13 (6%) conducted analyses that could potentially inform on the effectiveness of the interventions for diverse students. Overall, the majority of empirical studies are reporting the race or ethnicity of their samples, though this does not seem to be reflected in meta-analyses which mostly leave out demographic information like race or ethnicity. African-American students are being overrepresented in samples (which supports the findings from the Sinclair et al., 2018 systematic review which noted the same overrepresentation) while Asian American, Hispanic/Latinx, Pacific Islander and Native American students are underrepresented in samples. However, this overrepresentation does not equate to equitable consideration of race in intervention research. Though researchers are including more of this minoritized population into their samples, only a few studies actually examined the differential effectiveness of interventions based on race. This shows that sampling representation may be improving for Black students in particular but this has not translated to more nuanced analyses on the potential for interventions to reduce disparities between racial groups.

Additionally, the focus on including more minoritized students seems to only focus on Black students and has not extended to other minoritized populations. The main concern highlighted by this systematic review is the lack of research on the effects of interventions on reducing disparities. Only 18.8% of the empirical studies and 6% of the meta-analyses conducted any analyses to look at the differential effectiveness of interventions across race.

Similar to the Gaias et al. (2020), Cipriano et al. (2022) conducted their own systematic review to investigate the how studies reported their findings on students with disabilities and minoritized students. Their systematic review focused on studies of elementary schools universal school-based social-emotional learning interventions from 2008-2020 and analysed 269 studies on universal elementary school social-emotional interventions. Their results showed that there is little known about the effectiveness of universal social-emotional learning interventions on minoritized elementary students. Only about 28% of the studies explicitly analysed the effectiveness of universal school based social-emotional learning interventions on racially minoritized students. This systematic review supports the findings of the Gaias et al. (2020) systematic review. Though Cipriano et al. (2022) found a higher percentage of studies that examined the differential impact of interventions across race, 28% versus 18.8%, both of these studies highlight the lack of research into the potential for interventions to reduce racial disparities and address the increased mental health needs of minoritized students.

Overall, there is much need for improvement in school-based intervention research. The systematic reviews discussed in this section (Cipriano et al., 2022; Gaias et al., 2020; Sinclair et al., 2018) revealed that educational research is using samples that underrepresent several minoritized populations and few studies are examining interventions for differential effectiveness across race or ethnicity. Research has made some strides, as these reviews also noted that most studies published recently tend to report the race or ethnicity of their samples.

However, there is much work that must be done to truly meet the mental health needs of minoritized youth. Educational researchers must go beyond simply reporting the demographic features of their samples, they must study the effect of these interventions on minoritized students.

Impacts of Culturally Relevant Interventions

Improvements in educational research are an important factor in reducing racial disparities in schools and addressing the unmet mental health needs of minoritized students. Another important factor is adapting interventions to be culturally relevant to diverse students. Cultural adaptations of interventions has been defined as "the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture and context in such a way that it is compatible with the client's cultural patterns, meanings and values" (Bernal et al., 2009, pp. 362). Hendriks and Graafsma (2019) proposed a four phase process for adapting interventions to be more culturally appropriate, as well as 17 guidelines to consider during this process. The four phases include the inventory phase, where research is conducted on the target population, the adaptation phase, when the research collected in the previous phase is used to choose appropriate activities and make appropriate adaptations, the implementation phase, when the logistics of the intervention are planned and the evaluation phase, when the intervention is assessed for effectiveness (Hendriks & Graafsma, 2019). The most common ways that social, emotional and behavioral interventions have been adapted for students of color include adapting the language of the intervention, adapting intervention content to match the values of the target population, adapting the location of the interventions and matching the interventionist to the target population (Brown et al., 2018).

There are several studies that have shown the benefits of culturally adapted interventions on the outcomes of diverse students. Case in point, Cramer and Castro-Olivo

(2016) examined the outcomes of a culturally adapted social-emotional learning curriculum. The participants included 20 students in ninth and tenth grades, 16 of the students were male and 4 female. The racial demographics of the sample was 75% Latino/Hispanic, 15% African-American and one participant identified as Caucasian. Additionally, 25% of the sample were born in Mexico, 35% reported their primary language as English, 40% identified Spanish as their primary language and 25% identified both English and Spanish as their primary language. The interventionists adapted the Strong Teens curriculum using the recommendations of Bernal et al. (1995). These adaptations included using culturally appropriate language, identifying the needs of the students, using cultural metaphors and explaining metaphors that the students may not understand, encouraging students to reflect on their own values and how these are connected to the skills they are learning, introducing concepts that relate to the target group, use cultural knowledge to align procedures and considering culture-specific experiences. The results of the study indicated that the culturally adapted intervention was effective at increasing resilience and that this resilience was maintained two-months post-intervention. Though the researchers did observe a decrease in internalizing behaviors, this decrease was not statistically significant. However, most students in the study indicated high levels of treatment acceptability, in that they liked the treatment, would recommend the treatment to peers, agreed that the treatment was designed for students like them. This aspect of the study is especially relevant as it is directly related to retention. One of the reasons behind the disparity in mental health services is the early departure of minoritized students from interventions and this early departure stems from feeling like they can not talk about their cultural experiences and like their interventionist does not understand them. However, the outcomes from this study shows that these beliefs can be mitigated through cultural adaptations.

Hernandez et al. (2018) developed an eight week positive psychology intervention that was adapted to Hispanic/Latino adults and examined it for feasibility and acceptability. Adaptations included: the addition of religious content, incorporating religion into activities and adapting the language of the intervention to suit the Spanish speaking participants. The participants were 16 Hispanic/Latino adults with two or more risk factors for cardiovascular disease. Sixty-eight percent of the sample were female and the mean age was 54 years old. The eight week intervention was delivered by a bilingual clinical social worker and included activities around topics like personal strengths, positive events, gratitude, altruistic behaviour, mindfulness, positive appraisal and attainable goals. The researchers measured the participants' blood pressure at the beginning and end of the intervention, their physical activity was measured throughout the intervention using an accelerometer. Additionally, participants completed self-reports on emotional and psychological well-being, subjective health status, happiness and overall psychological functioning. These measures were also taken at the beginning and end of the intervention. The results of this study reported that 97% reported satisfaction with the intervention, 98.5% reported satisfaction with the skills taught, 98.5% reported satisfaction with the in-session activities and 98.6% reported confidence in their ability to use the skill in their life. At post-intervention, 73% showed improvement in the use of happiness-inducing behaviors, 54.5% showed improvements in emotional vitality and 27.3% showed improvement in subjective well-being. However, only the increases in emotional vitality and subjective well-being were statistically significant. This study shows that culturally adapted interventions can have positive impacts on minoritized individuals. Additionally, it supports the idea that culturally adapted interventions are acceptable to minoritized individuals. Similar to the Cramer and Castro-Olivo (2016) study, the intervention had high social validity with the participants which would positively impact the retention rates of minoritized individuals.

Similar to Hernandez et al. (2018), Hendriks et al. (2020) evaluated the effectiveness of a culturally adapted positive psychology intervention. The study was completed in the Caribbean country of Suriname and was a parallel single-blinded randomized control trial that had an active intervention group and a wait list control group. There were 158 participants from three different companies, 39.3% of the sample was male and 60.7% were female. The mean age of the sample was 36.53 years. The researchers asked the participants to complete self-report measures on several different areas including resilience, mental well-being, depression, anxiety, stress, psychological flexibility, financial distress, positive and negative affect and client satisfaction. The researchers adapted the Strong Minds program following the guidelines for cultural adaption by Domenech-Rodriguez and Wieling (2004). They reduced the number of sessions from 12 to six, changing assessment measures, rebranding sessions to appeal to the participants, using interventionists who had similar demographics to the participants, developing a new session based on research on the target group and adapting the language in the manual. The results showed that the intervention was better than the waitlist condition as they found increases in resilience, mental well-being, positive affect and decreases in depression, anxiety and negative affect. There were not significant decreases in stress or financial distress or significant increases in psychological flexibility. The researchers also reported that the attendance rates of the participants was moderate, with 40% of the sample attending all six sessions. Though attendance was low, this may have been due to external causes like scheduling issues or conflicts since the study was completed with adults. Though the attendance rate was moderate, 94% reported that they were satisfied with the program and 95% reported that they would recommend the program to a friend. However, 50% of the participants reported that the program did not meet their specific needs. This may have been due to the fact that the program was not individualized for each participant but was instead a group intervention and thus would not address unique

issues faced by participants. Overall, this study supports the findings of previous studies that culturally adapted interventions are effective and have high acceptability with minoritized populations.

Kurtz et al. (2022) investigated the effectiveness of the Strong Kids intervention on reducing internalizing behaviors after it was culturally adapted to the culture of the community in which the elementary school resided. The researchers first conducted a focus group with 10 stakeholders which included parents, classroom teachers, specialist teachers and school psychologists. The themes that came from this focus group included revising the curricula to increase its relevance to events occurring in the community and supporting children needs through communicating with parents, address concerns held by parents and teaching the children to generalize the skills to multiple settings. The researchers used the ecological validity model of Bernal et al. (1995) to review and revise each of the lessons in the Strong Start and Strong Kids interventions by Merrell. Adaptations included: using culturally relevant examples during activities, adding more opportunities for parent and teacher communication and encouraging students to use their primary language during the intervention They implemented the adapted Strong Kids intervention with 43 elementary school students in kindergarten through to fifth grade and measured their internalizing behaviors at pre and post intervention. Results from this study showed a decrease in negative affect from pre to post intervention and indicate improvements in internalizing issues. This adds to the support for the effectiveness of culturally adapted interventions and shows that these interventions have positive impacts on behaviour. A stronger design- but lacking in the literature- might involve a direct comparison of an adapted intervention to its non-adapted version.

Overall, the research on the effectiveness of culturally adapted interventions shows that they are beneficial for minoritized youth. However, none of the studies on the

effectiveness of culturally adapted interventions compared the adapted version of the intervention to the non-adapted version of the intervention. This is a gap in the literature that means that we can acknowledge the benefits of culturally adapted interventions but cannot currently state that they are better than the non-adapted version. The studies indicated that there were positive outcomes for participants and that the acceptability of the treatment was high. Both outcomes are important to note but the acceptability of the treatment is especially relevant in this discussion. One of the reasons behind the disparity in mental health provision between White students and minoritized students is the early departure of minoritized students (Whitaker et al., 2018). They are often treated by White female clinicians (Cabral & Smith, 2011), and may feel like their unique life experiences will not be understood by someone outside of their race or ethnicity (Cabral & Smith, 2011; Chang & Yoon, 2011). However, culturally adapted interventions can address this and help minoritized students to feel like they are understood and thus increase the likelihood that they will remain in treatment. One specific area of interventions that this study will focus on are positive psychology interventions which aim to increase the subjective well-being of students.

Positive Psychology

Positive psychology was first conceptualized as a response to psychology's focus on reducing mental health concerns (Seligman & Csikszentmihalyi, 2000). While the focus on addressing mental health concerns (i.e., psychopathology) has led to significant advances in mental health research and treatment, positive psychology focuses on the second factor of the dual factor model, enhancing subjective well-being. Subjective well-being can be separated into several components including life satisfaction—either globally or satisfaction with life domains (e.g., work, home, school)—positive affect, and negative affect. Subjective well-being is considered high when there is frequent positive affect and relatively infrequent negative affect, basically when there are more pleasant experiences than negative ones.

In 2005, Lyubomirsky et al. proposed a three-factor model, called the happiness pie (due to reference to a pie chart), to explain determinants of subjective well-being which proposes that 50% of variability in happiness levels is explained by genetic factors, 10% of happiness is explained by life circumstances and 40% of happiness is explained by voluntary activities. Though this happiness pie has been used by positive psychology researcher since it was created it has recently undergone criticisms. Brown and Rohrer (2020) criticized the model on the lack of an error term and on the breakdown of the pie. They argued that the contribution of life circumstances to happiness are underestimated while the contribution of genetics and voluntary activities is overestimated and other contributions (e.g., prenatal development effects) are ignored. However, the criticisms of the model are largely based on the contributions of voluntary activity on happiness, and does not negate the impact that voluntary activity has on happiness and thus positive psychology continues to use positive activities as the basis for increasing subjective well-being. In response to the criticisms, Sheldon and Lyubomirsky (2021) draw attention to the benefits of intentional activity and effort on subjective well-being. They agreed that there were issues with the original happiness pie but noted that individuals who invested effort into positive activities did experience improvements in their subjective well-being (Sheldon & Lyubomirsky, 2021). Indeed, recent advances in the literature provide support for the efficacy of positive psychology interventions, and provide guidance on pathways by which positive activities indeed lead to lasting gains in subjective well-being (Donaldson, Cabrera, & Gaffaney, 2021).

Positive psychology interventions are treatments that focus on increasing positive feelings, cognitions or behaviour (Bolier et al., 2013). These interventions can be delivered as group interventions, individual therapy or as self-guided for instance through self-help books. Positive psychology interventions are used in schools (for a review, see Tejada-Gallardo et

al., 2020) for several different reasons. Children spend a significant amount of time in school which makes it a logical setting for mental health services. Additionally, adolescence is a common period of time for mental health concerns to emerge (Briggs, 2009; Macleod & Brownlie, 2014). According to Suldo (2016) approximately 13% of students in grades six through eight fall within the troubled category of the dual-factor model and are experiencing low subjective well-being and elevated psychopathology. These students need treatment that addresses both areas of their mental health needs, the symptoms of psychopathology as well as the low subjective well-being.

Positive Psychology Interventions

Shoshani and Steinmetz (2014) examined a yearlong school-based positive psychology intervention to investigate the effect of the intervention on student mental health outcomes, including self-efficacy, optimism, life satisfaction, psychological distress and mental health symptoms. This study was conducted in Israel and included 537 seventh and ninth grade students who participated in a yearlong positive psychology intervention and were compared to 501 students from another school who comprised the control group. The authors reported that in the intervention group 65 of the students left the study before completion (34 due to absence, two due to incomplete questionnaires and 29 dropped out at some point during the intervention). In the control group 59 students left the study before completion (22 due to absence, 4 due to incomplete questionnaires and 33 started the study then dropped out later). The intervention was administered by teachers and consisted of 15 sessions. The results showed that participation in the positive psychology intervention was associated with decreases in general distress, anxiety and depressive symptoms. Students who participated in the intervention also experienced increases in self-esteem, self-efficacy and optimism. This shows the potential for school-based positive psychology interventions to target internalizing concerns as well as enhancing subjective well-being. However, it is

notable that the authors did not report the demographic characteristics of the students who withdrew from the study. As was mentioned previously in this literature review, early departure is one of the reasons behind the disparities in mental health services for minoritized students. More information on the students who withdrew would have been helpful in determining what types of students decided to depart the study before completion.

Tejada-Gallardo et al. (2020) conducted a meta-analysis on school-based positive psychology interventions. They reviewed nine studies with a collective sample of 4,887 participants with an age range of 10-18 years old, 54% of whom were female while 46% were male. The interventions in the nine studies were all administered in groups, and the lengths of the interventions ranged from four weeks to 30 weeks. They found that multicomponent positive psychology interventions, which are interventions that target two or more components of subjective well-being through a variety of activities, have a small effect size on subjective well-being ($g = 0.24$), psychological well-being ($g = 0.25$), and depression ($g = 0.28$). However, multicomponent positive psychology interventions that were paired with another positive intervention (e.g., anxiety management strategies and Well Being Therapy) had large effects for subjective well-being and depressive symptoms. This meta-analysis shows the positive impact that positive psychology interventions, especially multicomponent positive psychology interventions, can have on the subjective well-being of students. However, as was noted with the Shoshani and Steinmetz (2014) study, this article did not include information on retention rates of the studies included in the meta-analysis or the demographics of students who withdrew from the studies.

Donaldson et al. (2021) conducted a systematic review of randomized controlled trials that evaluated the efficacy of positive psychology interventions. They analysed 25 meta-analyses, 42 review papers to find high quality randomized control trials of positive psychology interventions. They identified 23 studies within eight papers that met their

criteria. From these studies they found that positive psychology interventions have small to moderate effects on subjective well-being, psychological well-being, anxiety, stress and depression. They also found that individualized one-on-one interventions were associated with better outcomes than self-help or group, multicomponent interventions had better outcomes than single component interventions, older participants showed larger effects than younger participants, women showed greater effects than men and clinical participants showed greater effects than non-clinical patients. The authors also reported that participants from non-Western, Educated, Industrial, Rich and Democratic (non-WEIRD) countries showed greater effects than participants from WEIRD countries, though it was noted that the quality of the studies from non-WEIRD countries were lower than those from WEIRD countries. Overall, the authors noted that positive psychology intervention have the potential to increase well-being across diverse populations; however, more research needs to be conducted in this area. The review identified 14 promising interventions, but all of them were conducted in WEIRD countries. This shows that the need for research with diverse populations includes both minoritized individuals as well as individuals from non-WEIRD countries. However, as with the other articles included in this section of the literature review, the authors did not include information on the retention rates of the studies included in the systematic review.

Khanna and Singh (2019) recognized the need for diversity in positive psychology research and conducted positive psychology interventions with Indian adolescents to investigate the effectiveness of positive psychology intervention with youths living in India. The study included 372 students with an age range of 11-13 years. The authors did not report any students withdrawing from the study, other than the 8 students excluded from the original 380 recruited students due to their absence. Fifty-six percent of the sample were male and participants were from two different schools across 12 different classrooms in India. The

researchers chose five interventions from the positive psychology literature with prior support for improving happiness: three good things in life, gratitude visit, you at your best, using signature strengths and using signature strengths in a new way. Each of these interventions were randomly assigned to a classroom, as well as one placebo control intervention (recalling early memories). The researchers collected pre and post data through self-reports on well-being, affect, happiness and depressive symptoms. They found that the gratitude visit and signature strength-based interventions were associated with increases in well-being, life satisfaction and happiness, however the other positive psychology interventions (like "you at your best" and "three good things") had no impact on the outcome variables. The authors hypothesized that the gratitude visit and signature strengths activities were effective because of the positive interaction and feedback associated with the two activities. Whereas the you at your best and three good things activities may have been less effective due to their writing components which may have been negatively perceived due to their similarity to classwork. However, the results from this study shows that some positive psychology interventions have the potential to enhance the subjective well-being of students across cultures. However, more research needs to be done to further investigate the effectiveness of these interventions for diverse students as well as ways to culturally adapt the interventions to be more culturally relevant, as not all intervention traditionally assumed to translate to gains in subjective well-being effectively did so in this study.

Overall, the research on positive psychology interventions shows that they have positive impacts on well-being for youth (Shoshani & Steinmetz, 2014; Tejada-Gallardo et al., 2020; Khanna & Singh, 2019) and adults (Donaldson et al., 2021). However, positive psychology was first conceptualized and studied in Western countries by White individuals and were based on Western ideologies and assumptions that may not be relatable or relevant to students from diverse backgrounds. The research also shows that there is a lack of research

on the effectiveness of positive psychology interventions across diverse populations, both minoritized individuals as well as individuals from non-WEIRD countries (Donaldson et al., 2021; Khanna & Singh, 2019). Additionally, it was noted that one of the studies (Shoshani & Steinmetz, 2014) and both the systematic review and meta-analysis lacked detailed information on retention rates and the demographics of students who withdrew from the studies. This information would have been helpful in examining the retention of minoritized students in positive psychology interventions (Donaldson et al., 2021; Tejada-Gallardo et al., 2020).

Overview of the Well-Being Promotion Program

The Well-Being Promotion Program (WBPP) is a school-based positive psychology intervention to improve the subjective well-being of students at the Tier I or Tier II levels (Suldo, 2016). This intervention includes 10 core sessions, often delivered across 10 weeks, and is a multicomponent intervention based on Seligman's (2002) happiness framework. Across the 10 sessions students engage in several different activities intended to evoke positive feelings about the past, present, and future, including: me at my best, gratitude journaling, gratitude visits, acts of kindness, discussing character strengths, using signature strengths in new ways, savoring, optimistic thinking, and best possible self in the future. In addition to the in-session activities, students are also given take home challenges to complete to increase the likelihood that the intervention will result in changed behaviour.

The WBPP was first evaluated by Suldo et al. (2014) for its effectiveness at increasing the subjective well-being of middle school children. The authors reported that 42% (55 of 132) of students recruited enrolled in the study (i.e., had parent consent and student assent to participate). The participants included 55 sixth grade students between the ages of 10-12 years who were randomly assigned to either the treatment group or a waitlist control group. The racial breakdown of the intervention group sample was 25% White, 15% Black,

25% Asian, 30% Hispanic/Latino and 5% Native American. Of this sample, 60% were female and 40% were male and 40% identified as low socio-economic status. The racial breakdown of the control group was 40% White, 10% multiracial, 5% Asian, 30% Hispanic/Latino, 5% Native American and 10% other racial/ethnic group. The results from this study showed that participation in the WBPP intervention group was associated with significant gains in life satisfaction between pre and post intervention. Specifically, the treatment group showed a significant increase in life satisfaction while the control group showed a decrease in life satisfaction during the same time period. Additionally, most of the students (86%) identified activities from the intervention as the most important aspects of the WBPP. These results show that the WBPP is effective at improving the life satisfaction of students and is perceived by this diverse group of early adolescents as an acceptable intervention. The authors also reported the retention rate for the study and indicated that 10 students withdrew from the program during the 10 week intervention, eight because they moved from the area and two because they preferred to attend class. The high acceptability by most students and high retention rates (only two students withdrew due to personal reasons) may indicate that there is high treatment acceptability for minoritized students as well which is an important factor to consider given the previous discussion on retention of minoritized students in school-based treatment. However, further research needs to be done to examine the retention rates of minoritized students as well as its acceptability with this population of students. Additionally, the study did not examine the differential effectiveness of the intervention across race. This is another area that needs to be further researched to determine the effect of this intervention on minoritized students.

Roth et al. (2017) examined the efficacy of an expanded version of the WBPP by examining the impact of the intervention on youth subjective well-being as well as internalizing and externalizing symptoms. The authors reported that 38% (42 of 111) of

students recruited enrolled in the study. The participants in this study were 42 seventh grade students with ages between 11-13 years. The demographic features of the sample were 50% male, 83.3% White, 9.5% Black, 2.4% Asian/Pacific Islander, 21.4% Hispanic and 4.8% other. The WBPP was expanded by including (a) a parent component and (b) monthly follow-up sessions after the 10th core session concluded. The parent component included a one-hour session on the psychoeducation of the intervention, and the two follow-up sessions occurred in the two months after the participants completed the intervention. In this study, youth participants were randomly assigned to a treatment group or a delayed treatment control group. Regarding retention in the intervention, the authors did not include explicitly report retention data in their article however, 20 of the 21 students in the intervention group attended all 12 sessions suggesting minimal if any attrition. Further, students expressed high acceptability for the intervention. The researchers also found that there were significant increases in subjective well-being and positive affect for the students in the intervention group. The gains in positive affect were also maintained at two months follow-up. This supports the findings of the earlier study conducted by Suldo et al. (2014). In both studies the participants in the intervention group experienced an increase in subjective well-being and the participants indicated high acceptability of the intervention. Notably, this study also did not report the differential effectiveness of the WBPP across demographic groups such as minority status (whether the student is a member of a minoritized group or not).

Lenz et al. (2020) conducted a mixed methods study to examine the effectiveness of the WBPP with elementary school children. They specifically looked at the outcomes of the intervention on protective factors (self-concept and self-confidence) and life satisfaction and the experiences of the students during the intervention. The participants were sampled from a predominantly Hispanic, bilingual elementary school in Central Southern United States. There were 34 children in fourth or fifth grade with a mean age of 10. Of this sample 47%

were female, 68% were Hispanic, 24% were White, 6% were Asian American and 2% were Black; 53% spoke Spanish as their first language and 47% spoke English as their first language. The authors did not include any information on retention rates. The authors implemented an adapted version of the WBPP that consisted of nine sessions across five weeks instead of the original 10 sessions often delivered on a weekly basis. The participants completed the Individual Protective Factors Index (IPFI) and the Satisfaction With Life Scale for Children (SWLC) at preintervention and postintervention and participated in a focus group interview at postintervention. From the quantitative side of the study, they found an increase in protective factors associated with completion the positive psychology intervention and, though the difference in scores from preintervention to postintervention was not statistically significant, it had a medium effect size of d=0.53. They also found a strong relationship between protective factors and subjective well-being (r = .39, p= .01). From the qualitative side of the study they found three main themes from the focus group interviews with the participants: improved emotional expression, enhanced self-discovery and increased empathy. The authors hypothesized that the three themes are related to the increase in protective factors. This study again shows the potential benefits of the WBPP to students. The relationship between protective factors and subjective well-being may indicate that the WBPP is associated with increases in subjective well-being and may also reduce the likelihood of a student developing mental health concerns. However, as with many of the studies in this literature review, the authors did not examine the effectiveness across minority status.

Overall, these studies show that the WBPP is an effective intervention that is associated with increases in well-being. However, there is a gap in the literature on this intervention. No studies have been conducted to examine this intervention for its acceptability and effectiveness within minoritized students. Is the WBPP perceived as

culturally relevant by participants from minoritized groups? In what ways does the intervention align with the participants' cultures and in what ways does it not? This is an important aspect of intervention research because minoritized students have increased need for mental health services but are less likely to have their mental health needs met than their White counterparts. Additionally, though the retention rates were reported in one of the studies (Suldo et al., 2014), it was not reported in the other studies and was not analysed by demographic subgroups to determine the retention of minoritized students. The proposed study will address these gaps in the literature by examining the effectiveness of the WBPP across race, the cultural relevance of the WBPP as perceived by minoritized students and the retention rates of minoritized students.

Chapter Three: Methods

This dissertation analysed data collected during Year 1 (2021-22 school year) and Year 2 (2022-23 school year) of a larger 5-year efficacy study conducted by research teams in both Florida and Massachusetts. The Florida team consisted of professors and graduate students from the University of South Florida and the Massachusetts team consisted of professors and graduate students from the University of Massachusetts, Amherst. The larger study was focused on evaluating the efficacy of the WBPP with students in middle school from grades five through eight in schools at both the Florida and Massachusetts sites and is funded by the Institute of Educational Sciences (R305A200035). This current study analysed student outcome data from Years 1 and 2, as well as qualitative data from individual interviews conducted during Year 2 with students, interventionists, and coaches at the conclusion of the intervention delivery. This study used mixed methods to analyse the quantitative data of the student outcomes as well as the qualitative data from the exit interviews.

Participants

The quantitative portion of this study examined the data from 302 middle school students assigned to the intervention condition in a randomized control trial (RCT) to evaluate a Tier 2 positive psychology intervention for students with low subjective well-being. The data from all 302 students were utilized to answer research question one on equity in enrollment. However, by the end of the study 16 students were removed from the dataset leaving 286 students in the sample (5% attrition, and 95% retention) for research question two. Of the 16 students one was Black or African American, one Asian, ten were White, four were Hispanic and one was Bi/Multiracial. Of the 16 students, 12 moved from the school or

decided to discontinue and four students completed the intervention but were not available to complete the post-intervention assessments and thus could not be included in the outcome analysis for research question two.

Student participants were identified in a schoolwide screening of self-reported subjective well-being. Students were identified based on life satisfaction scores that indicated low subjective well-being, operationalized as a mean score below 5.0 on the Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS; Seligson et al. 2003, described below). Additionally, these students had a mean score below 5.5 on the Students' Life Satisfaction Scale (SLSS; Huebner, 1991) and positive affect scale below 4.5 on the Positive and Negative Affect Schedule for Children (PANAS-C-10; Ebesutani et al., 2012). The students were in grades five through eight in eight middle schools in Florida and Massachusetts and the data was collected during the 2021-2022 and 2022-2023 academic years. Please see Table 1 for the demographic features of the schools as reported by the National Center for Education Statistics (NCES) based on data from the 2021-2022 school year, compared to the demographic features of the sample of student participants. The data collected by NCES on race was based on parent report while the sample data on race was based on student self-report. Please see Table 2 for other demographic data on the student sample including grades, gender, schools and states.

Table 1
*Racial Demographic Features Reported from NCES and Sample**

State	School	Year (1 or 2)	Race	NCES N(%)	Sample N(%)
FL	1	1	American Indian/Alaska Native	5 (0.4%)	0 (0%)
			Asian	40 (3.25%)	3 (6%)
			Black	197 (16%)	11 (23%)
			Hispanic	390 (32%)	7 (15%)
			Native Hawaiian/Pacific Islander	8 (1%)	0 (0%)
			White	514 (42%)	19 (39%)
			Bi- or multi-racial	76 (6%)	8 (17%)
MA	2	1	American Indian/Alaska Native	1 (0.17%)	0 (0%)
			Asian	19 (3.3%)	1 (2%)
			Black	23 (4%)	1 (2%)
			Hispanic	98 (17%)	4 (9%)
			Native Hawaiian/Pacific Islander	-	0 (0%)

Table 1 (Continued)

			White	388 (68%)	34 (77%)
			Bi- or multi-racial	45(8%)	4 (9%)
MA	3	1	American Indian/Alaska Native	-	0 (0%)
			Asian	31 (8%)	1 (2%)
			Black	29 (7%)	2 (5%)
			Hispanic	71 (17%)	3 (7%)
			Native Hawaiian/Pacific Islander	-	0 (0%)
			White	252 (61%)	33 (75%)
			Bi- or multi-racial	28 (7%)	5 (11%)
FL	4	2	American Indian/Alaska Native	5 (0.5%)	0 (0%)
			Asian	12 (1%)	0 (0%)
			Black	130 (13%)	6 (12%)
			Hispanic	275 (27%)	13 (25%)
			Native Hawaiian/Pacific Islander	0 (0%)	0 (0%)
			White	540 (54%)	29 (57%)
			Bi- or multi-racial	57 (6%)	3 (6%)
FL	5	2	American Indian/Alaska Native	0 (0%)	0 (0%)
			Asian	5 (0.6%)	1 (2%)
			Black	118 (14%)	6 (12%)
			Hispanic	372 (43%)	14 (27%)
			Native Hawaiian/Pacific Islander	2 (0.2%)	0 (0%)
			White	349 (40%)	23 (45%)
			Bi- or multi-racial	26 (3%)	7 (14%)
MA	6	2	American Indian/Alaska Native	-	0 (0%)
			Asian	19 (3%)	2 (6%)
			Black	17 (2.5%)	0 (0%)
			Hispanic	115 (17%) 18	7 (21%)
			Native Hawaiian/Pacific Islander	1 (0.15%)	0 (0%)
			White	498 (74%) 78	23 (70%)
			Bi- or multi-racial	19 (2.8%) 3	1 (3%)
MA	7	2	American Indian/Alaska Native	2 (0.3%)	1 (3%)
			Asian	25 (4%)	0 (0%)
			Black	18 (3%)	2 (5%)
			Hispanic	132 (19%)	9 (23%)
			Native Hawaiian/Pacific Islander	-	0 (0%)
			White	480 (71%)	23 (59%)
			Bi- or multi-racial	21 (3%)	4 (10%)
MA	8	2	American Indian/Alaska Native	1 (0.2%)	0 (0%)
			Asian	9 (2%)	3 (12%)
			Black	9 (2%)	0 (0%)
			Hispanic	97 (18%)	3 (12%)
			Native Hawaiian/Pacific Islander	-	0 (0%)
			White	412 (77%)	15 (60%)
			Bi- or multi-racial	8 (1.5%)	4 (16%)

**The school population data was provided by NCES (https://nces.ed.gov/ccd/schoolsearch/) which collects race data as reported by parents when they enroll their children in the school. The Sample data on race was self-reported by child in a demographics survey.*

Table 2

Demographic Features of Students in Intervention Condition of the RCT

Demographic Variable	Student N(%)
Grade	
5th	25 (8%)
6th	87 (29%)
7th	98 (32%)

Table 2 (Continued)

8th	93 (31%)
Gender	
Female	161 (53%)
Male	109 (36%)
Non-binary	21 (7%)
Other	12 (4%)
School	
1 (FL)	48 (16%)
2 (MA)	33 (11%)
3 (MA)	21 (7%)
4 (FL)	51 (17%)
5 (FL)	51 (17%)
6 (MA)	33 (11%)
7 (MA)	41 (13%)
8 (MA)	25 (8%)
State	
FL	150 (49.5%)
MA	153 (50.5%)

The qualitative portion of this study reviewed and analysed data from exit interviews with a subset of participants in the Year 2 sample. This subset ultimately included nine students, four school mental health providers (SMHP), and three coaches. The author used a stratification process to identify the students included in this subset. First, the sample was modified so that it only included diverse students. According to this study diverse students were any non-White students which included Hispanic, Black, Asian and Bi/Multiracial students. The sample of Year 2 students who identified as non-White was predominantly female, with 60 of the 86 students identifying as female, 6 students identifying as non-binary, one identifying as other and 19 identifying as male. The second step was to examine students' ratings of intervention acceptability and examine distribution of scores. The third step was to choose three students in the lowest percentile (30th percentile and lower), three students near the middle percentile (50th percentile) and three students in the highest percentile (70th percentile and higher) of intervention acceptability ratings. The last step was to screen the transcripts of exit interviews completed with the randomly chosen students. The screening process focused on the amount of detail and explanation included in the students'

responses. If a student's responses were monosyllabic or the student was unable to articulate reasons for their responses even when prompted, then the transcript was rejected and the next student was chosen and their transcript reviewed. There was some variability within the transcripts that were rejected; some students were monosyllabic for the entire interview, while others became less talkative when they were asked about their culture. The author would like to note that some of the students may have felt uncomfortable discussing culture and race with strangers and that is why they became monosyllabic and thus had their transcripts rejected. In future studies, researchers may want to invest more time in building relationships with students before having conversations of this nature. The author ultimately screened 25 transcripts until nine transcripts were identified that had detailed explanations and full responses. The 25 transcripts considered included 17 female respondents, five male respondents, one respondent who indicated "other" as their gender identity and two non-binary respondents. Please see Table 3 for the demographic features of the students chosen for the qualitative portion of this study. The four SMHP were then chosen because they provided the WBPP intervention to the nine identified students, please see Table 4. And, lastly, the three coaches were chosen because they provided coaching for the four SMHP, please see Table 5.

Table 3
Students Chosen for Qualitative Analysis

Child Id	Percentile Rank	Acceptability Score	State	School	Grade	Gender	Race/Ethnicity
			Low Acceptability				
Eleanor	0.10	1.00	FL	4	7	Female	Hispanic/Latino
Ava	0.20	2.22	MA	6	6	Female	Hispanic/Latino
Charlie	0.30	3.00	FL	4	7	Non-binary	Hispanic/Latino
			Moderate Acceptability				
Mia	0.40	3.67	FL	4	7	Female	Bi/Multiracial
Amelia	0.40	3.67	FL	4	8	Female	Bi/Multiracial
Sophia	0.60	3.78	FL	4	7	Female	Black
			High Acceptability				
Evelyn	0.70	4.33	MA	6	5	Female	Hispanic/Latino
Emma	0.80	4.56	FL	5	7	Female	Asian
Maya	0.80	4.56	MA	6	8	Female	Bi/Multiracial

Table 4
School Mental Health Providers Chosen for Qualitative Analysis

SMHPs	Coached by	State	School	Gender	Race/Ethnicity
Emmett	Aida	FL	4	Male	Black or African American
Alice	Luna	MA	6	Female	White
Adam	Luna	MA	6	Male	White
Grace	Olivia	FL	5	Female	White

Table 5
Coaches Chosen for Qualitative Analysis

Coaches	Associated SMHPs	State	Gender	Race/Ethnicity
Olivia	Grace	FL	Female	White
Aida	Emmett	FL	Female	Asian
Luna	Adam Alice	MA	Female	White

Data Collection Procedure

In FL, this study used passive consent for screening during Year 1 and active consent for screening during Year 2 to acquire parent permission for students in the selected schools to participate in the universal screening of emotional well-being (see Appendix A and C for active and passive parent consent forms). During Year 1 using passive consent, caregivers were notified of the upcoming screening and only those who indicated they did not want their child to take part were excluded. Recruitment occurred in three schools during Year 1, Schools One, Two and Three. In School One, 936 completed the screening survey which was 77.4% of the student population. With regards to the students who did not complete the survey 8.4% of caregivers opted out of the study and 14.1% of the students were absent throughout the screening process. In School Two, 507 students completed the screening which was 87.5% of the student population. With regards to the students who did not complete the screening, 6.9% of caregivers opted out of the study and 5.5% of students were absent throughout the screening process. Lastly, in School Three, 325 students completed the screening which was 78.9% of the student population. With regards to the students who did

not complete the screening, 5.6% of caregivers opted out of the study and 15.5% of the students were absent throughout the screening process. Student absences were particularly high this school year due to illness and quarantine associated with the COVID-19 pandemic.

During Year 2, approximately 50% of students in each FL school participated in the screening; 11 – 14% opted out in each school, and no response either yes or no was received by families of the remaining third of students. The study personnel used multiple methods to communicate with families. They used printed consent forms in both English and Spanish which were sent home with students. Additionally, study personnel communicated with caregivers via text messages which were also sent in both English and Spanish. In MA, passive consent for screening procedures were used during both Years 1 and 2. Approximately 90% of students in each MA school participated in the screening (about 10% opted out). The screener was then administered in the Fall semester to all the students in the schools who had parent consent to participate (FL, Year 2) or were not opted out (FL, Year 1; MA, Years 1 and 2), and the data was used to identify students with low life satisfaction (BMSLSS scores fell below the cut-off score of five).

There were some key differences in recruitment between Year 1 and Year 2. In Year 2 the consent form and recruitment script were revised to be more inclusive, for example the Year 2 recruitment script used the word “caregiver” instead of parent. Additionally, in Year 2 an informational flyer was created to be more accessible, please see the Appendix B for examples of the recruitment scripts and consent forms. However, both years used the same general procedures. Specifically, each student who was identified as having low life satisfaction in the screening was individually invited by a research team member to be a part of the research study. The individual, in-person invitation to the study was done purposefully to keep discussions private and exhaust all questions. The research team members engaged in the recruitment activities were diverse and included members from different races/ethnicities

including Black, White, Hispanic, and Asian. The students were given a hard copy of the parent consent form. The return of consent forms was incentivized; students were told if they returned the consent forms they would receive a treat (school supply, snack) regardless of whether the caregiver gave permission to participate or refused the invitation. This was another effort to help encourage consent return and ensure that students discussed the study with their parents. In Year 1, 48% of invited students in FL (School One) enrolled in the study (i.e., received written caregiver consent and assented for themselves to participate in the study). In the MA schools, 38.7% (School Two) and 48.2% (School Three) of invited students enrolled in the intervention study.

In Year 2, recruitment procedures were enhanced in an effort to minimize stigma associated with a mental health intervention and increase the recruitment of minoritized students. In addition to changing wording on the parent consent form, the research team gave students a flyer with more information on the project and asked to discuss the project with their caregivers and return the consent form (See Appendix B for flyer). In FL, in Year 2 approximately 65% of invited students enrolled in the intervention study, which is substantially higher than the enrolment rates for the prior studies of the WBPP (Roth et al., 2017; Suldo et al., 2014) and 17% higher than Year 1 (however, the use of active consent for screening procedures in Year 2 may have removed from the pool of students screened families who are less likely to respond to invitations of any type). In MA, in Year 2 approximately 40% of invited students enrolled in the intervention study, which is similar to Year 1.

The students who received consent to participate in the study were then randomly assigned to either participate in the Well-Being Promotion Program (WBPP) intervention in the Fall (intervention now) or in the Spring of the following school year (intervention later). In total, 593 students were enrolled in the RCT across 2021-22 (Year 1) and 2022-23 (Year

2), 302 in the intervention now condition and 291 in the delayed-intervention control condition. This dissertation only examines data from the students in the intervention now condition. Students assigned to the intervention now group were placed into counseling groups of approximately 5 – 11 students per group (led by one leader and a co-leader) and took part in the WBPP. The intervention groups met once a week for 10 weeks for 30-45 minute sessions and were pulled from elective classes (e.g. band) or rotated through missing core courses in different weeks. After the 10 weeks of intervention the students attended follow-up meetings once a month to review the topics covered in the WBPP, until the end of the school year (2 to 4 follow-up meetings per school).

All students in the study (both those receiving the program now and those waiting to receive the program later) completed surveys four times over the academic year: baseline, post-intervention, four-six month follow-up, one year follow-up. This data was collected via REDCap which is a secure web application for managing online surveys. The students completed the surveys using computers and were de-identified and tracked longitudinally through the use of ID numbers. Study personnel called groups of students to complete these surveys and followed up with students who were absent. Students received a $5 gift card each time they completed the surveys. These surveys gathered data on attitudes towards learning, classroom behaviour, strengths, relationships and subjective well-being. For the purposes of this study, only the measures of subjective well-being (the SLSS and PANAS-C-10, described later) completed at the first two time points (baseline and post-intervention) were examined. Students in the intervention now condition also completed a measure of intervention acceptability at post-intervention.

Students in the intervention group were invited to complete an exit interview about their experiences participating in the 10 core sessions of the WBPP to share what they learned during the WBPP and to give feedback about the program. This exit interview

included nine questions that gauged the students' perceptions of the cultural relevance of the WBPP (see Appendix E for the student exit interview). The interventionists involved in conducting the WBPP, and their coaches, also completed exit interviews at the end of the intervention to share their own views on the intervention. This author assisted in the development of four questions that were added to the SMHP exit interview and four questions that were added to the coach exit interview to collect data on the strategies or methods that the interventionists use to increase the cultural relevance of the intervention (see Appendix F and Appendix G for the SMHP and Coach Interviews). This author also conducted some of the interviews with the students, however, there were several research assistants and research personnel who also conducted the interviews with students, which were audio recorded and transcribed for analysis. These other individuals had their own subjectivities which may have influenced how they interacted with the students and may have also impacted the responses gathered for this study.

Intervention

The Well-Being Promotion Program

The Well-Being Promotion Program is a school-based positive psychology intervention to increase the subjective well-being of students. This intervention can be delivered individually or in groups. Previous studies on the WBPP have shown increases in subjective well-being in sixth and seventh grade students when all 10 sessions were conducted with small groups of youth (Roth et al., 2017; Suldo et al., 2014). The WBPP focuses on fostering positive emotions about one's past, present and future and each session is approximately 45 minutes long. A session by session outline of the WBPP is included in Table 6.

Table 6
Outline of WBPP Sessions

Session	Target	Activities
1	Positive introduction	You at your best
2	Gratitude	Gratitude journals
3	Gratitude	Gratitude visit
4	Kindness	Acts of kindness
5	Character strengths	Introduction to signature strengths
6	Character strengths	Survey assessment of signature character strengths
7	Character strengths; savoring	Use of signature strengths in new ways; savoring methods
8	Optimistic thinking	Optimistic explanatory style
9	Hope	Best-possible self in the future
10	All	Termination; review of strategies and plan for future use

Leader Training in the WBPP

The 15 interventionists included in this study completed 12 hours of training on the WBPP before they implemented the intervention in their groups. The training was facilitated by Dr. Suldo, Dr. Fefer, post-doctoral fellows and graduate students. This training occurred in six two-hour long workshops during which interventionists gained knowledge on positive psychology and the WBPP, engaged in role play opportunities to practice leading sessions, and discussed the logistics of the study procedures. During the second workshop the interventionists were trained on cultural humility and specific methods that they could use to increase the cultural relevance of the intervention including: examining their own cultural identities and reflecting on how they may influence their facilitation of the WBPP, encouraging and appreciating the unique life experiences of the students, using culturally relevant examples during the sessions and aligning the session contents with the values and goals of the students. For certification interventionists had to demonstrate an acceptable level of procedural fidelity, demonstrate acceptable group counselling skills and pass a post-test knowledge quiz.

In addition to the training workshops that interventionists completed, there were weekly 30-minute coaching sessions held with the interventionists and coaches who were experts in positive psychology. Before the coaching sessions, the coaches reviewed audio recordings of the WBPP session and prepared feedback on the session as well as a preview of the upcoming sessions. During the coaching session the coach discussed feedback on the previous session with the interventionist and reviewed the upcoming session. These coaching sessions focused on the content of the WBPP sessions as well as the group process (see group process form in Appendix H). The group process form asks the interventionist to reflect on how they facilitated engagement, enhanced relationships and practiced cultural humility during the session.

Measures

This study used indicators of subjective well-being during the screening process to determine eligibility for intervention and to determine change over time. Additionally, this study used indicators of acceptability to determine intervention acceptability and exit interviews to collect qualitative data on the experiences of students, SMHPs and coaches. The measures that were used to determine eligibility included the BMSLSS, SLSS and PANAS-C-10. The measures that were used to measure change over time included the SLSS and the PANAS-C-10. And the measure used to determine acceptability of the intervention was the TEI-SF. This study used the scores from the SLSS and the PANAS-C-10 for research question two. Additionally, this study used the TEI-SF to choose the students for the qualitative portions of this study, research questions three and four.

BMSLSS

The BMSLSS (Brief Multidimensional Students' Life Satisfaction Scale ,see Appendix I) assessed students' perceived levels of life satisfaction across several domains (Seligson et al., 2003). This measure parallels the more extensive Multidimensional Students'

Life Satisfaction Scale (MSLSS) and uses the same domains assessed in this longer measure, family life, friendship, school, self, living environment and overall life. The BMSLSS is a six item assessment that uses a likert scale from 1 (*terrible*) to 7 (*delighted*). The BMSLSS has acceptable internal consistency reliability (ranging from .76-.85) and acceptable test-retest reliability (ranging from .65-.91; Huebner et al., 2006). Additionally, in a study by Roth et al. (2017) the BMSLSS had a Cronbach's Alpha of .75 when used to assess the life satisfaction of a sample of seventh grade students.

SLSS

The SLSS (Students' Life Satisfaction Scale, see Appendix J) is a measure that assesses general life satisfaction and can be used with participants in grades three to twelve. It consists of seven items, each with a likert scale between 1 (*strongly disagree*) to six (*strongly agree)*, that asks students to rate their level of agreement on statements about quality of life. Higher mean scores in this assessment are associated with higher levels of global life satisfaction. Huebner (1991) conducted a study with 254 youth and reported a high internal consistency of $\alpha = .82$ and a high test-retest reliability of $r = .74$ and $r = .68$. These psychometric properties were further supported by Suldo and Shaffer (2008) who reported an alpha of .89 and Roth et al. (2017) who reported an alpha .83–.86.

PANAS-C-10

The PANAS-C-10 (Positive and Negative Affect Scale for Children see Appendix K) measures how frequent youth feel negative and positive emotions (Ebesutani et al., 2012) and is a shortened version of the PANAS-C-10. The PANAS-C-10 consists of 10 items in total, five of which assess the frequency of negative emotions and the other five assesses the frequency of positive emotions. Participants reflect on their feelings over the past few weeks then answer the 10 questions using a likert scale from 1 (*very slightly or not at all)* to five (*extremely*). The positive affect is measured by calculating the mean of the positive items and

the negative affect is calculated by calculating the mean of the negative items. Higher scores indicate higher positive affect and negative affect. Laurent et al. (1991) conducted a study with 707 students in grades four to eight using the PANAS-C-10. They found high internal consistency for the positive affect scale (α = .89) and the negative affect scale (α = .92). Laurent et al. (1991) also found strong construct validity based on the relationship of positive and negative affect with anxiety and depression. Positive affect had a *r*=-.30 with anxiety and *r*=-.55 with depression, and negative affect had an *r*=.68 with anxiety and *r*=.60 with depression. Ebesutani et al. (2012) reported similar results when they conducted a study with 799 youths and used the PANAS-C-10. Positive affect had an α = .86 and negative affect had an α = .82.

TEI-SF

A modified version of the TEI-SF (Treatment Evaluation Inventory-Short Form, Kelley et al., 1989; see Appendix L) was used to measure students' perceptions of the acceptability of the WBPP. The TEI-SF assesses acceptability and discomfort of an intervention by asking students to indicate how they feel about the intervention. It consists of nine items (e.g., I like the activities in the program) using a likert scale from 1 (*strongly disagree*) to five (*strongly agree*). The items in this measure were modified from a focus on addressing mental health problems through treatment to directly refer to the WBPP (e.g. I find the Well-Being Promotion Program to be an acceptable way to increase my own happiness/well-being). Palermo et al. (2016) conducted a study to assess the acceptability of an insomnia intervention for both the adolescents experiencing the insomnia as well as their parents. They found that the internal consistency was high, α=.93 for parents and α=.92 for children.

Student Exit Interview

The student exit interview was conducted at the end of students' participation in the core 10 sessions of the WBPP, and consisted of 16 questions (see Appendix E). The first six questions asked the students to give feedback on the program and asks them to describe what they learned and what they thought were the most important and beneficial aspects of the program. The next eight questions were the ones that were used to answer research question three. These eight questions asked the students to describe how and if the WBPP fits their values and unique life experiences and if and how the interventionists showed that they understood the students' unique life experiences. The last question in the interview asked a general question of what the students would change about the WBPP and how it can be improved. Students received a $5 gift card for taking part in the exit interview.

Mental Health Provider Exit Interview

The mental health provider exit interview was conducted at the end of the WBPP and consists of 16 questions (see Appendix F). The first four questions asked the mental health provider to give feedback on the program and asks them to describe what they learned and what they thought were the most important and beneficial aspects of the program for their students. The next four questions were the ones that were used to answer research question four. These four questions asked the mental health providers how they incorporated the students' culture into the intervention and how they ensured that students felt comfortable in their sessions. The last eight questions focused on fidelity as well as feedback on the training sessions and the coaching sessions that the interventionists took part in.

Coach Exit Interview

The coach exit interview was conducted at the end of the WBPP and consists of 16 questions (see Appendix G). The first twelve questions focused on the coaches' experiences providing support to the SMHPs and the effectiveness of the coaching on the fidelity of

implementation. Question four and the last three questions of the protocol were the ones that were used to answer research question four. These four questions asked the coach how they used the group process checklist to support the SMHPs, how they discussed culture with their SMHPs, what methods their SMHPs used to incorporate culture into the WBPP and what resources are needed to help with this process.

Data Analysis

This mixed methods study used a convergent design whereby quantitative and qualitative data were collected at the same time, analyzed separately then merged. In this study, the quantitative portion examined the representativeness of the study sample and the effectiveness of the WBPP across racial groups. The qualitative portion explored the student, interventionist, and coaches' perspectives on the cultural relevance of the intervention. The reason that both quantitative and qualitative data were collected was to gain a comprehensive understanding of the experiences of minoritized students who participate in the WBPP.

Quantitative Data Analysis

Reliability

The internal consistency of the outcome measures (SLSS, PA, and NA scores) was examined to show the validity of the scale at each time point (for the purposes of this study, baseline and post-intervention). Cronbach's Alpha was calculated for the different factors as well as the overall scale. With Cronbach's Alpha values between .70 and .90 indicate acceptable to exceptional internal consistency (Tavakol & Dennick, 2011).

Research Question One

1. Are the racial/ethnic groups of the school samples representative of the racial/ethnic groups of the school populations?

For this research question the author used a quantitative approach to compare the percentages of students across racial/ethnic groups who enrolled in the WBPP against the

demographic features of the school population. This author used a chi-square goodness of fit test. This test compared the proportion of students in the racial/ethnic subgroups in the samples to the proportion of students in the racial/ethnic subgroups in the school population. The null hypothesis was that the proportion of students in the racial/ethnic subgroups in the samples and the school populations are the same. This comparison was done with each of the five schools and let us know if the proportions of students in the racial/ethnic subgroups of the study samples are representative of the school populations. If the percentages of students across race/ethnicity in both the sample and population were similar then we could assume that the study recruited a representative sample of students based on the school population and that there were no differences in participation or assent across race/ethnicity. However, if there were significant differences between the proportion of students from racial/ethnic subgroups in the sample compared to the school population then we could assume that the sample was not representative of the school population and there was a difference in participation across race/ethnicity. If the initial chi-square analysis found significant differences between the sample and population then a second set of analyses were completed to determine which racial group, or groups, had a significant difference between the sample and the student population. A chi-square analysis was completed for each racial group, comparing the sample to the student population.

Research Question Two

2. Do students from different racial/ethnic subgroups respond similarly to the WBPP with regards to outcomes in subjective well-being (life satisfaction, negative affect and positive affect)?

For this research question the author used a quantitative approach. Typically for this sort of analysis a multiple regression may be run, however, the students were placed in small groups of same-age peers to receive the intervention. Because they were in groups, the students were

nested within groups and the groups were nested within schools, which violates the assumption of independence. Instead, multilevel modelling was used to analyse the data. The advantages of this statistical approach is that results were shown for all levels (student, group and school) and the data is not assumed to be independent (Raudenbush & Bryk, 2002). For this analysis the first level units were the students, the second level units were the intervention groups and the third level units were the schools. The outcome variable in the first multilevel modelling analysis was post-life satisfaction. The level one predictor variables were pre-life satisfaction and race/ethnicity. The intercepts of the level one model was assumed to vary randomly across the intervention groups, but the regression coefficients of pre-life satisfaction and the race/ethnicity variables were fixed. This statistical analysis assumes that the outcome data and the errors for both levels are normally distributed. To determine if they are the skewness and kurtosis of the outcome data was examined and a histogram of the errors for both levels was also examined. Additionally, the size of the sample (286 student participants) led to a more normal distribution so the assumptions were met. This analysis was repeated with the two other outcome variables, negative affect and positive affect, in two separate multilevel modelling analyses. Pre-negative affect and pre-positive affect acted as level one predictor variables along with race/ethnicity.

Model Specification

Life satisfaction equation:

Post life satisfaction Outcome = γ_{00}+ γ_{01} Hispanic + γ_{02} Black or African American + γ_{03} Asian + γ_{04} Bi/Multiracial + γ_{05} pre-life satisfaction + γ_{11}Hispanic * pre-life satisfaction + γ_{12} Black or African American * pre-life satisfaction + γ_{12}Asian * pre-life satisfaction + γ_{13} Bi/Multiracial * pre-life satisfaction + u_{0j} + r_{ij}

Negative affect equation:

Post negative affect outcome = γ_{00}+ γ_{01} Hispanic + γ_{02} Black or African American + γ_{03} Asian + γ_{04} Bi/Multiracial + γ_{05} pre-negative affect + γ_{11}Hispanic * pre-negative affect + γ_{12} Black or African American * pre-negative affect + γ_{12}Asian * pre-negative affect + γ_{13} Bi/Multiracial * pre-negative affect + u_{0j} + r_{ij}

Positive Affect Equation:

Post positive affect outcome = γ_{00}+ γ_{01} Hispanic + γ_{02} Black or African American + γ_{03} Asian + γ_{04} Bi/Multiracial + γ_{05} pre-positive affect + γ_{11}Hispanic * pre-positive affect + γ_{12} Black or African American * pre-positive affect + γ_{12}Asian * pre-positive affect + γ_{13} Bi/Multiracial * pre-positive affect + u_{0j} + r_{ij}

Qualitative Analysis

Theoretical Orientation

The author used the interpretivist paradigm as the theoretical orientation for the qualitative portion of this study. The interpretivist paradigm focuses on building an understanding of a person's perspectives, experiences and meaning making processes. The author chose this paradigm because the purpose of the qualitative section of this study is similar. The exit interviews conducted with the students were for the purpose of building an understanding of how they perceive the cultural relevance of the WBPP. The interpretivist paradigm theorizes that there is no absolute truth because every person has different life experiences and identities which change the way they perceive the world. The author shares this belief that students have different perspectives on the cultural relevance of the WBPP based on their own identities and experiences. One of the author's roles in this study was to create meaning from the students' interpretations of what cultural relevance means and how they experienced in throughout the WBPP.

Researcher Positionality

As a Black woman doing research on cultural relevance and competence, I know that I was influenced by my personal feelings, experiences and opinions on the subject matter and this may be felt in my writing. The main subjectivities that may have influenced my writing are my deep desire for equity in education and intervention work and my personal opinion that current interventions are lacking in cultural relevance. Both of these subjectivities originate from my time and work in the schools. I have primarily been placed in schools in low-income neighbourhoods and have seen how the system has failed minoritized students. This was especially jarring for me when I learned of the origins of IQ testing and about the biased nature of the current IQ tests being used in schools. It was, and has been, hard to reconcile myself with the dark past of IQ tests as I use them myself because they are a necessary part of the evaluation process. I have also bared witness to the isolation that minoritized students experience when they are attending predominantly White schools. In one such school a student approached me and asked me to be her teacher because she'd never had a Black teacher. I felt heavy as I told her that I wasn't a teacher and that I wasn't a permanent part of the school staff. Students want to feel heard and understood and a part of that is feeling represented by the adults around you.

As a minoritized individual myself it was especially difficult to confront the inequities faced by minoritized students and that led to my desire for equity in education and my belief that the interventions being used in schools are not culturally relevant. These two subjectivities may have benefited the project because they both acted as motivators for me to put in the time and effort to interview and discover what students truly think about the intervention they have completed. However, these subjectivities may have influenced how I asked questions during the interviews as well as how I interpreted the responses of the students. My body language, tone and facial expressions may have conveyed how I want the

students to respond and that may have influenced their responses. To mitigate this I secured a second coder to review the qualitative data, who worked with me to process the student responses and pull meaning from them.

The second coder was a graduate student who also identified as a Black woman. She also worked with middle school students by providing mental health supports to students of diverse backgrounds. Given the similarity in both of our backgrounds as members of a minoritized group and with our work in the mental health field, we held similar opinions and positions when it came to minoritized students. My second coder also had a strong desire for equity in schools and this subjectivity may have also influenced how she interviewed students and interpreted the data. However, we were both aware of our similarities and positionalities and were able to use it as a lens through which we analysed and coded transcripts.

Research Question Three and Four

3. In what ways is the WBPP perceived as culturally relevant by participants from minoritized groups? In what ways does the intervention align with the participants' cultures and in what ways does it not?

4. What do interventionists do to enhance the cultural relevance of the WBPP, as reported by interventionists, observed by coaches, and/or perceived by students?

The author used the questions from the exit interviews to address both research questions three and four on the perceived cultural relevance of the WBPP and the strategies used by interventionists to increase the cultural relevance of the intervention. The responses were audio recorded and then transcribed, and the transcriptions were reviewed by two coders, the author and a second coder. The second coder was a graduate student who was an expert in the WBPP and an IRB-approved member of the larger study team. A constant comparative method was used to identify ideas and themes from the interviews. The transcripts of the students, SMHPs and coaches were chosen using the method described

earlier in this section (see Tables 3-5). The two coders progressively developed codes and a codebook for the themes and ideas while reviewing the interview transcripts. They did this by reviewing and coding the transcripts separately then meeting to discuss codes and come to a consensus about the coding. This happened in stages and the coders reviewed the transcripts several times before finalizing the codes. The codes were based on commonalities in responses across the responses and were iterative. The codebook went through multiple iterations as the two coders reviewed the interview transcripts multiple times and met to discuss changes. Both open coding and axial coding were used to interpret the data (Corbin & Strauss, 1998). Open coding refers to categorizing the data and axial coding refers to grouping these categories based on a main theme or idea (Creswell, 2013).

The strategies posited by Ryan and Bernard (2003) were also used to create the themes. The data was first separated based on the concepts found in the responses of the students and the interventionists. These concepts were then reviewed and assessed for repetition and ideas that were unique were compared to the repeated concepts using the constant comparative method. These comparisons occurred until all ideas were categorized into concepts. These concepts were then examined for underlying themes and grouped based on these themes. Once the themes were developed the transcripts were coded based on the themes' descriptions. This was an iterative process and the codes and themes were refined and recoded throughout the process as the coders developed a deeper understanding of the students' perspectives. The themes were placed into three categories. Broad themes were considered *main themes,* themes that fit within the main themes but were distinctive subthemes were considered *secondary themes* and themes that fit within the secondary themes but were also distinctive subthemes were considered *tertiary themes*. This method of coding was used for both qualitative research questions to code and interpret the data.

Ethical Considerations

The larger study was approved by the USF Institutional Review Board (IRB) as well as the districts governing the participating middle schools. Parental consent was collected at the beginning of the study. Student assent was also collected at the beginning of the study. The consent and assent forms clearly stated the purpose of the study as well as any risks that may be involved in participating in the study so that parents and students were fully aware of what they are signing on for. Additionally, the author de-identified the students participating in this study. They were assigned identification numbers and their data were only connected to these numbers. All electronic data are stored in a password protected folder and all paper copies are stored in locked file cabinets in the research labs at the University of South Florida and the University of Massachusetts, Amherst.

Chapter Four: Results

Assignment to Racial/Ethnic Groups

For analytic purposes, the racial groups in the study were reduced to five groups: White, Hispanic, Black or African American, Asian and Bi/Multiracial. The Bi/Multiracial group included students who indicated that they belonged to multiple racial groups, as well as a small number of students (ultimately, two) who did not fit cleanly into the other four groups, specifically students who identified as American Indian or Alaska Native (N = 1), students who identified as Native Hawaiian or Other Pacific Islander (N = 0), and students who did not report a racial group (N = 1). The American Indian or Alaska Native and Other racial groups were included in the Bi/Multiracial group because of their small sample sizes. The author would like to note that 16 students were categorized as Bi/Multiracial because they identified as both Hispanic and another, non-White racial grouping, such as Hispanic and Black. This is relevant for research question one where the NCES racial data as reported by parents are compared to the sample racial data as reported by students. There may be a difference in how parents report their child's race (e.g., simply Hispanic) versus how students report their own race (e.g., Hispanic and Black) which may have affected the analysis of research question one.

Missing Data Analysis and Treatment

There were 16 participants who did not complete the post-intervention SLSS and PANAS-C-10 assessments. These participants were removed from the dataset reducing the sample size from 302 to 286. Of the 16 students, 12 moved from the school or decided to discontinue the WBPP and four students completed the intervention but were not available to complete the post-intervention assessments. Of the 16 students, one was Black or African

American (3.84% attrition, 96.16% retention), one Asian (10% attrition, 90% retention), ten were White (6.13% attrition, 93.87% retention), four were Hispanic (7.27% attrition, 92.73% retention) and one was Bi/Multiracial (3.12% attrition, 96.88% retention). Although sample sizes of students in the intervention were low for some groups, these numbers indicate that retention in the intervention study was high across racial groups, ranging from 90% to 97% of students within various racial groups.

Creation of Composite Scores

The SLSS consists of seven items which are scored on a scale from 1 (*strongly disagree*) to 6 (*strongly agree*). Two items on the SLSS (items 3 and 4 in Appendix J) are reverse scored, meaning that they are scored 6 (*strongly disagree*) to 1 (*strongly agree*). To calculate the reverse scores, new items are created by subtracting the raw score from seven. For instance two on the SLSS2 would be the same as a five on the new item. Then, the composite score is calculated by averaging the 5 positively worded items with the 2 new variables that are the reversed versions of the 2 negatively worded item. The PANAS-C-10 consists of 10 items in total, five of which assess the frequency of negative emotions and the other five assesses the frequency of positive emotions. The PANAS-C-10 is scored on a scale from 1 (*very slightly or not at all)* to 5 (*extremely*). The positive affect is measured by calculating the mean of the positive items and the negative affect is calculated by calculating the mean of the negative items.

Analysis of Consistency of Data with Assumptions

The author used a simplified model of two levels to analyse the residuals. Thus, level one (student) and level two (treatment group) residuals were examined for normality, homoscedasticity, and outliers through the computation of skewness and kurtosis indices. The maximum skewness was -1.87 and the maximum kurtosis was 3.5, the average skewness 0.25 was and the average kurtosis was 1.57. According to Brown (2015) acceptable skewness falls

between -3 to 3 and acceptable kurtosis falls between -10 to 10. No consequential violations to normality or homogeneity were identified, nor were influential outliers identified.

Descriptive Statistics

The internal consistency of the outcome measures (SLSS, PA, and NA scores) was examined to show the validity of the scale. With Cronbach's Alpha values between .7 and .9 indicate acceptable to exceptional internal consistency (Tavakol & Dennick, 2011). The Cronbach's Alpha for the SLSS was .82 which indicates acceptable internal consistency. The Cronbach's Alpha for Positive Affect was .85 which indicates acceptable internal consistency. Lastly, the Cronbach's Alpha for negative affect was .80 which indicates acceptable internal consistency. The minimum and maximum values for the SLSS composite scores was 1 to 6, for the PA composite scores it was also 1 to 5 and for the NA composite scores it was 1 to 5.

Descriptive analysis of this variable indicated that the average life satisfaction for students was 3.35 (*SD* = 0.97) at pre-intervention, and these scores were found to be normally distributed (Table 9). A life satisfaction outcome variable, post-intervention SLSS, demonstrated a slight increase in global life satisfaction (*M* = 3.68, *SD* = 1.11). The distribution of the Level 1 predictor variable for positive affect, baseline Positive Affect, was evaluated for the sample of students. Descriptive analysis of this variable indicated that the average positive affect for students score was 2.62 (*SD* = 0.83), and these scores were found to be normally distributed (Table 7). The positive affect outcome variable, post-intervention Positive Affect, demonstrated a slight increase in positive affect (*M* = 2.96, *SD* = 0.94). The distribution of the Level 1 predictor variable for negative affect, baseline negative affect, was evaluated for the sample of students. Descriptive analysis of this variable indicated that the average negative affect for students score was 2.51 (*SD* = 0.9), and these scores were found

to be normally distributed (Table 7). The positive affect outcome variable, post-intervention negative affect, demonstrated a slight decrease in negative affect (M = 2.4, SD = 1.1).

Table 7
Descriptive Statistics of Level 1 Predictor Variable

Assessment	Baseline				Post-intervention			
	M	SD	Sk	Ku	M	SD	Sk	Ku
SLSS	3.35	0.97	0.24	-0.03	3.68	1.11	-0.03	-0.12
Positive Affect	2.62	0.83	0.29	-0.2	2.96	0.94	0.26	-0.45
Negative Affect	2.51	0.89	0.34	-0.61	2.39	1.09	0.04	-0.17

Note. M=mean; SD=standard deviation; Min=minimum value; Max=maximum value; Sk=skewness; Ku=Kurtosis.

Research Question One

Are the racial/ethnic groups of the school samples representative of the racial/ethnic groups of the school populations?

As described in Chapter 3, in both Year 1 and Year 2 the study personnel met with students one by one to talk about the WBPP and invite them to participate in the study. In Year 2, the researchers made special efforts to make recruitment more equitable. The study personnel sent home consent forms in both English and Spanish and communicated with parents via text messages which were also in both Spanish and English. There were 16 participants who did not complete the post-intervention SLSS and PANAS-C-10 assessments. These participants were removed from the dataset reducing the sample size from 302 to 286.

Chi Square Goodness of Fit Test

School One FL Year 1

The sample of students who enrolled in the study and were randomly assigned to the intervention, and the larger school population, were compared across the five racial groups (White, Hispanic, Black or African American, Asian and Bi/Multiracial). According to the chi-square goodness of fit test the difference between the racial demographics of the sample and the racial demographics of School One as reported by the NCES were statistically significant (*p-value* = 0.0034). The sample percentages and the school percentages differed

some for all five races, this difference ranged from 17% difference to a 2.4% difference (see Table 8).

A second set of analyses were completed to determine which racial group had a significant difference between the sample and the student population. A chi-square analysis was completed for each racial group, comparing the sample to the student population. According to the chi-square follow up analyses there was a significant difference between the sample and the student population for the Bi/Multiracial group (*p-value* = 0.0019). The Bi/Multiracial group made up 16.67% of the sample compared to 6.24% of the school population. There was also a significant difference between the sample and the student population for the Hispanic group (*p-value* = 0.0097). The Hispanic group made up 14.58% of the sample compared to 32.04% of the school population. There were no statistical differences between samples and student populations for the other racial groups (Asian *p-value* = 0.43; Black or African American *p-value* = 0.19; White *p-value* = 0.73). Overall, in the sample Hispanic students were underrepresented and Bi/Multiracial students were overrepresented.

Table 8
School One Racial Demographics

Race	Sample Frequency	Sample %	School %
Hispanic	7	14.58	32.04
White	19	39.58	42.23
Black or African American	11	22.92	16.18
Asian	3	6.25	3.28
Bi/Multiracial	8	16.67	6.24

School Two MA Year 1

The sample of students who enrolled in the study and were randomly assigned to the intervention, and the larger school population, were compared across the five racial groups (White, Hispanic, Black or African American, Asian and Bi/Multiracial). According to the chi-square goodness of fit test the difference between the racial demographics of the sample

and the racial demographics of the School Two as reported by the NCES were not statistically significant (*p-value* = 0.62). Though the difference was not statistically significant the sample percentages and the school percentages differed some for all five races, this difference ranged from 9% difference to a 0.7% difference (see Table 9).

Table 9
School Two Racial Demographics

Race	Sample Frequency	Sample %	School %
Hispanic	4	9.09	17.10
White	34	77.27	67.71
Black or African American	1	2.27	4.01
Asian	1	2.27	3.31
Bi/Multiracial	4	9.09	7.85

School Three MA Year 1

The sample of students who enrolled in the study and were randomly assigned to the intervention, and the larger school population, were compared across the five racial groups (White, Hispanic, Black or African American, Asian and Bi/Multiracial). According to the chi-square goodness of fit test the difference between the racial demographics of the sample and the racial demographics of the School Three as reported by the NCES were not statistically significant (*p-value* = 0.1127). Though the difference was not statistically significant, the sample percentages and the school percentages differed some for all five races, this difference ranged from 14% difference to a 2.5% difference (see Table 10).

Table 10
School Three Racial Demographics

Race	Sample Frequency	Sample %	School %
Hispanic	3	6.82	17.27
White	33	75	61.31
Black or African American	2	4.55	7.05
Asian	1	2.27	7.54
Bi/Multiracial	5	11.36	6.81

School Four FL Year 2

Of note, the sample of students who enrolled in the study and were randomly assigned to the intervention for School Four did not include any students who identified as Asian. This did not differ significantly from the school demographics as reported by NCES which reported twelve (1%) students who identified as Asian. The sample of students in the intervention, and the larger school population, were compared across the four racial groups (White, Hispanic, Black or African American and Bi/Multiracial). According to the chi-square goodness of fit test the difference between the racial demographics of the sample and the racial demographics of the School Four as reported by the NCES were not statistically significant (*p-value* = 0. 9805). Additionally, the differences between the sample percentages and the school percentages were all less than 3% (see Table 11).

Table 11
School Four Racial Demographics

Race	Sample Frequency	Sample %	School %
Hispanic	13	25.49	27.44
White	29	56.86	53.89
Black or African American	6	11.76	12.97
Bi/Multiracial	3	5.88	5.68

School Five FL Year 2

The sample of students who were enrolled in the study and randomly assigned to the intervention, and the larger school population, were compared across the five racial groups (White, Hispanic, Black or African American, Asian and Bi/Multiracial). According to the chi-square goodness of fit test the difference between the racial demographics of the sample and the racial demographics of the School Five as reported by the NCES were statistically significant (*p-value* = <0.0001). The difference between the sample percentages and the school percentages ranged from 15% difference to a 0.96% difference (see Table 12).

A second set of analyses were completed to determine which racial group, or groups, had a significant difference between the sample and the student population. A chi-square

analysis was completed for each racial group, comparing the sample to the student population. According to the chi-square follow up analyses there was a significant difference between the sample and the student population for the Hispanic group (*p-value* = 0.03). The Hispanic group made up 28% of the sample compared to 42.75% of the school population. There was also a significant difference between the sample and the student population for the Bi/Multiracial group (*p-value* = <0.0001). The Bi/Multiracial group made up 14% of the sample compared to 2.98% of the school population. There were no statistically differences between samples and student populations for the other racial groups (Asian *p-value* = 0.48; Black or African American *p-value* = 0.68; White *p-value* = 0.56). Overall, in the sample Hispanic students were underrepresented and Bi/Multiracial students were overrepresented.

Table 12
School Five Racial Demographics

Race	Sample Frequency	Sample %	School %
Hispanic	14	28.00	42.75
White	22	44.00	40.11
Black or African American	6	13.00	13.56
Asian	1	1.00	0.57
Bi/Multiracial	7	14.00	2.98

School Six MA Year 2

Of note, the sample of students who enrolled in the study and were randomly assigned to the intervention for School Six (MA) did not include any students who identified as Black or African American. This differed some from the school demographics as reported by NCES which reported 17 (2.5%) students who identified as Black or African American. The sample of students in the intervention, and the larger school population, were compared across the four racial groups (White, Hispanic, Asian and Bi/Multiracial). According to the chi-square goodness of fit test the difference between the racial demographics of the sample and the racial demographics of the School Six as reported by the NCES were not statistically

significant (*p-value* = 0. 3371). The difference between the sample percentages and the school percentages ranged from 8% difference to a 1% difference (see Table 13).

Table 13
School Six Racial Demographics

Race	Sample Frequency	Sample %	School %
Hispanic	7	21.21	17.66
White	23	69.7	76.49
Asian	2	6.06	2.91
Bi/Multiracial	1	3.03	2.91

School Seven MA Year 2

The sample who enrolled in the study and were randomly assigned to the intervention for School Seven (MA) did not include any students who identified as Asian nor did it include any students who identified as Native Hawaiian/Pacific Islander. This did differ from the school demographics as reported by NCES which reported 25 (4%) students who identified as Asian. The sample of students who enrolled in the study and were randomly assigned to the intervention, and the larger school population, were compared across five racial groups (White, Hispanic, Black or African American, American Indian/Alaska Native and Bi/Multiracial). The racial groups were modified for this school because there was a student who identified as American Indian/Alaska Native in this sample, and it would be a more accurate analysis if the student remained in that racial group. According to the chi-square goodness of fit test the difference between the racial demographics of the sample and the racial demographics of School Seven as reported by the NCES were statistically significant (*p-value* = 0. 0257). The difference between the sample percentages and the school percentages ranged from 15% difference to a 2% difference (see Table 14).

A second set of analyses were completed to determine which racial group, or groups, had a significant difference between the sample and the student population. A chi-square analysis was completed for each racial group, comparing the sample to the student population. According to the chi-square follow up analyses there was a significant difference

between the sample and the student population for the White group (*p-value* = 0.032). The White group made up 58.97% of the sample compared to 73.51% of the school population. There was also a significant difference between the sample and the student population for the Bi/Multiracial group (*p-value* = 0.001). The Bi/Multiracial group made up 10.26% of the sample compared to 3.21% of the school population. There were no statistical differences between samples and student populations for the other racial groups (Hispanic *p-value* = 0.63; Black or African American *p-value* = 0.18; American Indian/Alaska Native *p-value* = 0.34). Overall, in the sample White students were underrepresented and Bi/Multiracial students were overrepresented.

Table 14
School Seven Racial Demographics

Race	Sample Frequency	Sample %	School %
Hispanic	9	23.08	20.21
White	23	58.97	73.51
Black or African American	2	5.13	2.75
American Indian/Alaska Native	1	2.56	0.31
Bi/Multiracial	4	10.26	3.21

School Eight MA Year 2

The sample who enrolled in the study and were randomly assigned to the intervention for School Eight (MA) did not include any students who identified as Black or African American. This differed from the school demographics as reported by NCES which reported nine (2%) students who identified as Black or African American. The sample of students in the intervention, and the larger school population, were compared across the four racial groups (White, Hispanic, Asian and Bi/Multiracial). According to the chi-square goodness of fit test the difference between the racial demographics of the sample and the racial demographics of the School eight as reported by the NCES were statistically significant (*p-value* = <0.0001). The difference between the sample percentages and the school percentages ranged from 18% difference to a 6% difference (see Table 15).

A second set of analyses were completed to determine which racial group, or groups, had a significant difference between the sample and the student population. A chi-square analysis was completed for each racial group, comparing the sample to the student population. According to the chi-square follow up analyses there was a significant difference between the sample and the student population for the White group (*p-value* = 0.03). The White group made up 60% of the sample compared to 78.33% of the school population. There was also a significant difference between the sample and the student population for the Asian group (*p-value* = 0.0004). The Asian group made up 12% of the sample compared to 1.71% of the school population. Additionally, there was a significant difference between the sample and the student population for the Bi/Multiracial group (*p-value* = <0.0001). The Bi/Multiracial group made up 16% of the sample compared to 1.52% of the school population. There was no statistical difference between sample and student population for the Hispanic racial groups (*p-value* = 0.43). Overall, the White students were underrepresented in the sample and the Bi/Multiracial and Asian students were overrepresented in the sample.

Table 15
School Eight Racial Demographics

Race	Sample Frequency	Sample %	School %
Hispanic	3	12.00	18.44
White	15	60.00	78.33
Asian	3	12.00	1.71
Bi/Multiracial	4	16.00	1.52

Research Question Two

Do students from different racial/ethnic subgroups respond similarly to the WBPP with regards to outcomes in subjective well-being (life satisfaction, negative affect and positive affect)?

Multilevel Modelling

Life Satisfaction

The results of the multilevel model of SLSS post-test student scores that included the race by SLSS pre-test interactions are shown in Table 16. This model examined the difference between the White group and each racial group (Hispanic, Black, Asian and Bi/Multiracial). According to this initial multilevel model there are no statistically significant differences between the White group and the other racial groups. The only statistically significant variable was the SLSS1c, which was centered so that the mean of score on SLSS across all students was 0. This result indicates that as SLSS pre-test scores go up the predicted value of SLSS post-tests also goes up (*p-value*=<0.0001). None of the interactions between racial groups and SLSS pre-test scores were statistically significant which showed that the difference between racial groups did not appear to depend on the initial SLSS (Hispanic*SLSS *p-value*=0.52; Black*SLSS *p-value*=0.84; Asian*SLSS *p-value*=0.08; Bi/Multiracial*SLSS *p-value*=0.51). Thus the author ran the analysis again without the interactions (see Table 17).

According to the second multilevel (Table 17) model the differences between the White group and the other racial groups are not statistically significant. The only statistically significant variable was the SLSS1c, which indicates that as SLSS pre-test scores go up the predicted value of SLSS post-tests also goes up (*p-value*=<0.0001). The variance and covariance of the between the treatment groups and schools is shown in Table 18. It shows that most of the unexplained variance in student SLSS post-test scores is between students, as opposed to between the means of small treatment groups, or the means of schools.

Table 16
SLSS Fixed Effects from Initial Analysis

Variable	Estimate	Standard Error	t-value	P-value
Intercept	3.72	0.11	35.06	-
Hispanic	0.08	0.14	0.53	0.59
Black	-0.14	0.19	-0.71	0.48

Table 16 (Continued)

Asian	0.10	0.36	0.28	0.78
Bi/Multiracial	0.005	0.18	0.03	0.98
SLSS1c	0.65	0.07	8.83	<.001
Hispanic*slss	-0.09	0.15	-0.64	0.52
Back*slss	-0.04	0.18	-0.21	0.84
Asian*slss	-1.20	0.68	-1.78	0.08
Bi/Multiracial*slss	0.12	0.18	0.66	0.51

Table 17
SLSS Fixed Effects from Second Analysis

Variable	Estimate	Standard Error	t-value	P-value
Intercept	3.70	0.09	39.17	-
Hispanic	0.07	0.14	0.52	0.60
Black	-0.13	0.19	-0.65	0.52
Asian	-0.24	0.30	-0.78	0.44
Bi/Multiracial	0.02	0.18	0.10	0.92
SLSS1c	0.64	0.06	11.33	<.0001

Table 18
SLSS Variance and Covariance

Variable	Estimate	Standard Error	Z-value	P-value
Treatment Group	0	-	-	-
School	0.03	0.04	0.83	0.24
Residual	0.84	0.07	11.4	<0.0001

Positive Affect

The results of the multilevel model of positive affect post-test student scores that included the race by positive affect pre-test interactions are shown in Table 19. This model examined the difference between the White group and each racial group (Hispanic, Black, Asian and Bi/Multiracial). According to the multilevel model there was one statistically significant difference, which was between the White group and the Asian group. The predicted post-intervention positive affect score for Asian students who have an average pre-intervention positive affect score is 0.64 higher than White students who have an average pre-intervention positive affect score and this difference is statistically significant (*p-value*=0.03). This finding is also clinically significant because it indicates that the WBPP may be especially effective at evoking positive emotions in Asian students, increasing the average score on the five-point response scale by over half of a point. Thus, the WBPP may be a

beneficial intervention for clinicians working with Asian students with low positive affect. The only other statistically significant variable was the PANASP1c which was centered so that the mean of score on positive affect across all students was 0. This result indicates that as positive affect pre-test scores go up the predicted value of positive affect post-tests also goes up (*p-value*=<0.0001).

None of the interactions between racial groups and positive affect pre-test scores were statistically significant which showed that the difference between racial groups did not depend on the initial positive affect score (Hispanic*PANASP *p-value*=0.83; Black*PANASP *p-value*=0.44; Asian*PANASP *p-value*=0.21; Bi/Multiracial*PANASP *p-value*=0.85). The analysis identified one trend. The difference between the White and Hispanic groups for students who scored in the average was -0.24 (*p-value*=0.06) with a confidence interval of .02 to -.50. This means that the predicted post-intervention positive affect score for Hispanic students who have an average pre-intervention positive affect score is trending lower than White students who have an average pre-intervention positive affect score by 0.24. However, this trend is not statistically significantly and needs to be further evaluated in studies with larger sample sizes.

The variance and covariance of the between the treatment groups and schools is shown in Table 20. It shows that most of the unexplained variance in student positive affect post-test scores is between students, as opposed to between the means of small treatment groups, or the means of schools.

Table 19
Positive Affect Fixed Effects

Variable	Estimate	Standard Error	t-value	P-value
Intercept	3.03	0.06	46.98	-
Hispanic	-0.24	0.13	-1.86	0.06
Black	-0.18	0.18	-1.04	0.29
Asian	0.64	0.29	2.14	0.03
Bi/Multiracial	-0.23	0.16	-1.47	0.14
PANASP1c	0.55	0.08	6.96	<0.0001
Hispanic*panasp	0.03	0.15	0.22	0.83

Table 19 (Continued)

Back*panasp	0.15	0.19	0.77	0.44
Asian*panasp	-0.56	0.44	-1.26	0.21
Bi/Multiracial*panasp	0.04	0.19	0.19	0.85

Table 20
Positive Affect Variance and Covariance

Variable	Estimate	Standard Error	Z-value	P-value
Treatment Group	0	-	-	-
School	0	-	-	-
Residual	0.64	0.06	11.40	<0.0001

Negative Affect

The results of the multilevel model of negative affect post-test student scores that included the race by negative affect pre-test interactions are shown in Table 21. This model examined the difference between the White group and each racial group (Hispanic, Black, Asian and Bi/Multiracial). According to the initial multilevel model there are no statistically significant differences between the White group and the other racial groups. The only statistically significant variable was the PANASN1c, which was centered so that the mean of score on negative affect across all students was 0. This result indicates that as negative affect pre-test scores go up the predicted value of negative affect post-tests also goes up (*p-value*=<0.0001). None of the interactions between racial groups and negative affect pre-test scores were statistically significant which showed that the difference between racial groups did not depend on the initial negative affect score (Hispanic*PANASN *p-value*=0.88; Black*PANASN *p-value*=0.15; Asian*PANASN *p-value*=0.33; Bi/Multiracial*PANASN *p-value*=0.63). Thus, the author ran the analysis again without the interactions (see Table 22).

According to the second multilevel model the difference between the White group and the other racial groups is not statistically significant. The only statistically significant variable was the PANASN1c (*p-value*=<0.0001). The variance and covariance of the between the treatment groups and schools is shown in Table 23. It shows that most of the

unexplained variance in student positive affect post-test scores is between students, as opposed to between the means of small treatment groups, or the means of schools.

Table 21
Negative Affect Fixed Effects from Initial Analysis

Variable	Estimate	Standard Error	t-value	P-value
Intercept	2.25	0.22	10.42	-
Hispanic	0.01	0.13	0.10	0.92
Black	0.15	0.20	0.73	0.46
Asian	0.03	0.29	0.09	0.93
Bi/Multiracial	0.13	0.16	0.80	0.43
PANASN1c	0.50	0.07	6.82	<0.0001
Hispanic*panasn	0.02	0.15	0.15	0.88
Black*panasn	-0.34	0.23	-1.46	0.15
Asian*panasn	-0.44	0.46	-0.97	0.33
Bi/Multiracial*panasn	0.09	0.19	0.48	0.63

Table 22
Negative Affect Fixed Effects from Second Analysis

Variable	Estimate	Standard Error	t-value	P-value
Intercept	2.25	0.22	10.41	-
Hispanic	0.01	0.13	0.10	0.92
Black	0.28	0.19	1.47	0.14
Asian	-0.06	0.28	-0.22	0.83
Bi/Multiracial	0.13	0.16	0.79	0.43
SLSS1c	0.49	0.06	8.58	<0.0001

Table 23
Negative Affect Variance and Covariance

Variable	Estimate	Standard Error	Z-value	P-value
Treatment Group	0.18	0.07	2.63	0.0043
School	0.33	0.26	1.28	0.09
Residual	0.66	0.06	10.99	<0.0001

Research Question Three

In what ways is the WBPP perceived as culturally relevant by participants from minoritized groups? In what ways does the intervention align with the participants' cultures and in what ways does it not?

The exit interviews of nine students (see Table 3) were used to gain a better understanding of the students' identities and their perceptions of the WBPP. This researcher

focused on a subset of responses to the interview protocols described in Chapter 3, specifically the nine students' responses to the questions below.

Interview Questions:

- Describe whether or not the program activities easily related to your own life. (if student appears confused, reword with: in other words, did program activities feel relevant to you, clicked with you, matched up with what's important to you?)
    - PROBE: Which discussions, examples, or activities did you feel were relatable to you?
    - PROBE: Which didn't feel like they were relatable to you?
- Describe whether or not your group leaders incorporated your culture, identity, and unique life experiences into the discussions and activities?
    - Reword if confused: Did you feel like group leaders incorporated anything that you identify with or things that make you unique?
    - Follow-up: How did they incorporate your identity OR How could leader incorporate your identity more?
    - Follow-up: Anything to add about how group leaders attended to your... [culture/identity/ unique life experiences... whatever wasn't covered already by student but mentioned by student as a salient part of their identity [question 10]
- How did group leaders show that they understood your unique life experiences? OR What made you feel like they did not understand your unique life experiences?
- Describe whether or not you felt accepted, safe, and comfortable during the sessions.
    - PROBE: What session activities or interactions in the group made you feel accepted, safe, comfortable sharing? OR
    - Why did you feel uncomfortable or like you couldn't share?
- Describe whether or not you felt like you fit in with the other members of your group?

    - PROBE: Please describe what made you feel connected OR what made you feel different from the group?
    - If they felt different from the group probe further:
        - PROBE: Do you think this had anything to do with your culture or identity? If so, why?
- What advice would you give group leaders to help all students feel accepted, safe, comfortable, and respected?

Four of the nine students whose interview data were analysed were Hispanic/Latino, three were Bi/Multiracial, one was Black or African American and one was Asian. This study used an interpretivist approach to analyze the interview transcripts. The author used the constant-comparative method which uncovered four main themes *Alignment with Culture*, *Cultural Efforts*, *Feelings of Acceptance* and *Advice for Interventionists*. There were also several secondary and tertiary themes that were also uncovered using the constant-comparative method (see Table 24). In this section I explore each theme and their associated secondary and tertiary themes.

Table 24
Descriptions of Student Themes

Main Theme	Secondary Theme	Tertiary Theme
Alignment with Culture	Relatable Activities	
		Familiarity
		Building Skills
	Unrelatable Activities	
		Lack of Connection
Cultural Efforts	Intervention Content	
	No Cultural Efforts	
	Group Therapy Practices	
		Rapport Building
		Active Listening
	Intentional Cultural Efforts	
		Showing Curiosity
		Incorporating Student Identity
Feelings of Acceptance	Comfortable and Safe	
		Safety
		Support
		Activities

Table 24 (Continued)

	Fit In	
		Connections
	Did Not Fit In	
		Differences
Advice for Interventionists	Remain Consistent	
	Build Rapport	
	Discuss Culture	

Student Themes

Alignment with Culture

The main theme *Alignment with Culture* focused on how the students perceived the intervention activities. This main theme had two secondary themes, *Relatable Activities* and *Unrelatable Activities*. The responses were coded as *Relatable Activities* when the students indicated that the activity aligned with their culture or was relatable to them. There were three tertiary themes that were associated with the *Relatable Activities*, these included *Familiarity* and *Developing Skills*. *Familiarity* was coded when the students indicated that the intervention activity was relatable because it was a practice that they had previously been introduced to or a practice that they already engaged in. *Developing Skills* was coded when the students indicated that the intervention activity was relatable because it changed the students' mindsets, way of thinking or behaviors. Responses were coded as *Unrelatable Activities* when the students indicated that the activity did not align with their culture or wasn't relatable to them. *Unrelatable Activities* was associated with one tertiary theme, *Lack of Connection*. *Lack of Connection* was coded when the students indicated that the intervention activities were not relatable because they did not seem relevant, they were unfamiliar or they found it difficult to accomplish.

The students identified seven intervention activities that they thought aligned with their culture or was most relatable to them (Table 26). Of the seven, hope was the most popular. It was mentioned by five of the nine students. Optimistic thinking was the second

most popular activity and was mentioned by four out of the nine students. This was followed by gratitude journaling, goal directed thinking and character strengths which were all mentioned by three out of the nine students. Then the last two activities were gratitude visits and acts of kindness which were both mentioned by two out of the nine students. The reasons behind these choices fell within two codes, *Familiarity* and *Developing Skills*.

Many of the students indicated that the activities were relatable because they were familiar. For example, Evelyn stated "gratitude visit related to my life because I do that basically almost every day because I like to write letters to my family members or to strangers." This student viewed gratitude visits as relatable because it was something that she was already doing as well as something that she enjoyed.

Sophia stated, "And then the optimistic thinking, I really try to see things in a better view. If it's not working now, it'll probably work in the future. I'm one of those kind of people." This student viewed optimistic thinking as relatable because it was something that she already does, but beyond that she also viewed optimism as a part of her personality. Eleanor stated "And then acts of kindness I've already been doing, but it showed me how to be a little bit more of what I was doing." This student, similar to the other students quoted, viewed acts of kindness as relatable because it was already an activity that she engaged with, but the WBPP helped her to understand how this activity was impacting her and how to do it more. For each of the relatable activities at least one student indicated that the activity was relatable because it was something that they had done before. It seems that familiarity led to the students finding certain activities more relatable than others.

Many of the students also indicated that the relatable activities led to building skills. Maya stated, "Because I personally don't have hope for things, but I do have goals, and making me realize that my goals can be achieved and that I can have hope for those things was nice." This student was verbalizing a new mindset that she had discovered through the hope and

goal directed thinking activity. She was able to make the connection between hope and goals when she had previously believed that she was hopeless. Emma stated, “I think they really did relate to my life, especially the hope and goal directed thinking and optimistic thinking because I struggled in those fields a lot. And I think this helped me not struggle as much.” This student originally found hope, goal directed thinking and optimistic thinking difficult, but was able to develop her skills in these areas through the WBPP. She found these activities relatable because they helped to strengthen her weaknesses. Then there was Mia who stated “I feel like they did because the character strengths and stuff made me use those strengths and not just in school, but with my friends, with my family, doing sports and all that.” This student indicated that the character strengths activities were relatable because they made her practice her strengths more often and with different people.

Overall, the students identified seven relatable activities. These included gratitude visit, gratitude journal, optimistic thinking, acts of kindness, hope, goal directed thinking and character strengths. There were two main reasons that these activities were chosen, they were familiar and/or they led the students to develop skills.

The students identified seven intervention activities that were not relatable to them or did not align with their culture. The activity that was mentioned by the most students was using signature strengths in new ways which was reported by three students. The remainder of the activities, savoring, best possible future self, acts of kindness, you at your best, hope and optimistic thinking were each reported by one student. This is a marked difference from the intensity of discussions pertinent to relatable activities. With the relatable activities several of the students identified multiple activities that they found relatable, whereas with the *Unrelatable Activities* most of the students only identified one activity. This indicates that generally the students found most of the intervention activities relevant because they were only able to identify one of the nine activities as unrelatable.

This response was especially interesting because even as the student reported that she did not feel connected to the savoring and best possible self in the future activities, she also reported that she found both helpful. So, even though these activities initially did not align with her culture, she still found value in them. Emma stated "Maybe I think maybe the acts of kindness one because it was kind of hard to really think about it. Usually I just do it, and it was kind of hard to put it down on a chart and think." For this student the acts of kindness activity was not relatable because of the reflection and planning aspects of the activity. This student found it difficult to plan her acts of kindness ahead of time and this led to her feeling disconnected from the activity. Charlie had a similar reason for why they found some of the intervention activities unrelatable. Charlie stated,

> Character strengths because I don't really know my character strengths and I don't really want to. Honestly, I've never really wanted to know myself because I'm afraid if I know myself too well, I'm going to think about dark, my overthinking thoughts, like my dark thoughts about my past.

This student also reported that an intervention activity was unrelatable because of the reflection aspect of the activity. In the case of Charlie there are some additional concerns that the student has that go beyond the intervention, their dark thoughts about the past, that also had an impact on their perceptions of the intervention activities. For this student the character strengths activity was unrelatable because it conflicted with their desire to reduce their self-awareness.

Overall, the students identified seven *Unrelatable Activities*. These included savoring, best possible future self, character strengths, acts of kindness, you at your best and optimistic thinking. The main reason that these activities were unrelatable was a lack of connection, whether that was due to the difficulty that some students faced completing the activity, the unfamiliarity of the activities or external stressors not connected to the intervention.

Table 25
Coding Across Students

	Alignment with Culture					Cultural Efforts								Feelings of Acceptance								Advice		
ID	RA	F	DS	UA	LC	IC	NC	GT	RB	AL	CE	SC	IS	CS	S	Su	A	FI	C	DF	D	RC	BR	DC
Evelyn	X	X		X	X			X	X		X	X		X	X			X	X			X	X	
Ava	X	X				X		X	X		X			X		X		X	X					
Maya	X		X	X	X			X	X	X	X		X	X		X		X	X	X	X		X	
Emma	X		X	X	X						X		X	X		X		X	X	X	X		X	
Mia	X		X					X	X		X		X	X	X	X				X	X			X
Sophia	X	X	X	X	X		X	X		X	X	X	X	X	X	X	X	X	X				X	
Eleanor	X	X	X	X	X		X							X	X					X	X		X	
Charlie	X	X	X	X	X			X		X				X	X			X	X				X	
Amelia	X	X	X	X	X	X	X							X			X	X	X			X		

**RA – Relatable Activity; F-Familiarity; DS-Developing Skills; UA-Unrelatable Activities; LC-Lack of Connection; IC-Intervention Content; NC-Co Cultural Efforts; GT-Group Therapy Practices; RB-Rapport Building; AL-Active Listening; CE-Intentional Cultural Efforts; SC-Showing Curiosity; IS-Incorporating Student Identity; CS-Comfortable and Safe; S-Safety; Su-Support; A-Activities; FI-Fit In; C-Connections; DF-Did Not Fit In; D-Differences; RC-Remain Consistent; BR-Build Rapport; DC-Discuss Culture*

Table 26
Relatable and Unrelatable Activities Identified by Students

Relatable Activities Activity	Frequency	Tertiary Theme	Unrelatable Activities Activity	Frequency	Tertiary Theme
Gratitude Visit	2	Familiarity	Savoring	1	Lack of Connection
Gratitude Journal	3	Familiarity	Best Possible Future Self	1	Lack of Connection
Optimistic Thinking	4	Developing Skills Familiarity	Character Strengths	3	Lack of Connection
Acts of Kindness	2	Developing Skills Familiarity	Acts of Kindness	1	Lack of Connection
			You at Your Best	1	Lack of Connection
Hope	5	Developing Skills Familiarity	Hope	1	Lack of Connection
Goal Directed Thinking	3	Developing Skills Familiarity	Optimistic Thinking	1	Lack of Connection
Character Strengths	3	Familiarity Developing Skills			

Cultural Efforts

The main theme *Cultural Efforts* focused on how the students perceived the cultural efforts made by the interventionists. This theme had four secondary themes, *Intervention Content, No Cultural Efforts*, *Group Therapy Practices* and *Intentional Cultural Efforts*. The responses were coded as *Intervention Content* when the students indicated that the intervention activities and discussions were the aspects of the intervention that incorporated their culture and/or identity. *No Cultural Efforts* was coded when the student indicated that the interventionists did not incorporate their culture into the intervention. *Group Therapy Practices* was coded when the students indicated that their culture and/or identity was incorporated into the intervention when the interventionists used clinical practices to build connections. There were two tertiary themes associated with *Group Therapy Practices, Rapport Building* and *Active Listening. Rapport Building* was coded when the students indicated that the interventionists did something that strengthened their relationship with the interventionist. And *Active Listening* was coded when the students indicated that the interventionists engaged in actions that made the students feel heard.

Intentional Cultural Efforts was another secondary theme and it was coded when the students indicated that the interventionists added to the intervention discussion and/or activities to incorporate student culture and/or identity. *Intentional Cultural Efforts* had two tertiary themes, *Showing Curiosity* and *Incorporating Student Identity*. *Showing Curiosity* was coded when the students indicated that the interventionists asked follow up questions to learn more about the students' cultures. *Incorporating Student Identity* was coded when the students indicated that the interventionists intentionally included their unique life experiences into the intervention activities and discussions.

Two of the nine students indicated that the intervention activities made them feel like the interventionists' incorporated their culture and/or identity. Ava stated "The discussion activities. They weren't the worst, but they definitely weren't the best. It's a 50/50." This student reported that the discussion activities were where her culture and identity were incorporated into the intervention. She later added,

> Well, I did read it, my story from the very first one, me at my best, at the very first session. But then it got, I don't know, because I feel like they got to know me a lot more because they know I dance and I want to be a professional dancer when I get better. So, that's how I think they know me best with my dance.

In addition to the discussion activities she identified the me at my best activity as an opportunity for her to share about her identity. The me at my best activity also led to her feeling like the interventionists had a better understanding of her and could identify a significant facet of her identity. Amelia was the second student who reported that the intervention activities were a way to integrate her culture and/or identity into the intervention. She stated "I think the activities helped me at my best. That was one that, and we had to say we are this way, what made us this way. We are great at this. So why? It makes sense." This student also identified the me at my best activity as one that gave her the opportunity to share

about herself. However, the author would like to note that Amelia indicated that the intervention did not directly discuss or incorporate her culture. Amelia made the above quote as a reference to how her personality and identity were incorporated into the intervention but also stated that her culture was not discussed.

Overall, the intervention activity that served as an opportunity for students to share their identity was the me at my best activity. However, from both Ava and Amelia's responses this activity only allowed them to share one facet of themselves and this did not lead to discussions of culture.

Three of the nine students reported that culture and/or identity were not incorporated into the intervention. Sophia stated "Not culture, because we didn't really talk about that because it doesn't matter, we're human. And then the identity, we really didn't talk about that either." This student reported that identity and culture were not explicitly discussed in during the intervention. Additionally, she indicated that cultural discussion does not matter because "we're human." This was an interesting point because it shows that this student does not believe that cultural discussions are needed in the intervention. However, later in the interview she also stated,

> So, unique life experiences. We shared a lot of that, and they were some crazy life experiences. I will never forget them. And it was like I was able to share that. It was really open to sharedness, that's not a word.

Sophia did not perceive any incorporation of culture or identity but she did recognize an incorporation of unique life experiences by the interventionists. She also perceived the group as a safe space where people could share. There were other students who also reported that culture and/or identity were not incorporated into the intervention. Eleanor stated "Not really. They didn't do anything about that. They didn't put it in none of their examples because most majority of their examples were somebody giving gifts and stuff." This student reported that

the interventionists did not incorporate aspects of her identity into the examples used during the intervention sessions. The last student who reported the lack of cultural incorporation was Amelia who stated “I think it was more of our personality more than how our culture... we didn't really talk about culture much, but we really did talk about our personality, what makes us that way.” Amelia reported that the intervention mainly focused on personality rather than culture, which aligns with Sophia who also noted that the focus was more on unique life experiences versus cultural experiences.

Overall, there were three students who explicitly stated that culture and/or identity were not incorporated into the intervention. Instead, the students indicated that personality and unique life experiences were the focus of the intervention activities and discussions. It seems that the session discussions did not include specific cultural customs, language, festivals, etcetera. Instead, the session discussions focused on the specific and unique experiences of the students.

Some of the students indicated that there were certain actions taken by the interventionists that made them feel like the interventionists understood their unique life experiences. These actions all fell under the umbrella of *Group Therapy Practices* and included the three secondary themes *Rapport Building* and *Active Listening*.

Four of the nine students mentioned that they felt understood by the interventionists because the interventionists used *Rapport Building*. Evelyn stated “And they would just make us feel like we were all beautiful and just perfect.” This student felt connected to the interventionists because they made her feel special and accepted through the conversations that they had with her. This student also indicated that rapport between her and her peers also helped her to feel understood. She stated,

> Knowing other people. Sometimes I'd been through a lot of weird things and maybe there was another or two people that went through the same thing. And so I was like,

> "Oh, so I'm not the only one who went through that." And knowing that they went through that, knowing that they're not going to judge me, and I'm not going to judge them because I went through the same thing.

In this quote Evelyn talks about the connection that she felt with the other students in the group. This doesn't speak directly to the actions of the interventionists but alludes to their indirect actions of building that safe space for the group and facilitating those connections between group members. Another student who mentioned rapport was Maya who stated,

> Well, we would sometimes have small conversations, and she'd be like, "See, that's a good way to use gratitude." So she would agree with what you are saying, or put it into a sentence and be like, "Oh, blah, blah, blah, this happened. That's good, or that's bad." She would use our things in sentences and ways to teach us.

Maya's observation was similar to Evelyn's, she reported that her interventionist would have more one on one conversations with her, during which they would connect her experiences with the skills they were learning in the sessions. This is another example of an interventionist engaging in *Rapport Building* and they did this through having personal conversations with the students.

Three of the nine students mentioned that they felt understood by their interventionists because the interventionists used *Active Listening*. Sophia stated "They listened and if they had somebody to talk about us, they would talk about it. We would talk about it. They wouldn't just dismiss it like most people would. They talked about it." This student reported that her interventionists not only listened to what she and the other students had to say, but also created opportunities for the students to share. These actions made Sophia feel heard and it also made her feel like the interventionists understood her. Charlie stated,

> They just, as I said earlier, took time to listen, listen to what I was saying in the group, everyone did. They were just listening and saying Yeah, like they were saying they understand and just giving me feedback on it too.

This student reported that the interventionists listened to what they were saying, but beyond that the students in the group also listened to what they were saying. This alludes to the indirect actions of the interventionists in creating a safe space for the students where they felt heard by their peers as well as the group leaders. Charlie also shared that the interventionists made comments or "feedback" on the things that were shared which also showed them and the students that the interventionists were listening and interested. Eleanor shared how the interventionists listened to body language as well as verbal responses and how that made her feel understood. Eleanor stated,

> So some people would always choose me because I'm Hispanic, not the same as them. They didn't do that. They chose rightfully. So let's say if you weren't raising hand and everybody else was, they wouldn't directly pick on me. They'll go for one of those. So they understood that I didn't want to contribute.

This student felt understood because participation was voluntary and because the interventionists paid attention to body language and called on students who wanted to be called on. This simple example of *Active Listening* and voluntary participation felt culturally relevant to this student who seems to have some personal experience around being called out because of her ethnicity.

Overall, four students felt like their interventionists understood them and their life experiences because of *Rapport Building* and three because of the *Active Listening*. The author notes that while *Rapport Building* and *Active Listening* are essential skills for clinicians to have, they do not necessarily make an intervention more culturally relevant. Both of these skills can help to create a safe space for students, which from the reports of the

students they did, but they do not actively create opportunities for students to share their culture and learn about each other's cultures.

Some students shared specific actions that interventionists did that were *Intentional Cultural Efforts*. These efforts included two secondary themes *Showing Curiosity* and *Incorporating Student Identity*. The responses were coded as *Showing Curiosity* when the students indicated that the interventionists asked questions about their culture. The responses were coded as *Incorporating Student Identity* when the students indicated that the interventionists made connections between the students' unique life experiences and the skills they were learning in the intervention.

Two of the nine students indicated that the interventionists incorporated their identity by *Showing Curiosity*. Evelyn stated,

> But sometimes we would say, because I'm from Puerto Rico, I'm Puerto Rican, and so they would be like, "Oh, tell me about that. Tell me about when you were born, where were you born." And they'd be like, "Oh, tell me more about your culture, what language you speak," stuff like that. And so they would make me feel like I have a unique culture and I have a good culture that I can teach to other people.

This student reported that the interventionist asked questions about her culture which gave her the opportunity to share more about being Puerto Rican. Additionally, she reported that this curiosity led to feelings of pride in her culture. This response highlighted the benefits of incorporating culture into an intervention as it can help student feel more positive about their culture and increase their desire to share their culture with others. Sophia stated "They listened and if they had something to talk about us, they would talk about it. We would talk about it. They wouldn't just dismiss it like most people would. They talked about it." This student's response indicates that the interventionists asked follow up questions to gain further understanding of the student's unique life experiences and culture.

Four of the nine students indicated that the interventionists incorporated their identity into the intervention. Emma stated “I think that they incorporated them well and they used these experiences to help us relate more to our lessons and see why they would be important for us specifically to learn them.” This student reported that the interventionists helped the students to see links between their life experiences and the skills they were learning through the intervention. The explicit linkage between the lessons and the students life experiences helped to make the intervention more relevant for this student. Mia stated,

> I don't think really about my culture and identity, but definitely the real life experiences because sometimes when they would be talking they would relate it with someone or sometimes when you say, for example, family, friends, school and stuff, they would say, for example, when you're doing this at school or you're doing this at home or something, that made me better understand what they were saying and be able to participate.

This response was an interesting one that the author wanted to highlight because this quote was also double coded for *No Cultural Effort* as well as *Incorporating Student Identity*. The double coding of this quote seems contradictory because *Incorporating Student Identity* falls under the secondary code of *Intentional Cultural Efforts* which is the opposite of *No Cultural Efforts*. However, this quote highlighted how student perceptions of culture versus unique life experiences impacts their responses. This student perceives a difference between the two and thus she reported that the interventionists did not make efforts to incorporate culture while also providing an example of the interventionists incorporating her identity into the intervention. This also highlighted a pattern that the author observed in the students’ responses, whereby the interventionists appeared to focus more on unique life experiences versus student culture.

Overall, two students felt like their culture was incorporated when the interventionists were *Showing Curiosity* and four students felt like the interventionists actively incorporated their identity into the intervention by connecting their experiences with the skills they were learning.

Feelings of Acceptance

The main theme *Feelings of Acceptance* focused on how comfortable and safe the students felt within their treatment groups. This main theme had three secondary themes, *Comfortable and Safe, Fit In* and *Did Not Fit In*. The responses were coded as *Comfortable and Safe* when the students indicated that they felt both of these while in their treatment groups. There were three tertiary themes that were associated with the *Comfortable and Safe* theme, *Safety, Support* and *Activities. Safety* was coded when the students indicated that they felt comfortable because they felt comfortable because they knew that they could share whenever they felt comfortable and because they knew that the stories they shared would not be spread to other students. *Support* was coded when the students indicated that they felt comfortable because they felt connected to the group. And *Activities* was coded when the students indicated that a particular activity made them feel comfortable. The next secondary theme was *Fit In* and this was coded when the students indicated that they felt like they fit in with their group. There was one tertiary theme associated with *Fit In*, which was *Connections*. *Connections* was coded when students indicated that they felt like they fit in because of the similarities between them and the other students and/or because of the collective sharing of experiences that occurred during sessions. The next secondary themes was *Did Not Fit In* and this was coded when students indicated that they did not feel like they fit in with their groups. There was one tertiary theme associated with *Did Not Fit In*, which was *Differences*. *Differences* was coded when students indicated that they did not fit in with their group because they felt different from the other students.

All nine students indicated that they felt *Comfortable and Safe* during the intervention sessions. Five of the nine students indicated that they felt comfortable because of *Safety*. For example, Mia stated

> I definitely did because it was behind closed doors and he would always repeat what happens in this room stays in this room… But I didn't want to start anything or bring people down just for my own benefit. And I don't think anybody in the group would've wanted that either. So, I felt safe and comfortable sharing my thoughts and feelings.

This student indicated that she felt comfortable because she knew that what was talked about during the sessions would not be spread to other students outside of the group. She indicated that the interventionist often stated this and that she also believed that the other students in the group would also keep the stories shared to themselves. Eleanor stated

> I felt comfortable towards the end because in the beginning when I didn't want to share, because what if those people shared the information out to their friends or something? I was comfortable towards the end because we were there for, what? Two months in that group? One?

This student shared that her comfort level changed as time passed and she saw that no one was spreading stories outside of the group. For her it took some time before she felt that sense of safety but once she did she was comfortable in the sessions. For another student the aspect of the group that helped her feel safe was the voluntary participation. Evelyn stated "So you could just open up whenever you wanted to and you didn't have to answer the question if you didn't want to." She indicated that having the freedom to choose when and if she shared in group helped to create a feeling of safety. This student didn't have to worry about being called on or being forced to share and knowing that participation was voluntary helped her to feel safe and comfortable. Then Charlie stated

> I did because I knew some of the people. I knew [interventionist name] so I felt safe and I trusted them because I already knew them, so I felt really safe. But now if they were all new people, I feel like I would be in my shell, basically.

This student indicated that they felt comfortable specifically because of the interventionist leading their group. Student Charlie had an existing relationship with the interventionist (a school counselor) and that foundation of trust was necessary for them to feel safe. This response highlights the benefits of school-based mental health providers who are able to build and maintain strong relationships with students and leverage these relationships to support students.

Five of the nine students indicated that they felt *Comfortable and Safe* because of the *Supportive* group and interventionists. Mia stated "And when we would be talking, it seemed like he was giving us his full attention to us. So that made me feel like he actually cares. So it made me feel more comfortable." This student reported that the attentiveness of the interventionist made them feel cared for and that led to them feeling *Comfortable and Safe*. This response shows how small things like paying attention can help to build a safe space for students. Mia then went on to state

> So I felt like our group was very diverse. It wasn't all just white people go in this group, Black people go in this group, all of that. And I felt like that helped me more, because me at my best self, I think I did mention something about my race and if I was the only mixed person there and it was just all people who were white, then I wouldn't feel as comfortable sharing that because then they wouldn't be able to understand what I'm going through and they wouldn't be able to relate. So having them there made me feel more confident.

This student had mentioned the attentiveness of her interventionist in the earlier quote then went on to talk about how the diversity of the group also made her feel supported and

comfortable. She indicated that she only felt comfortable talking about her race because there were other people of color in the group. This response illustrates the importance of having a diverse group of students in intervention groups so that everyone feels comfortable and understood. Ava stated “I felt really comfortable during the sessions because I feel like we just, everybody supported each other in the sessions. Nobody else was bullying and stuff.” A similar sentiment was shared by Maya who stated,

> When I talked about living in a homeless shelter and talking about that my cat passed away, there was no one really making jokes about it. They were like, "I understand how you feel, my something passed away," or, "It stinks, you live in a homeless shelter, but at least you're with your family and stuff."

Both of these students, Ava and Maya, indicated that the group was supportive of them and that was why they felt *Comfortable and Safe*. The author noted that the specific reason that these students felt supported was because the other students did not make fun of them or bully them when they shared in the sessions. This may indicate that these students may not typically feel comfortable sharing with peers because of the threat of bullying and their groups felt like safe spaces because the interventionists created safe spaces.

There were two students who indicated that the activities during the session helped them to feel *Comfortable and Safe*. Sophia stated,

> The signature strength and savoring gratitude. Those make me feel comfortable. I know I can share with you. You're not going to say anything. I feel like I got this connection with you. You know me. I know you. We're not going to, you're not go tell anybody. You got that.

This quote was coded under all three tertiary themes, *Safety, Supportive* and *Activities*. This student mentioned that she felt like she could share with the others in the group because she knew that they weren’t going to say anything to others outside of the group which fell under

the *Safety* coding. She also indicated that she felt a connection with her group and her interventionists that also made her feel comfortable and this fell under the *Supportive* coding. Then lastly she named two activities, character strengths and savoring, as the activities that helped her feel comfortable. Amelia also mentioned character strengths as the activity that made her feel *Comfortable and Safe.*

Overall, all the students felt *Comfortable and Safe*. Five felt comfortable because of *Safety* within the group, five felt comfortable because the group was *Supportive* and two felt comfortable because of the *Activities.* The author noted that many of the responses from the students indicated that their comfort was due to both the interventionists and the other students in the group. This emphasizes the importance of creating a safe space in a group intervention because the interventionist set the tone of the group and by creating group norms and reminding the students of those norms they were able to create safe spaces for all of these students.

Seven of the nine students felt like they *Fit In* with the other students in their groups. The main reason that these students felt like they *Fit In* was because of their *Connections* with the other students. Ava stated it the best when she said “I don't know. Because we all talked and stuff and we all just got really close because we would open up. So, I feel like that's how we got to know each other really well.” This student indicated that she felt connected to the other students because they were all sharing their experiences with each other and thus gained a deeper understanding of each other. This sentiment was echoed by all of the other students; Amelia stated,

> How we were all in middle school and we all knew that we had gone through the same things. A lot of us had rough days, but we all bounced back between our rough days. I would just see someone in the corner just sad. And I'm like, I've been there before. So we kind of all related to that.

This response was similar to Ava, this student expressed that she felt like she fit in because all of the students in the group were in middle school and experiencing rough times. The group allowed them to share these experiences with each other and connect over the stressfulness of life. Yet another student, Evelyn stated “I feel like I did because we shared all these experiences that we experienced. And knowing that other people went through the same thing.” This student agreed with the other two students, Ava and Amelia. Sharing stories and experiences with the other members of her group helped her to feel connected to the other students because they were going through similar experiences.

Overall, seven students felt like they *Fit In* with the students in their group and they felt this way because they formed *Connections*. The students mainly talked about sharing stories with their group and hearing other people’s studies and how that led to feelings of connectedness. However, the author would like to note that the interventionists likely contributed to this by creating opportunities for students to share and a space for this to be done.

There were four students who felt like they *Did Not Fit In* and for all of these students they felt this way because of *Differences* between them and the other students. The author would like to note that all of these students felt partially like they *Did Not Fit In* and partially like they did *Fit In*. Their responses indicated that they connected with some of the students but felt disconnected from others which led them to state that they felt both like they *Fit In* and like they *Did Not Fit In*. One example of this was Maya who stated that “Since I'm the older one, because I stayed back, I'm 15. Everyone else is 12 to 14, so that was a bit off. But besides that, it was nice having a diverse group.” Overall, she felt like she did *Fit In* but because of the *Differences* in age between her and the other students she felt a little like she didn’t belong. Emma stated “I think I fit in with some of them, and sometimes I was a bit different, my goals and my thoughts on things.” And then also stated “My hope thinking,

optimistic thinking, was different than some other students." This student felt like she connected with some of the students but because she had some different responses for hope and optimistic thinking she saw herself as different from the rest of the group. Mia shared that she felt like she mainly *Did Not Fit In*. Her explanation for why was "I feel like if people in the group share more, then I might have, but since I didn't really talk to them or get to know them that well, I can't really fully say." This student found it difficult to form connections with some of the students in her group because there wasn't enough sharing according to her perceptions. This highlights the importance of sharing within a group intervention as it seems to be a key aspect of forming connections amongst group members.

Overall, the four students who stated that they *Did Not Fit In* only felt this way to a certain degree. These students felt like they connected with some students but not all. For most of these students the lack of connection was due to perceived differences between them and the other students. However, even though these students felt like they *Did Not Fit In*, they all still felt *Comfortable and Safe* in the group sessions.

Advice for Interventionists

The main theme of *Advice for Interventionists* focused on any suggestions that the students had for the interventionists to help students feel accepted, safe, comfortable and respected. This main theme had three secondary themes *Remain Consistent, Build Rapport* and *Discuss Culture*. The responses were coded as *Remain Consistent* when the students indicated that the intervention was helpful and that the interventionist should continue doing what they're doing. The responses were coded as *Build Rapport* when the students suggested that the interventionists engage in more activities that will strengthen the relationships between the students and the interventionists. Lastly, *Discuss Culture* was coded when the students suggested that the interventionists engage in explicit discussions of culture.

There were two students who indicated that the intervention was good as is and did not need to change. Evelyn stated “Just continue what they're doing because it really helped me.” This student indicated that the intervention helped her and that she wants the interventionists to continue to facilitate the intervention as is. The author would like to note that this student made a suggestion later in the interview which was coded as *Build Rapport* which shows that she likes the intervention but does want to see some changes. Another student who suggested that the interventionists *Remain Consistent* was Amelia who stated

> To start off easy and then get more intense, because we don't want to throw everything out at the beginning of the group and make everyone uncomfortable, because the first thing that we did with me at my best, and we all explained it to everyone too, but that was kind of a good opening I feel like, because it was just, how do you feel about yourself? It was a time to tell people how you feel about yourself. So it was like an introduction kind of. And then later on we did like [inaudible 00:19:35] thinking and character strengths. Character strengths, I think we all liked that, because we got to learn how other people in the group are. At first we learned how we are and then we got to pass it around and learn each other.

This student indicated that she prefers when group interventions start slow, then discussed how the WBPP aligned with her preference. Additionally, Amelia discussed how the me at my best and character strengths activities helped her to feel more comfortable in the group and helped her to connect with the other students.

There were six students who suggested that the interventionists include actions that would strengthen the relationships between students and interventionists. Maya stated “Just listen carefully. Pay attention to others. If someone's not talking, listen to them. If they're getting talked over and stuff, listen to them. It feels nice being listened to.” This student suggested that the interventionists engage in active listening so that students feel heard and

form a connection with them. Emma suggested that the interventionists use self-disclosure to help students feel more comfortable. She stated “I think that they maybe should also open up about themselves as well. Instead of just having us open up, maybe they could open up to give us example or to show us that it was okay to open up.” By sharing their own stories and being vulnerable they will encourage the students to do the same. Sophia made a similar suggestion when she stated “Tell things that happened because you're not going to get over them if you don't tell.” and “Encourage the students to share more.” This student suggested that the interventionists should encourage the students to share more in the sessions. Evelyn also suggested that the interventionists check in with students and ask them if they feel accepted, safe, comfortable and respected. She stated “…sometimes ask the students that they're with sometimes.”

Overall, the students’ suggestions focused on active listening, checking in and encouraging the students to share. The author noted that these are not suggestions that directly address incorporating culture but they will allow interventionists to create a safe space where students feel comfortable sharing their culture.

There was one student who suggested that the interventionists explicitly discuss culture. Mia stated,

> I feel like talking more about the diversity and ethnicity would help people more. And I feel like talking about being an outcast from people, I don't feel like an outcast personally, but I know friends who at their lowest point just didn't want to engage with anyone or talk to anyone because they got bullied because of their race. And talking about how to get better from that, I guess, or not really avoid it, but saying if it does happen, what to do. And I'm okay because, other than what I told you, I never had to deal with serious bullying for that reason. And so I think just them noting that they're aware of that and saying that it's okay I think could help people.

This student indicated that she and her friends have experienced bullying because of their race and suggested that the interventionists discuss diversity and ethnicity in the intervention. The author notes that the WBPP is a positive psychology intervention, not a bullying prevention program and thus it would be inappropriate for the WBPP to go in depth about bullying and racism. However, this student's suggestion is one that can be incorporated into the WBPP. She is proposing that the intervention create space for students to share about their culture without fear of bullying. This suggestion reminds me of one quote from Evelyn which was analyzed earlier under the theme of *Curiosity*,

> But sometimes we would say, because I'm from Puerto Rico, I'm Puerto Rican, and so they would be like, "Oh, tell me about that. Tell me about when you were born, where were you born." And they'd be like, "Oh, tell me more about your culture, what language you speak," stuff like that. And so they would make me feel like I have a unique culture and I have a good culture that I can teach to other people.

This student felt proud of her ethnicity and race because the interventionists asked her questions and seemed genuinely interested in learning more about her. This corroborates Mia's suggestion because merely asking questions and listening attentively can help students to create positive emotions about their race and ethnicity.

This research question highlighted the student perspectives. Based on the student responses we learned that the student participants view the intervention as centered on unique life experiences. However, this perspective does not seem to detract from the intervention, the students indicated that they found many of the activities relatable and they built connections with each other and the SMHPs who lead their groups. The students identified two ways that the interventionists incorporated culture, through curiosity and connecting their experiences with the skills they were learning. The next research question gives further

insight into the cultural relevance of the WBPP and focuses on the perspectives of the SMHPs and their coaches.

Research Question Four

What do interventionists do to enhance the cultural relevance of the WBPP, as reported by interventionists, observed by coaches, and/or perceived by students?

The exit interviews of four SMHPs (see Table 4) serving the aforementioned nine students were used to gain a better understanding of the SMHPs experiences leading the WBPP groups referenced in the preceding section. This researcher focused on a subset of responses to the interview protocols described in Chapter 3, specifically the four SMHPs' responses to the questions below.

SMHP Interview Questions:

- Describe your experiences ensuring that all students were engaged with the program content and activities?
    - Probe: What specific approaches or strategies did you use?
- Describe your experiences ensuring that all students felt welcomed and safe in the group?
    - Probe: What specific approaches or strategies did you use?
- Describe your experiences building and maintaining relationships with and among students in the group?
    - Probe: What specific approaches or strategies did you use to address and/or repair relationships?
- How did you incorporate students' cultures and unique life experiences into the discussions and activities during the WBPP sessions?
    - Probe: Was it difficult to incorporate students' cultures and unique life experiences into the intervention, why or why not?

- OR
- Probe: What prevented you from incorporating students' cultures and unique life experiences into the sessions?

- If they indicate that they DID incorporate students' cultures and lived experiences into the sessions, then ask: Which of the approaches/methods were most well-received by the students in your opinion?
  - Probe: What was the reaction of the students when you used this strategy?
  - Probe: What strategies did not work as well?

The exit interviews of three coaches (see Table 5) supporting the aforementioned four SMHPs were used to gain a better understanding of the coaches experiences preparing the SMHPs who led the WBPP groups referenced in the preceding section. This researcher focused on a subset of responses to the interview protocols described in Chapter 3, specifically the three coaches' responses to the questions below.

Coach Interview Questions:

- Describe the ways that you supported interventionist group process (i.e., engagement, relationships, session flow, cultural humility)?
  - Follow-up: In what ways did you see group process stay strong or change as a result of coaching? What role do you think you played in this?
- Describe how your background and unique life experiences influenced your approach to coaching and your relationship(s) with interventionist(s).
- Describe whether or not coaching included discussions around cultural humility as well as incorporating students' cultures and unique life experiences into the sessions.
  - Probe: What approaches did interventionists use to incorporate students' cultures and unique life experiences into the sessions?

    - Probe: If not mentioned, ask: How did the group process form impact these discussions?
- Describe any approaches/methods used by you or the interventionist(s) you coached that you feel contributed to students feeling welcome, understood, and safe in the group.
- Ideally what resources and supports do you think would be helpful to coaches and interventionists seeking to incorporate student and leader's unique life experiences like culture and gender identity into the sessions?

This study used an interpretivist approach to analyze the interview transcripts. The author used the constant-comparative method which uncovered three main themes in the SMHP interviews and three main themes in the coach interviews. The three SMHP themes were *Building and Maintaining Relationships, Building Safe Spaces* and *Cultural Efforts*. The three coach themes were *Cultural Efforts, Discussions of Cultural Relevance* and *Needed Resources*. There were also several secondary and tertiary themes that were also uncovered using the constant-comparative method (see Tables 29 and 30). In this section we explore each theme and their associated secondary and tertiary themes.

Table 27
Descriptions of School Mental Health Provider Themes

Main Theme	Secondary Theme
Building and Maintaining Relationships	
	Rapport Building
	Fostering Peer Relationships
Building Safe Spaces	
	Rapport Building
	Norms
Cultural Efforts	
	Opportunities To Share
	Language
	Curiosity

Table 28
Descriptions of Coach Themes

Main Theme	Secondary Theme	Tertiary Theme
Building Safe Spaces	Group Therapy Practices	
		Group Norms
		Rapport Building
Discussions of Cultural Relevance	Ice Breakers	
	Incorporating Identity	
	Difficulty with Cultural Relevance	
Needed Resources	Group Discussion	
	Survey	
	Guidelines for Inclusivity	

Table 29
Coding Across SMHPs

	Building and Maintaining Relationships		Building Safe Spaces		Cultural Efforts		
ID	RB	FPR	RB	N	OS	L	C
Emmett	X	X	X		X		
Alice	X	X	X		X		
Adam	X		X	X	X	X	X
Grace	X		X	X	X		

** RB-Rapport Building; FPR-Fostering Peer Relationships; RB-Rapport Building; N-Norms; OS-Opportunities to Share; L-Language; C-Curiosity*

Table 30
Coding Across Coaches

	Building Safe Spaces			Difficulty with Cultural Relevance			Needed Resources		
ID	GTP	GN	RB	IB	II	DC	GD	S	GI
Olivia	X	X	X	X	X				X
Aida	X		X		X	X	X		
Luna	X		X	X				X	X

**GTP-Group Therapy Practices; Group Norms; Rapport Building; IB-Ice Breakers; II-Incorporating Identity; DC-Difficulty with Cultural Relevance; GD-Group Discussion; S-Survey; GI-Guidelines for Inclusivity*

SMHP Themes

Building and Maintaining Relationships

The main theme *Building and Maintaining Relationships* focused on how the SMHPs connected with the students in their groups and how they sustained these connections. This main theme had three secondary themes, *Rapport Building* and *Fostering Peer Relationships*.

The responses were coded as *Rapport Building* when the SMHPs indicated that they engaged in positive interactions with students that helped to strengthen their relationships. *Fostering Peer Relationships* was coded when the SMHPs indicated that the students were forming connections with each other due to the session activities.

All four SMHPs indicated that *Rapport Building* was one of the ways that they built connections with their students. For instance, Emmett stated,

> I have snack, so I would often just inform students. "Just come by my office". "Thank you once again for being a part of the group, just for a reminder, you guys will have follow up sessions". So it's a giving group, and I think everybody fed off of that.

This SMHP used his presence in the school to connect with the students outside of the group sessions. He was able to meet with students and provide one on one interactions that strengthened his relationships with the students. Another SMHP mentioned checking in with students outside of the group sessions. Alice stated, "I don't know I mean you know they see me in the hallway we check in we say "Hi." " This SMHP also strengthened their relationships with their students by greeting them and talking with them outside of the group sessions. Another SMHP discussed a different method that they used to build rapport. Grace stated

> …we shared our own personal experiences. You know, I talked about my kids. I talked about my dog. I talked about my husband. I talked about when I was in high school. I talk about my work as a school psychologist and working with kids, you know. I tried to make it relevant.

This SMHP made connections in her group by disclosing her own experiences with the students. This was especially notable because student Emma suggested that SMHPs use self-disclosure to help students feel more comfortable. This shows that the SMHPs are already

engaging in some of the practices that the students want to see. The last SMHP, Adam, discussed using language that is inclusive, he stated,

> Culturally…I'm trying to think in my group, I mean, we, you know, we don't really have a huge disparity in ethnicity and different things at our school. But I did not feel there was any glaring that wouldn't have been appropriate or welcoming for a student of color or any other kind of you know, type of student.

This SMHP focused more on the ways that he maintained a safe space by engaging in appropriate and welcoming behaviour so that all students feel like they're a part of the group.

Overall, the SMHPs used their skills to connect with students and strengthen their relationships with their group. Two of the SMHPs used their presence in the school to interact with students outside of the group sessions while one SMHP discussed using self-disclosure and the last indicated that he tried to create a safe environment. Though the SMHPs used different methods to connect with their students, all of these actions helped to build and maintain their relationships with the students in their intervention groups.

Two of the four SMHPs mentioned the relationships that were fostered between the students in their groups. Emmett stated,

> So some of the peers that were in the group itself ended up becoming more- becoming friends out there in the school environment, and then I will often see them, maybe send them together at lunch, where at one point in time they would never actually have any interactions.

Another SMHP, Alice stated "I hadn't seen them interacting before previous to them being in group together and now they seem to be like teasing each other on the playground playfully." This SMHP indicated that she also saw the development of relationships between students.

Overall, these SMHPs indicated that the group facilitated connections between students in addition to strengthening the individual relationships between the students and

SMHPs. This shows that the interventionist was able to indirectly help students to create new friendships and a larger support system with their peers. While this may not have a direct impact on the relationship between the SMHP and the student, it is a sign that the SMHP was fostering an environment conducive to student connections.

Building Safe Spaces

The main theme *Building Safe Spaces* focused on the methods that the SMHPs used to help the students feel safe, comfortable and respected during the group sessions. This theme had two secondary themes, *Rapport Building* and *Group Norms*. *Rapport Building* was coded when the SMHPs indicated that they that they engaged in positive interactions with students and this helped to build a safe space for them. *Group Norms* was coded when the SMHPs indicated that the group expectations helped the students to feel safe and comfortable in the sessions.

All four of the SMHPs indicated that they engaged in *Rapport Building* to help students feel comfortable and safe. One SMHP, Alice stated "You know checking in if people seem like they were off, and you know again, shouting out good behavior and shouting out things we wanted to see." Alice also stated,

> Well we did some icebreakers in the beginning. I think a lot of them like they all knew at least someone who was there hey all knew another student, and they all knew me to start out with. It was a familiar space, and then we just kind of try to continue, like making sure everyone was okay throughout.

This interventionist used several methods to connect with students, including checking in with the students, in and out of sessions, praising students and using ice breakers to strengthen connections. These methods helped to create and strengthen relationships between the interventionist and the students as well as strengthen the relationships between the students. They also made the group sessions feel more safe for students because they were

meeting with people who they felt connected to. Grace used a similar method, she discussed how she checked in with students during the sessions to help them with the intervention activities. She stated "…so just kind of like working with them to kind of draw out what I know is inside, but maybe they're not thinking about it." So similar to Alice, she had one on one conversations with students. However, Grace's conversations focused on the intervention activities and helping students to draw connections between their experiences and the session activities. Another SMHP, Adam discussed learning more about the students and how that led to stronger relationships. Adam stated,

> And(-) for some of the kids that are on my teams it gave me a deeper understanding of, you know, some of the things they're going through or what their home life is like. And so, you know, I definitely feel it strengthened some of those relationships with those kids.

This SMHP also talked about how the strong relationships with the students helped outside of the group sessions because these students are more comfortable meeting with him when or if they need support.

Overall, all of the SMHPs used rapport to build safe spaces for the students. This was mostly done through checking in with students. One thing of note is that *Rapport Building* has come up several times in both the student and SMHP interviews. All of the SMHPs indicated that they used *Rapport Building* to build and maintain relationships and in this section they also used it to build safe spaces. Students also noticed how important *Rapport Building* was for their relationships. Four of the nine students indicated that they felt understood by the interventionists because of the rapport building actions that they engaged in. These actions included making students feel special, feeling connected with the other students, having one on one conversations with interventionists and active listening. Additionally, six of the nine students suggested that the interventionists should engage in

more rapport building actions like active listening, self-disclosure and checking in with students. These responses show that both the SMHPs and the students appreciate the relationships that they build throughout the sessions.

Two of the four SMHPs indicated that the group norms helped them to create a safe space for their students. Grace stated,

> We did have our little like rules of like, you know, like confidentiality. Remember, we're sharing, and you don't broadcast people's business it, you know. In school like, you know, this is this is our safe space, and we all have to respect that, and if we are sharing it's the expectation that it's safe to do so.

This interventionist noted that confidentiality helps to create a safe space for students because the students know that they can share without fear of their stories being shared. Adam also mentioned group norms but they focused on the aspect of voluntary participation. Specifically, Adam stated,

> Yeah, I think, you know, we made that very clear that what the purpose of this was, that it was voluntary. We always reminded them that no one, you know, although we encouraged participation, it wasn't mandatory.

This interventionist made sure to clearly tell students that they could share if they wanted to but there was no pressure to do so. This helped students feel more comfortable in the session because they knew that they could pass if they wanted to and helped to differentiate group from their typical classroom settings where they may be called on by the teacher.

Half of the SMHPs mentioned the group norms and how they helped to create a safe space in the group sessions. They specifically mentioned the group norms of confidentiality and voluntary participation. These two group norms were also mentioned by students in their interview responses. Two of the nine students stated that they felt comfortable in the group sessions because they knew that the experiences they shared would remain within the group.

One of the nine students stated that they felt comfortable and safe because they knew that sharing was voluntary. These student responses confirm that the group norms aided in creating a safe space and that the students appreciated and noticed the actions that the interventionists took to make them feel comfortable.

Cultural Efforts

The main theme *Cultural Efforts* focused on how the interventionists incorporated culture into the intervention. This theme had three secondary themes, *Opportunities To Share*, *Language* and *Curiosity*. *Opportunities To Share* was coded when the interventionists discussed the ways that they facilitated discussions with students and gave them the chance to share their experiences with each other. *Language* was coded when the interventionists indicated that they used inclusive language with their students. *Curiosity* was coded when the interventionists indicated that they asked questions when the students talked about aspects of their culture.

All four of the SMHPs discussed *Opportunities To Share* as something that they did to incorporate culture into the intervention. Emmett stated,

> Culturally, their response is going to be different, but everybody still had opportunity to share, have that respect of what was going on in their situation, adapt to it, and then also provide personalized information to their situation, which allowed them to still have that connection even with peers and leaders within the group.

This interventionist observed that the students' responses differed depending on their cultural background and through the discussions they had an opportunity to share with the other students in the group. He also mentioned how sharing stories led to connections between the students which was also mentioned by several students who indicated that hearing and sharing stories made them feel connected. Alice had a similar observation but they connected it to the intervention activities. Alice stated,

> …someone wrote to their parent and then was we're talking about like the reasons why and you know like the things that the parent did for them so that kind of like brought up. You know, she was talking about being an immigrant to the country and why her father, you know was important her for those some reasons because of that and share that with the group. So like, things like with that like, and then, you know, other kids with their stories with the letters that they wrote too, so that provided an opportunity think, to highlight, let students like share their different family cultures and histories with the group. But I can't say like every group there was an opportunity for that.

This interventionist observed that some of the intervention activities naturally led to discussion of culture because the students shared details of their family life. So similar to Emmett, Alice noted that the opportunities to share were also opportunities to learn more about the students' cultures. However, Alice also noted that this wasn't true for all of the intervention activities. Adam also made a similar observation of how the intervention activities sometimes led to the students sharing about their culture. Adam stated,

> Yeah…Well, we certainly, if a student brought up something about one of their assignments at home that might have touched on a tradition in their family that, you know, wasn't shared necessarily by everyone else, I think [co-leader, name redacted] and I both were very quick to acknowledge "Wow! That's really interesting. How interesting that we all have different ways of celebrating Thanksgiving or not".

As with Alice, Adam noted that some of the intervention activities, including the homework assignments, led to cultural discussions and these cultural disclosures were praised by him and his co-leader. The praise would have reinforced the behaviour for the students and may have made the group feel even safer to the students. Grace also talked about some students who would use the opportunities to share to inform the group of her cultural practices:

> …She's Indian, and she talked about how like in her family there are certain traditions after school. She had, like tradition, Indian dancing, and how this was, you know, big in her culture, and she learned certain dances, and then her family would get together for holidays and celebrations, and how she used it.

This shows that some students did feel comfortable discussing their cultural identity in the group sessions. However, this sort of cultural exchange seems to have occurred organically without any intentional prompting from the interventionist to acquire further insight into the students' culture.

Overall, the SMHPs all provided opportunities for the students to share which is an aspect that is embedded in the WBPP intervention. Sometimes the students took these opportunities and shared about their cultural identity with the group which allowed the SMHPs to learn more about the student. However, the author would like to note that the opportunities to share were not intentionally used to elicit information on the students' cultural backgrounds and identities. These opportunities were a part of the intervention activities. This means that the students disclosed information about their cultural identities because they felt comfortable doing so organically, not because there was a cultural discussion facilitated by the interventionist. This is corroborated by the student responses. Two of the nine students mentioned that the intervention activities gave them an opportunity to share about their identity. Additionally, seven of the nine students felt like they fit in with their group because they were listening to and sharing stories. Both of these responses show that the intervention activities and opportunities to share facilitated the creation of a safe space where they could disclose information about their cultural identities.

One of the SMHPs indicated that they paid special attention to the language that they used around the students. Adam stated,

> We made sure that, you know, but on the Thanksgiving break we wouldn't say, “hey I hope everyone has a great Thanksgiving dinner when you see your family,” and you know things that not all of our students were either able to do or maybe their family doesn’t, you know, celebrate that way. And then coming back from the break also not assuming all those type things. So those are ways, I think, or I certainly try to be careful of imposing my own cultures and values on students that might not celebrate holidays the same way, or what…So I think that's how, one, some ways, that I try to, at least in the class, for example.

This interventionist discussed how he used inclusive language with his students so that they felt comfortable and included. Adam also seemed to be self-aware of how his own cultural background may influence his assumptions. This shows that he was taking the time to reflect on his own identity and recognized the ways that his identity could impact his behaviors. Then going one step further he intentionally changed his behaviour to be more inclusive. While this wasn’t an action that directly led to incorporating student culture, it did help create a welcoming and safe environment for students of diverse backgrounds.

One of the four SMHPs indicated that they incorporated students’ identity through curiosity and asking questions. Specifically, Adam stated,

> And then when they bring up something, I think, maybe it wasn't in this, maybe it's a different group, a student brought up, they(-) celebrate 3 Kings Day, I think it's called, which is a Spanish holiday. And so, because they bring it up, then I can ask, “Oh, neat! Has anyone heard of that?” “No, oh can you, love to know more about it”.

This SMHP saw an opportunity to learn more about a student’s culture and he took it. This had the dual purpose of giving the student space to share more and to let the student and other students know that cultural disclosures were welcomed and encouraged. This is corroborated by the student responses. Two students indicated that their interventionists incorporated their

identity by *Showing Curiosity*. One student (Evelyn) noted that having her interventionist ask her questions about her culture led her to feel pride about her culture. This response highlighted the benefits of incorporating culture into an intervention as it can help students feel more positive about their culture and increase their desire to share their culture with others.

This research question highlighted the SMHPs' perspectives. Based on the SMHPs' responses we learned that the interventionists incorporated culture by creating opportunities for students to share, using inclusive language and using their curiosity by asking questions. This aligned with some of the students' responses as they also identified curiosity as one of the ways that interventionists incorporated culture. The SMHPs also identified several ways that they created and maintained relationships and built safe spaces which also aligns with the student responses as they reported strong connections between themselves and their interventionists. The next section gives further insight into the cultural relevance of the WBPP and focuses on the perspectives of the coaches.

Coach Themes

Building Safe Spaces

The main theme *Building Safe Spaces* focused on how the interventionists made the students feel comfortable and safe during the sessions, from the perspective of their coaches. This theme had one secondary theme, *Group Therapy Practices* which was coded when the coaches discussed the ways that the interventionists used clinical practices to build connections. *Group Therapy Practices* was associated with two tertiary themes, *Group Norms* and *Rapport Building*. The responses were coded as *Group Norms* when the coaches indicated that the SMHPs created group norms and used them to help students feel safe. Lastly, *Rapport Building* was coded when the coaches indicated that the SMHPs engaged in practices that strengthened their relationship with the students.

All three of the coaches indicated that their interventionists used *Rapport Building*. Two of the three coaches indicated that their SMHP used non-judgmental listening with their students. One coach, Olivia stated,

> We had a really diverse group of kids this year, which is great and the leaders did a really nice job of meeting them where they're at with kids who were homeless, had families in jail, parents who were immigrants that were leaving in the middle of the year and coming back, and with all of those students we just tried to offer as much like empathy and understanding as possible, and meet them outside of our regular time for make-up sessions and like praise their diligence for coming to school when possible.

This coach indicated that the interventionists had groups with students across different backgrounds, some of whom had more difficulty attending the groups sessions. And the interventionists' responses to this need was to meet with students outside of the group sessions and praise students whenever they were able to attend. These actions would help the students to feel supported and understood and would also help to create a safe space for them where they are accepted even when they miss sessions. Another coach indicated that their interventionist was especially good at strength spotting and connecting student actions with the intervention activities. Aida stated,

> So, he was able to really point out, for instance, X, Y, And Z, you did this the other day in lunch room, and I saw that, and that's an example of the strength of kindness. Or X, Y, And Z, I know you've been struggling with grades, and you've you know you've shown us your perseverance.

This coach noted that their interventionist was able to take note of student strengths and verbalize these strengths to students. This would serve a double purpose of strengthening the interventionists' relationships with the students and helping the students to see how the

intervention was relevant to their life. The last coach saw a similar strength in her SMHPs, Luna stated,

> And like just pay attention to those little moments and like picking up on the little breadcrumbs they give you and just paying attention to it, remembering it and bringing it up again. It just shows them that you care about them and even if it means just like having little like notes that you write down in sessions when students mention thing.

This coach noted that her interventionists were able to remember the stories that their students shared and use those stories to connect with the students. Like strength spotting, this would help to strengthen the students' relationships with their students because the students would feel cared for.

Overall, the coaches noticed that their SMHPs empathized with their students and showed they cared by remembering the stories their students shared and strength spotting. *Rapport Building* has been mentioned by students, SMHPS and now the coaches as well. Four of the nine students indicated that they felt understood by the interventionists because of the rapport building and six of the nine students suggested that the interventionists should engage in more rapport building actions. SMHPs also saw rapport as important to building safe spaces for the students. All three respondent types are in agreement that rapport helped students feel safe and comfortable.

One of the three coaches mentioned that group norms was another way that the interventionists incorporated culture into the intervention. Coach Olivia stated,

> …the insistence on making group norms at the beginning and revisiting them each week was a really helpful way of setting the expectation that everything we say here was going to say is confidential, we're here to support each other, there's no

disrespect. So, the revisiting group norms to me was like a very important part of that session agenda.

This coach noted that the group norms, especially those regarding confidentiality, support and respect, also helped to make students feel safe and comfortable. Olivia especially noted how repetition of the group norms at each session was important. This repetition acted as a reminder to students that they were in a safe space and they could talk freely. *Group Norms* were also identified by the students and SMHPs as an important part of the group sessions. Two students noted they felt comfortable in the group sessions because they knew that the experiences they shared would remain within the group. And two of the SMHPs mentioned how group norms helped them to create a safe space. All three respondent types—students, SMHPs and coaches—are in agreement that norms help to create a space that is comfortable and safe for students.

Discussions of Cultural Relevance

The main theme *Discussions of Cultural Relevance* were coded when the coaches indicated that they discussed cultural relevance with their interventionists and they described the contents of those conversations. This theme had four secondary themes, *Ice Breakers*, *Incorporating Identity* and *Difficulty with Cultural Relevance*. *Ice Breakers* was coded when the coaches indicated that the interventionists used ice breakers to incorporate student culture into the intervention. *Incorporating Identity* was coded when the coaches discussed how their interventionists included student identity in the intervention. *Difficulty with Cultural Relevance* was coded when the coaches indicated that their interventionists struggled to incorporate student identity into the intervention.

Two of the three coaches indicated that they discussed ice breakers with their interventionists during their coaching sessions, specifically they discussed using ice breakers to incorporate student identity and culture. One coach, Olivia stated

> We talked about ways to inquire specifically about students' family cultures. So, for instance, session 9 or 8 was after the holiday break, and the icebreaker that we discussed using was, "Tell me one of your family traditions that you did over the holiday break." and they can learn more about each other's families and backgrounds and cultures.

This coach had explicit conversations with their interventionists about how to start discussions about cultural practices with their students and even discussed how they could phrase the question so it was inclusive. Another coach, Luna stated,

> And then, when we came up around the holidays, too, I really tried to emphasize like to be like "Oh, let's do like a holiday icebreaker like that's a great idea. How are we going to make sure that it applies to every student?" So like one group they were like, you know, "Let's do something", I'm like, "How about winter activities like, what winter activities do you enjoy?" So trying to help them shift some of their language, too, and then as much as possible to draw in on what students share.

This coach also indicated that they had discussions with their interventionists about using ice breakers to learn more about students. In the case of Luna, the focus of the discussion was centred on using inclusive language which would help the students feel accepted and comfortable sharing.

These two coaches had discussions with their interventionists about using ice breakers to improve the cultural relevance of the intervention. While the coaches were only able to note these discussions occurred and did not indicate whether or not the interventionists acted on the suggestions, we can see from the SMHP responses that the suggestions were acted on. SMHP Adam, who was coached by Coach Luna, discussed using inclusive language as a way of being culturally relevant and even gave an example of rephrasing Thanksgiving break to something more inclusive.

Two of the three coaches indicated that they had discussions about incorporating identity into the intervention, however this discussion looked different for each coach. Coach Olivia stated,

> …we had great diversity in the students in our group, and I was fortunate one of my co-leaders comes from a Hispanic background that connected with a lot of the kids. So, for that dynamic I was able to really strength spot when that co-leader shared commonalities and led the group in discussing her culture and her familial beliefs.

One of Coach Olivia's interventionists used self-disclosure as a way to connect with her students and incorporated her own Hispanic culture into the intervention which allowed her to relate to both her Hispanic students as well as the other students in the group. This is an active and intentional way to incorporate culture into the intervention, by using your culture as the interventionist to start conversations around culture. Another coach, Aida stated,

> So, really personalizing and bringing in each student's identities into the session and seeing them as more than the vessel to teach positive psychology to. I think that was his shining strength, and I told him that and I think that he relates to that, and was able to keep honing on that kind of like a superpower.

This coach held discussions with her one of her interventionists about how he included student identity into the sessions. This differed from the other response because this shows a more direct incorporation of student identity. This interventionist was able to directly connect the intervention activities with the identities of his students.

Overall, two coaches had discussions about incorporating student identity into the intervention. In one of these discussions the coach encouraged the interventionist to use her identity as a Hispanic woman to relate to the students in her group. In the other discussion the coach praised the interventionist for his ability to incorporate identity. In both cases the coach

identified a method that the interventionists were using to incorporate identity into the intervention and reinforced those behaviors.

One of the three coaches indicated that one of their interventionists struggled with cultural relevance. Coach Aida stated,

> My other coachee, I think they tried to shy away from the cultural humility piece. So, there definitely was more push in session to talk about it and sometimes it is uncomfortable. This message is always, why do you keep pushing me to talk about cultural humility. There's nothing to talk about. But there, clearly, there's always culture involved in sessions. So, it's a constant struggle. I'm not sure that we really makes leaps and bounds, to be honest but definitely move the needles, even if it's a little bit, and that's all I could hope for is a 10-session program, you know.

The interventionist that the coach is referencing seems to be uncomfortable with the discussion of cultural humility. From the SMHP's perspective culture wasn't a part of the intervention, it didn't impact the intervention and thus shouldn't be a part of the coaching discussion. This raises a question of what to do when SMHPs aren't willing to have conversations about culture? It also reveals a misconception that this SMHP has that others may share, the belief that culture is a separate entity that doesn't impact mental health interventions. The author is not certain of how to address either of these issues but notes that increasing the cultural relevance of an intervention will only work if the interventionists understand its importance and are motivated to do the work.

Needed Resources

The main theme *Needed Resources* was coded when the coaches discussed resources that would help interventionists to include student culture into the intervention and also help the coaches to support them. This theme had three secondary themes, *Group Discussion, Survey* and *Guidelines for Inclusivity*. *Group Discussion* was coded when the coaches

mentioned that bringing the coaches together to discuss different ways to incorporate culture into the intervention. *Survey* was coded when the coaches discussed using a questionnaire to gather data on the students. *Guidelines for Inclusivity* was coded when the coaches discussed the need for recommendations, suggestions or advice on incorporating culture into an intervention.

One of the coaches indicated that a group discussion with the coaches was a needed resource. Coach Aida stated,

> Ideally, if we have those coaching supervision again, devoting some time as a group to do some of the social justice or cultural humility activities as a group so that we can practice doing these activities together before we like, incorporate some of this elements in our coaching, I think, will be good.

This coach noted that the coaches themselves needed to have a group discussion to help them brainstorm ways to incorporate culture before discussing it with their interventionists. Coach Aida goes on to say that the coaches need to invest their time into reflections on this topic so that they are a better support for the SMHPs. According to this coach, such a discussion would be needed to put all the coaches on the same page and create a common goal for the coaches.

One coach also indicated that a survey of the students would be helpful to making the intervention more culturally relevant. Coach Luna stated,

> And I found a lot more times they were much more comfortable disclosing to an adult rather than to their peers. So, I almost want to start incorporating, in some of the groups that I coach and lead, idea of like, I forget what they call them. But there's always like not an entry ticket but you know how teachers do usually at the beginning of classes like name, pronoun, things I need to know about you, what's your family like? How can I know about you? Like an all about me page or something?

This coach indicated that a survey or exit ticket would be helpful. Through this survey the interventionists could learn more about the students. She also indicated that this survey or exit ticket would be helpful for her as a coach. In addition to the students the survey could be given to the SMHPs and coaches so that they both build a deeper understanding of each other.

Two coaches indicated that they would like some sort of guideline or "cheat sheet" to help interventionists to be more inclusive. Coach Olivia stated,

> I would love more examples of what it looks like and how I can ask questions to the leaders in a way that gets them to reflect better. So, if there's examples of how others have done this well rather than me leading a little bit blind. That'd be great. So, like almost like a what to do, what not to do to make all students feel welcome, safe.

This coach felt like she was leading the SMHPs on a topic that she herself was still becoming familiar with. To her it felt a bit like she was leading while blind. A resource that would have helped her was a set of examples on how to make students feel comfortable and a list of questions to help SMHPs to reflect on cultural relevance. Another coach had a similar observation. Coach Luna stated,

> So, like I wish we could almost make like a little like cheat sheet, maybe of like inclusive language of that instead of this, say that. Maybe saying like, instead of saying, parents say caregivers, instead of saying Christmas break, say holiday break.

This coach had a similar desire for a resources that had examples on how to be inclusive but this coach was focused primarily on language. She wanted to have a sheet of alternative phrases and terms that the interventionists could use so that all students felt welcomed.

Overall, two of the coaches wanted some type of guide to help both them and their interventionists to incorporate culture into the intervention. One of the coaches wanted examples of how to incorporate culture into the intervention so she felt like here was a case

study to work from. While the other coach talked about a cheat sheet of inclusive language that she could share with her interventionists so that all students feel welcomed into the group. Though these are two different resources, they both highlight the coaches' desire for more direction.

This section highlighted the coaches' perspectives. Many of the coaches' responses aligned the SMHPs' responses on how the interventionists created and maintained relationships and built safe spaces. However, the coaches added to this study by reporting on their discussions with the interventionists on cultural humility. These discussions highlight the need for additional resources to aid the SMHPs in incorporating culture into the intervention.

Chapter Five: Discussion

The purpose of this study was to address gaps that currently exist in positive psychology research, specifically the lack of research into the effectiveness of positive psychology interventions across racial groups and the cultural relevance of positive psychology interventions. This study evaluated the WBPP, a school-based positive psychology intervention, on several different facets. Firstly, it sought to examine the representativeness of the school samples when compared to the school populations. Another facet that was examined was the differential effectiveness of the WBPP across racial groups for the outcomes of life satisfaction, positive affect and negative affect. Then, lastly, this study used interview responses from students, SMHPs and coaches to gauge a better understanding of the perceived cultural relevance of the WBPP. This chapter includes a summary of the findings for the four research questions with integration with prior relevant research, followed by implications for practice, a statement of the limitations of the study and a conclusion of the study.

Summary of Findings

Research Question One

Are the racial/ethnic groups of the school samples representative of the racial/ethnic groups of the school populations?

A chi-square goodness of fit test was used to compare the proportion of students in the racial/ethnic subgroups in the samples to the proportion of students in the racial/ethnic subgroups in the school population based on data from the NCES. This comparison was done with each of the eight schools to determine if the proportions of students in the racial/ethnic subgroups of the study samples were representative of the school populations.

This author hypothesized that the proportion of racial/ethnic subgroups in the samples would not match the racial/ethnic subgroups of the school populations and this hypothesis was accurate for half of the schools. Four of the eight schools did not have a statistical difference between the school sample and the school population (reported by NCES). These schools included both MA schools in Year 1 (School Two, School Three), and during Year 2 a School from FL (School Four) and one from MA (School Six). In these schools, it appears that the recruitment procedures were successful in enrolling a sample of youth that mirrored the demographic composition of the larger school's student body.

There were four schools who did have a statistical difference between the school sample and the school population (reported by NCES). These included the FL school in Year 1 (School One), and three of five schools in Year 2: one in FL (School Five) and two schools in MA (School Seven, School Eight). In all four of these schools, students who identified as Bi/Multiracial were overrepresented in enrollment in the intervention study. Further, Hispanic students were underrepresented in schools in FL during both Year 1 (School One) and Year 2 (School Five), and White students were underrepresented in schools in MA during Year 2 (School Seven, School Eight). In School Eight (MA, Year 2), Asian students were overrepresented. One possible explanation for the apparent overrepresentation of some of the racial groups and the underrepresentation of some of the racial groups is the different ethnicity and race reporting methods used by the NCES and this study. The NCES racial data was based on parent reports of student race, while this study attained its racial data from the students themselves. There may have been a difference between how parents report their child's race and how students report their own race. For instance, parents may be more likely to simply report their child as Hispanic even if the child is biracial while students may be more likely to report themselves as biracial if they are Hispanic and another non-White race. This may have led to the overrepresentation of students in the Bi/Multiracial group in all the

schools and the underrepresentation of the Hispanic group in two of the schools. Nevertheless, these comparisons show how difficult it can be to recruit a representative sample. Based on these results the author concludes that the study sample was partially representative because there were significant differences in participation or assent across race/ethnicity in half of the schools.

However, this aligns with the general trend of racial representativeness in research. Sinclair et al. (2018) completed a systematic review of 495 articles on education interventions. Of these 495 articles, 45.1% did not even report the racial identities of their samples. Of the remaining studies, they reported that some races were overrepresented (Black, American Indian or Alaska Native), underrepresented (Latino, White, Asian American, Multiracial) and only a few met the national percentage (American Indian or Alaska Native). Pina et al. (2019) also conducted a systematic review of 65 studies on psychosocial interventions. They examined the samples of the studies to determine if they were representative of minoritized racial groups. According to this study 27 were representative sample for Hispanic/Latino youth, 19 studies for Black youth, one study for Asian American youth and 18 studies for multi-ethnic youth. Additionally, Gaias et al. (2020) completed a systematic review of educational interventions. They examined 96 studies and 210 meta-analyses and found that White, Hispanic and Native American students were underrepresented, Black students were overrepresented and Asian students were well represented in the study samples. This study aligns with these systematic reviews. The researchers in the current study took extra steps in the second year of the study to improve recruitment equity (using text messages to communicate with parents, and communicating in English and Spanish) but the sample was still not fully representative in all schools. Further research needs to be done on how to improve recruitment practices and make samples more representative.

Research Question Two

Do students from different racial/ethnic subgroups respond similarly to the WBPP with regards to outcomes in subjective well-being (life satisfaction, negative affect and positive affect)?

Multilevel modelling was used to answer this research question. For this analysis the first level units were the students, the second level units were the intervention groups, and the third level units were the schools. The outcome variable in the first multilevel modelling analysis was life satisfaction, in the second analysis it was positive affect and in the third analysis it was negative affect.

This author hypothesized that different racial/ethnic subgroups would have similar outcomes in life satisfaction, positive affect and negative affect and this hypothesis was accurate with the exception of the Asian group and positive affect. The first multilevel model assessed the potential effect of race on the SLSS post-test student scores and this analysis found that there are no statistically significant differences between the White group and the other racial groups. The second multilevel model assessed the potential effect of race on the positive affect post-test student scores and this analysis found that there was one statistically significant difference, which was between the White group and the Asian group. Specifically, the predicted post-intervention positive affect scores for Asian students who have an average pre-intervention positive affect score is 0.64 higher than White students who have an average pre-intervention positive affect score and this difference is statistically significant (*p-value*=0.03). This finding is also clinically significant because it indicates that the WBPP may be a particularly beneficial intervention for Asian students with low positive affect. The third multilevel model assessed the potential effect of race on the negative affect post-test student scores and this analysis found that there are no statistically significant differences between the White group and the other racial groups. These results show that students

respond similarly to the WBPP with regards to outcomes in life satisfaction and negative affect. However, students who identify as Asian have a higher predicted post intervention score in positive affect than their White counterparts.

In sum, participation in the WBPP appears to be associated with increases and life satisfaction and decreases in negative affect similarly for students in different ethnic groups. With regard to impact on positive affect, students who are Asian may show particular benefit when compared to White students and there is a trend for students who are Hispanic to benefit less when compared to White students. There is not much research in this area to integrate these findings with, although leaders in this area have called for subgroup analyses to identify the students for whom a given intervention is effective (Pina et al., 2019). In the Pina et al. (2019) systematic review, the authors also looked at the analyses used in the 65 studies. They found that seven studies used subgroup analyses and 16 studies evaluated if race was a moderator. In the Gaias et al. (2020) systematic review of educational interventions the authors examined the analyses of the studies and meta-analyses. They found that 15 of the 96 studies conducted sub-group analyses. Of the15 studies, six reported equivalent outcomes across race, four reported that the intervention was most effective for non-White students, one study reported that the intervention was most effective for White students, another study reported that their intervention was most effective for non-Hispanic students and three studies had mixed results. All 15 of these studies were done on a variety of interventions, ranging from a literacy intervention to a social belongingness intervention, that did not include school-based positive psychology interventions. Cipriano et al. (2022) also conducted a systematic review and found that of 269 studies only 76 examined the effectiveness of their interventions on minoritized students. However, of those 76 studies, 74 analyzed race as a moderator and two examined homogenous racial samples and did not

compare outcomes across racial groups. The author was unable to find studies on positive psychology interventions that used a subgroup analysis.

These systematic reviews, and the lack of similar studies in positive psychology research, show that few studies look at the differential effectiveness of interventions across racial groups. However, when researchers do conduct a subgroup analysis, we gain actionable information on intervention effectiveness. Gaias et al. (2020) reported that 15 studies completed subgroup analyses and through those subgroup analyses their authors identified interventions that were equally effective and interventions that were biased against or for certain racial groups. This study also conducted subgroup analyses and through this learned that the WBPP has equivalent outcomes across race for life satisfaction and negative affect and is more effective for Asian students for positive affect. This is information that can be used by interventionists as they determine what interventions to use with their students.

Research Question Three

In what ways is the WBPP perceived as culturally relevant by participants from minoritized groups? In what ways does the intervention align with the participants' cultures and in what ways does it not?

This research question focused on how the WBPP was perceived by minoritized students and which parts of it aligned with students' cultures. This author hypothesized that the WBPP would be considered culturally relevant by participants and that it would align with participants' cultures and this hypothesis was partially accurate. Students perceived the WBPP to be focused on unique life experiences instead of culture but they also indicated that the intervention aligned with their culture. This response was especially interesting because the students saw a difference between culture and unique life experiences when some may perceive the two as very similar. However, unique life experiences may not be directly connected to one's culture because it can include things like school and experiences within

school which aren't always connected to culture. The distinction between unique life experiences and culture is an interesting one that this study did not delve further into. However, according to the student responses, this focus on unique life experiences allowed the students to share and connect with their peers and interventionists (group leaders). The students found many of the intervention activities to be relatable, including gratitude visit, gratitude journal, optimistic thinking, acts of kindness, hope and goal directed thinking, and character strengths. There were two main reasons that these activities were perceived as relatable, because they were familiar and/or they led the students to develop skills. On the other hand, there were several activities that the students did not find relatable including savoring, best possible future self, character strengths, acts of kindness, you at your best and optimistic thinking. The main reason that these activities were unrelatable was a lack of connection, whether that was due to the difficulty that some students faced completing the activity, the unfamiliarity of the activities or external stressors not connected to the intervention.

Beyond just the activities, the students felt like they had a connection with their interventionists because of the group therapy practices that these group leaders used during the intervention. The interventionists built rapport with their students and actively listened to them during the sessions which made the students feel heard and understood. According to Cuijpers et al. (2019), alliance, empathy, treatment expectations, therapist effects, and cultural adaptations of the treatment are important factors that improve the effectiveness of counselling and therapy. Of particular relevance in that list is therapeutic alliance which includes collaborating with clients to reach goals and developing a bond with clients (Bourdin, 1979). The student responses indicated that they had strong therapeutic alliance with their interventionists which would improve the effectiveness of the intervention.

However, though rapport building and active listening are essential skills for interventionists to have, they do not necessarily make an intervention more culturally relevant. Both skills can help to create a safe space for students, which from the reports of the students they did, but they do not actively create opportunities for students to share their culture and learn about each other's cultures. The students reported two main ways that interventionists incorporated their culture into the interventions: through curiosity and asking questions, and by connecting their experiences with the skills they were learning. Interventions that are culturally adapted can have positive outcomes for minoritized students and result in high treatment acceptability (Hendriks et al., 2020; Hernandez et al., 2018; Kurtz et al., 2022). This is especially important because minoritized students are more likely to end treatment prematurely (Whitaker et al., 2018), but the high acceptability of culturally adapted interventions can address this early departure. The overall retention rate across the ten week intervention and post-intervention data collection period in the current study was 95%, with 5% attrition. Of the 16 students who were not available for post-intervention for any reason, one was Black or African American (3.84% attrition, 96.16% retention), one was Asian (10% attrition, 90% retention), ten were White (6.13% attrition, 93.87% retention), four were Hispanic (7.27% attrition, 92.73% retention) and one was Bi/Multiracial (3.12% attrition, 96.88% retention). All of the retention percentages were over 90% for each racial/ethnic group, which supports high acceptability of the intervention for minoritized and White students alike.

Additionally, even though the interventionists only engaged in a few practices to incorporate culture into the intervention, all the students felt comfortable and safe. This indicates that the interventionists were able to create a safe space for the students that could be used for students to share more about their culture. In fact, many of the students indicated that sharing stories with their group and hearing other people's studies led to feelings of

connectedness. This is group cohesion, which is defined by Burlingame et al. (2011) as the sense of belonging that individuals feel in their group and the importance of the group on the individual's therapeutic journey. According to Marziali et al. (1997) group cohesion is associated with positive outcomes in treatment. Thus, the interventionists were able to create an environment where the students formed high group cohesion which may have had positive impacts on their treatment outcomes.

There were a few students who felt like they did not belong with the group but even those students felt comfortable and safe, which really highlights the interventionists and their efforts to make the group a safe space for all. The students had some suggestions for how to make students feel safe in the groups and these included active listening, checking in and encouraging the students to share. All of these suggestions would help to build stronger relationships within the group. In addition, one student suggested that the interventionists facilitate some discussion of culture in the intervention. Given the safe space that is created within the group by the interventionists, this would likely not be difficult and would also increase the bonds among the students and between the students and the interventionists.

This author concludes that the WBPP is perceived as relevant and beneficial by the students. They relate to most of the activities and tasks of the intervention and feel genuinely safe during the group sessions. The students seem to really enjoy sharing their stories and hearing about other people's life experiences. Sharing and listening seem to help build connections and make the group feel even more connected. This may be partially attributed to the initial training and support that the interventionists received. All interventionists completed 12 hours of initial training where they learned about positive psychology, role played sessions and discussed cultural humility. Additionally, interventionists also received ongoing training in the form of 30 minute coaching each week where they reviewed the previous week and discussed group process (student engagement, relationship enhancement,

session flow and cultural humility). The training and ongoing support emphasized skills like building relationships and practicing cultural humility, all of which would have helped the interventionists to facilitate group sessions and create a space for students to share. However, the author believes that adding more intentional discussions of culture to this intervention would likely only increase these feelings of connectedness.

Research Question Four

What do interventionists do to enhance the cultural relevance of the WBPP, as reported by interventionists, observed by coaches, and/or perceived by students?

This research question focused on how the interventionists enhanced the cultural relevance of the WBPP from the perceptions of the students, SMHPs and coaches. This author hypothesized that the interventionists would have several strategies or methods that they used to enhance cultural relevance of the WBPP and this hypothesis was accurate. According to the SMHPs they incorporated culture by providing *Opportunities to Share*, through their *Language* and through their *Curiosity*. The interventionists created space for the students to share about their lives and their identity and some students used this space to share about their culture. The students also discussed how sharing and hearing stories from other students made them feel like they belonged to the group and helped to strengthen their relationships with their peers. *Opportunities to Share* seemed to create a safe space for the students which would make it easier for them to share more about their culture. However, it is not an action that intentionally incorporated culture. The SMHPs also discussed using inclusive language during the sessions. This is another example that would help students to feel more comfortable in the group sessions but does not intentionally and actively lead to students sharing or discussing their culture. Lastly, the interventionists talked about *Curiosity*. One SMHP discussed asking questions of students when they did open up about their cultural identity. This is a method of actively learning more about student culture and

incorporating cultural discussions into the intervention. The students also noticed these efforts, two of the nine students indicated that their interventionists incorporated their identity by *Showing Curiosity* and one indicated that being asked questions about her culture led to feelings of pride.

Cultural adaptations are typically a more systematic process of modifying an intervention to align with its participants. Hendriks and Graafsma (2019) proposed a four phase process for adapting interventions to be more culturally appropriate that included the inventory phase, the adaptation phase, the implementation phase, and the evaluation phase (Hendriks & Graafsma, 2019). Some common methods of culturally adapting interventions include adapting the language of the intervention, adapting intervention content to match the values of the target population, adapting the location of the interventions and matching the interventionist to the target population (Brown et al., 2018). The methods used by the interventionists to incorporate identity did not follow this process, however, they were not expected to undergo this process because this was not a part of the larger study. This study was more interested in the methods that the interventionists used based on their training and coaching. According to the responses from students, interventionists and coaches, the interventionists were able to adapt the intervention content to match the values of the students to some extent. Specifically, they did this through their *Curiosity* as several of them asked questions so they could learn more about their students' unique life experiences. While Hendriks and Graafsma's (2019) four phase process was not used by the SMHPs, they were still able to incorporate culture into the intervention.

Though the SMHPs were only able to identify one method that actively incorporated culture they identified several ways that they created and maintained relationships and built safe spaces. The SMHPs created relationships by checking in with students outside of the group sessions, using self-disclosure and facilitating connections between the students. They

also used *Rapport Building* to both create relationships with the students and to create a safe space for them. Both the coaches and the students noticed that *Rapport Building* was used by SMHPs to create a safe space. The coaches indicated that the interventionists remembered the stories shared by their students and used strengths spotting to show the students that they cared about them. The students noticed these efforts and four of the nine students indicated that they felt understood by the interventionists because of the rapport building actions that they engaged in. The SMHPs also used the group norms to create a safe space. The norms that they indicated were most helpful in this was confidentiality and voluntary participation. Again, both the coaches and the students noticed that the group norms helped to create a safe space. One of the coaches noted that group norms was another way that the interventionists incorporated culture into the intervention, especially those regarding confidentiality, support and respect. The norms of confidentiality and voluntary participation were identified by students as well. Two of the nine students stated that they felt comfortable in the group sessions because they knew that the experiences they shared would remain within the group. One of the nine students stated that they felt comfortable and safe because they knew that sharing was voluntary. As was mentioned in the previous section, alliance, empathy, treatment expectations, therapist effects, and cultural adaptations of the treatment are important factors that improve the effectiveness of counselling and therapy (Cuijpers et al., 2019). This means that though the interventionists did not focus on incorporating culture into the intervention, they used their empathy and therapeutic alliance with the students and, consistent with current research, this may have increased the effectiveness of the intervention and prevented attrition (Cirasola et al., 2021).

The coaches supplemented this discussion with some additional information that was not ultimately acted upon by the SMHPs. They had discussions with the SMHPs about culture including discussions about using ice breakers and incorporating identity into the

intervention. One coach also noted that one of her interventionists was not comfortable with discussions of culture and did not perceive culture as an important aspect of the intervention. The additional information that the coaches shared indicates that discussions of culture during the coaching sessions may not suffice for the interventionists to effectively incorporate the students' culture into the intervention. In fact, the coaches noticed this themselves and indicated that they needed additional resources to support the SMHPs. The resources that they discussed were a cheat sheet of inclusive language, examples of how to incorporate culture into an intervention and a discussion amongst the coaches to create a goal and common understanding. The findings from this study may highlight an area that needs improvement within the training model for the WBPP. The current training model aligns with behaviour skills training which is one of the leading models for training and includes written instructions, modelling of the intervention, rehearsal or role playing and continued feedback (DiGennaro Reed et al., 2018; Snyder et al., 2015). The professional development of the SMHPs aligned with this training model, as the SMHPs completed a 12 hour training, which included role plays and modelling by the facilitators, and received ongoing feedback through their weekly coaching sessions. However, based on the responses from the coaches and SMHPs there may be a need for enhanced training on incorporating culture into the intervention and this could possibly be done through the suggestions made by the coaches, the cheat sheet, examples and discussion.

There was one theme that overlapped among the students, SMHPs and coaches. This theme was *Rapport Building*, which was defined as engaging in positive interactions that strengthened relationships and build a safe space. It was mentioned by students in connection with *Cultural Efforts* and *Advice for Interventionists*. It was mentioned by SMHPs in connection with *Building and Maintaining Relationships* and *Building Safe Spaces*. And it was mentioned by coaches in connection with *Building Safe Spaces*. Across all three

respondents *Rapport Building* was perceived as a way that the interventionists created a safe space for students and this may be one of the reasons that all nine students felt comfortable and safe in their group. However, this author concluded that the SMHPs mainly used one intentional method to incorporate culture into the WBPP and this method was curiosity, which helped students feel more comfortable sharing. Some of the SMHPs asked questions to learn more about the students' cultures. Though there was only one method that explicitly led to discussions of culture, the SMHPs engaged in several practices that created connections between the interventionists and the students as well as connections between the students. The SMHPs were also able to create a safe space for the students where they felt comfortable and safe.

Implications for Practice

The quantitative sections of this study gives insight into the representativeness of the study's sample and the effectiveness of the intervention across race. This study revealed that even with the extra efforts made in Year 2, there are still some racial groups who were overrepresented or underrepresented. One explanation for that may be the ways that the data was collected (parent report of single/primary ethnicity or race versus student report of all applicable racial and ethnic identities), however, it still indicates that more needs to be done with future recruitment to ensure that there is a representative sample. Importantly, the quantitative analyses revealed that students respond similarly to their White counterparts in life satisfaction, positive affect and negative affect with the exception of Asian students who potentially responded better in that they scored higher in positive affect than their White counterparts. This information is helpful for practitioners who are intervening with a diverse group of students because they will know that the intervention can be used with students across racial groups.

The qualitative section also revealed several insights that are useful for practitioners and researchers. The student responses indicated that sharing stories and listening to other people share stories helped the students to feel more connected to the group. This information can be used to make interventions more acceptable for students. The students also reported that they found the WBPP to be both relevant and beneficial to them. This is useful to know because it means that students generally enjoy the WBPP which may lead to fewer students leaving the intervention before termination. Lastly, the responses from the students, SMHPs and coaches indicated that there was a limited use of strategies to incorporate culture into the intervention. This occurred even when the SMHPs received initial training on cultural humility and ongoing coaching. This highlights how difficult SMHPs find it to integrate culture into the intervention and indicates that additional resources may be needed.

Based on the practices used by the research team of focus in this study, practices that this researcher perceives were associated with the promising findings, future school psychology researchers and practitioners should consider are:

Professional Development

- Comprehensive training
- Role-play/rehearsal
- Model best practice implementation of the intervention

Recruitment

- Provide flyers and information for caregivers in multiple languages
- Communicate with caregivers via multiple modalities (email, hardcopy and text)
- Invite students individually and in-person
- Utilize a diverse team of adults to invite students
- Incentivize returning consent forms

Screening

- Include as much of the school population as possible in the screening, by:
- Send multiple requests to caregivers regarding permission for screening
- Extend the screening period to accommodate for student absences

Implementation

- Incorporate ongoing coaching where interventionists review their performance and receive feedback
- Utilize a diverse group of interventionists
- Incentivize the completion of progress monitoring assessments

Cultural Responsiveness

- Show curiosity through asking initial and follow-up questions
- Make connections between the students' experiences and the intervention activities

Contributions to the Literature

This study used a mixed methods design which allowed the author to go beyond the numbers to gain insight from the students, interventionists and coaches themselves. The quantitative portion of the study examined the representativeness of the study sample and the effectiveness of the intervention across race. Such analyses are critical to conduct in intervention research, to examine not only to what extent does the intervention work but also for whom. Future research can follow this example by examining their study sample for representativeness and examining more interventions for effectiveness across racial groups to determine whether they maintain, reduce or worsen inequities. The qualitative portion of the study focused on the perspectives of the students, interventionists and coaches and provided rich data on the lived experiences of the individuals receiving and giving the intervention. This was an essential part of this study because culture is a lived experience that cannot be captured simply through numbers and surveys. To truly understand the experiences of

students and interventionists, researchers need to create a space for them to share. This study showed future researchers how this can be done and is an example of the rich information that can be gained from qualitative research. The mixed methods design of this study worked well because it provided scientific evidence of the effectiveness of the WBPP while also pulling in human voices and human experiences into the discussion. The author believes that further research would benefit from a similar design.

Additionally, there were several gaps in intervention research that this study addressed. Current intervention research use samples that underrepresent minoritized populations and make limited attempts to recruit diverse populations (Cipriano et al., 2022; Gaias et al., 2020; Sinclair et al., 2018). Additionally, most studies examining the effectiveness of interventions fail to examine the differential effectiveness of interventions across race/ethnicity (Cipriano et al., 2022; Gaias et al., 2020). These gaps are significant for minoritized students because it means that they are seldom represented in the creation and validation of interventions that are used with them. This study addressed these gaps by using recruitment strategies to increase the recruitment of diverse students and by examining and comparing the outcomes of students across race/ethnicity. This was significant because it would add to the intervention research literature on positive psychology with a cultural lens, a lens that is currently missing in intervention research and sorely needed.

Lastly, it is important for researchers to communicate the contexts in which a study was completed. In the case of this study, data was collected in two different states with different policies, and the intervention was completed at school during the school day. This study contributed to the literature by providing this context and describing how data collection occurred within these contexts. This study outlined the steps used to recruit students for an intervention study, from screening to randomly assigning students to groups, and described the length of the intervention sessions and when students were pulled from

classes. It also described the differences in recruitment across different states with differing laws and policies, for instance Florida required active consent while Massachusetts allowed passive consent. Finally, this study provided examples of recruitment flyers, invitation scripts and procedures for completing a similar study. This information provides context for the study and also creates a guide that other researchers can use in their study.

Limitations and Future Research

One limitation of this study was mentioned earlier in the methods section, the racial data collected by the NCES which served as the school population data in the analyses was collected by parent report, while the racial data for the sample was collected by student report. There may have been discrepancies between parent and student reports of race that may have impacted the analyses, with youth particularly likely to identify as multiracial and parents possibly more likely to select a dominant racial identity when enrolling their child in school. Additionally, this study looked at differences across racial/ethnic subgroups, however, the sample size for some of the racial groups were not large enough to be analyzed. The racial groups were categorized into five groups, White, Hispanic, Black or African American, Asian and Bi/Multiracial. The Bi/Multiracial group included students who indicated that they belonged to multiple racial groups, as well as a small number of students who identified as American Indian or Alaska Native, students who identified as Native Hawaiian or Other Pacific Islander and students who did not report a racial group. The American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander racial groups were included in the Bi/Multiracial group because of their small sample sizes. Because these racial groups were re-categorized as Bi/Multiracial this study was not able to analyze how students in these racial groups reacted to the WBPP. Lastly, this study used on race/ethnicity to identify minoritized students, however there are other groups that experience marginalization that were not acknowledged in this study. For instance, immigrants and

English Language Learners are marginalized populations that were not specifically examined in this study. In fact some of the students who identified as immigrants and English Language Learners may have indicated that were a part of the White group, which was perceived as the majority group in this study. Thus the experiences of some minoritized groups were not fully examined in this study.

There were also several areas that could be further explored in future research. One area is students' understanding of race and culture. While this area wasn't explored in this study, the author noticed that there was variability in the students' ability to identify and discuss their culture. It would be interesting to explore this and delve deeper into concepts of race and culture amongst middle school students. Another interesting finding that came up in this study was the fact that all students felt comfortable and safe in their groups even those that did not feel like they fit in. This is an interesting finding because one would assume that being comfortable and fitting in go hand in hand, however, it seems that students felt comfortable even as they felt separate from the group. This would be an interesting area to do further research to examine the connections and differences between feeling comfortable in a group and feeling like you fit in with a group and how that affects group interventions. Another area of future research related to safe spaces involves how to bridge the gap between creating a safe space, and creating a space where students feel comfortable discussing their culture. In this study, all of the students indicated that they felt safe and comfortable in their groups; however, they also indicated that there was minimal discussion of culture. This means that the interventionists were able to create a safe space but did not create a space where discussions of culture abounded. More research into this phenomenon would be very beneficial to clinicians who are able to use their counselling skills to help students feel safe but may be struggling to increase cultural discussions in treatment. Additionally, further research could be conducted with minoritized groups that were missed in this study. For

instance immigrants and English Language Learners were two groups that were not focused on in this study but future research could assess the effectiveness of the WBPP for these groups. Lastly, the distinction between unique life experiences and culture was also a very interesting finding. Some of the students in this study indicated that the WBPP focuses on unique life experiences, not culture. It would be interesting to explore this further and distinguish the differences and similarities between culture and unique life experiences.

Conclusion

This was a mixed methods study that examined the cultural relevance of the WBPP from four different angles. The quantitative sections of the study gave valuable information into the sample and the effectiveness of the intervention across racial groups. This information informed on the representativeness of the sample and the extent to which the intervention was biased but those two data points were not enough to truly examine the cultural relevance of the WBPP. To achieve that goal the author explored the lived experiences of racially diverse students, this created a richer and deeper understanding of the WBPP and added to the discussion started by the quantitative section.

This study had four main research questions to examine the equity of the WBPP. The first research question was quantitative and examined the representativeness of the study sample when compared to the school populations. Based on the results the author concluded that the study sample was partially representative because half of the school samples were significantly different from their school populations. This shows that there is still work to be done in making samples representative, but also provides evidence of some promise because half of the schools did achieve representative participation. The second research question examined the effectiveness of the WBPP on improving life satisfaction, positive affect and negative affect across racial groups. The analyses revealed that students respond similarly to their White counterparts in all three outcome variables with the exception of Asian students

who had a higher predicted post-intervention score in positive affect than their White counterparts. This question was of particular interest because positive psychology interventions have been critiques for being created for and by the White racial group, but this study shows that Black, Hispanic, Bi/Multiracial and Asian students have similar improvements in life satisfaction, negative affect and positive affect (with the exception of the Asian racial group). The next two research questions analysed student, SMHP and coach perceptions on the cultural relevance of the WBPP. The study found that students find the intervention relatable and beneficial and that they enjoy sharing their stories and hearing their peer's stories. Additionally, the SMHPs were able to create a safe space for the students that led to feelings of comfort and safety. However, the SMHPs showed a limited usage of methods to incorporate culture.

References

Ali, M. M., West, K., Teich, J. L., Lynch, S., Mutter, R., & Dubenitz, J. (2019). Utilization of mental health services in educational setting by adolescents in the United States. *Journal of School Health*, *89*(5), 393-401. https://doi.org/10.1111/josh.12753

Antaramian, S. P., Huebner, E. S., Hills, K. J., & Valois, R. F. (2010). A dual-factor model of mental health: Toward a more comprehensive understanding of youth functioning. *American Journal of Orthopsychiatry*, *80*(4), 462.

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, *40*(4), 361.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252–260. https://doi.org/10.1037/h0085885

Briggs, S. (2009). Risks and opportunities in adolescence: Understanding adolescent mental health difficulties. *Journal of Social Work Practice*, *23*(1), 49-64. https://doi.org/10.1080/02650530902723316

Brown, C., Maggin, D. M., & Buren, M. (2018). Systematic Review of Cultural Adaptations of School-based Social, Emotional, and Behavioral Interventions for Students of Color. *Education & Treatment of Children (West Virginia University Press)*, *41*(4), 431–455. https://doi.org/10.1353/etc.2018.0024

Brown, N. J., & Rohrer, J. M. (2020). Easy as (happiness) pie? A critical evaluation of a popular model of the determinants of well-being. *Journal of Happiness Studies*, *21*(4), 1285-1301.

Brown, T. A. (2015). *Confirmatory factor analysis for applied research*. Guilford publications.

Burlingame, G. M., Fuhriman, A. J., & Johnson, J. (2004). Processes and outcomes in group counseling and psychotherapy: A perspective. In J. L. Delucia-Waack, D. Gerrity, C. R. Kalodner, & M. T. Riva (Eds.), *Handbook of counseling and psychotherapy* (pp. 49–62). Sage. http://dx.doi .org/10.4135/9781452229683.n4

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537–554. https://doi.org/10.1037/a0025266

Chang, D. F., & Yoon, P. (2011). Ethnic minority clients' perceptions of the significance of race in cross-racial therapy relationships. *Psychotherapy Research, 21*(5), 567-582. https://doi.org/10.1080/10503307.2011.592549

Cirasola, A., Midgley, N., Fonagy, P., Consortium, I., & Martin, P. (2020). The factor structure of the Working Alliance Inventory short-form in youth psychotherapy: An empirical investigation. *Psychotherapy Research, 31*(4), 1–13. https://doi.org/10.1080/10503307.2020.1765041

Corbin, J., & Strauss, A. (2008). Basics of qualitative research: Techniques and procedures for developing grounded theory. Thousand Oaks, CA: Sage.

Creswell, J. W. (2013). Qualitative inquiry and research design. Los Angeles: SAGE.

Cramer, K.M., & Castro-Olivo, S. (2016). Effects of a Culturally Adapted Social-Emotional Learning Intervention Program on Students ' Mental Health. *Contemporary School Psychology 20*, 118-129. doi:10.1007/s40688-015-0057-7

Diener, E. (2000). Subjective well-being: The science of happiness and a proposal for a national index. *American Psychologist, 55*(1), 34–43. https://doi.org/10.1037/0003-066X.55.1.34

DiGennaro Reed F. D., Blackman A. L., Erath T. G., Brand D., Novak M. D. (2018). Guidelines for using behavior skills training to provide teacher support. *TEACHING Exceptional Children, 50*(6), 373–380. https://doi.org/10.1177/0040059918777241

Doll, B., Dart, E. H., Arora, P., & Collins, T. A. (2021). Framing school mental health services within a dual-factor model of mental health. In *Fostering the emotional well-being of youth: A school-based approach*. Oxford University Press.

Donaldson, S. I., Cabrera, V., & Gaffaney, J. (2021). Following the Science to Generate Well-Being: Using the Highest-Quality Experimental Evidence to Design Interventions. *Frontiers in Psychology*, 5868. https://doi.org/10.3389/fpsyg.2021.739352

Ebesutani, C., Regan, J., Smith, A., Reise, S., Higa-McMillan, C., and Chorpita, B. F. (2012). The 10-item Positive and Negative Affect Schedule for children, child and parent shortened versions: application of item response theory for more efficient assessment. *Journal Psychopathology and Behavioral Assessment, 34*, 191–203. https://doi.org/10.1007/s10862-011-9273-2

Engle, P. L., & Black, M. M. (2008). The effect of poverty on child development and educational outcomes. *Annals of the New York Academy of Sciences*, *1136*(1), 243-256. https://doi.org/10.1196/annals.1425.023

Gaias, L. M., Duong, M. T., Pullmann, M. D., Brewer, S. K., Smilansky, M., Halbert, M., Carey, C. M.,& Jones, J. (2020). Race and ethnicity in educational intervention research: A systematic review and recommendations for sampling, reporting, and analysis. *Educational Research Review*, *31*, 100356. https://doi.org/10.1016/j.edurev.2020.100356

Garland, A. F., Lau, A. S., Yeh, M., McCabe, K. M., Hough, R. L., & Landsverk, J. A. (2005). Racial and ethnic differences in utilization of mental health services among high-risk youths. *American Journal of Psychiatry*, *162*(7), 1336-1343. https://doi.org/10.1176/appi.ajp.162.7.1336

Gillborn, D. (2005). Education policy as an act of white supremacy: Whiteness, critical race theory and education reform. *Journal of Education Policy*, *20*(4), 485–505. https://doi.org/10.1080/02680930500132346

Girvan, E. J., Gion, C., McIntosh, K., & Smolkowski, K. (2017). The relative contribution of subjective office referrals to racial disproportionality in school discipline. *School Psychology Quarterly*, *32*(3), 392.

Grafström, A., & Schelin, L. (2014). How to select representative samples. *Scandinavian Journal of Statistics*, *41*(2), 277-290. https://doi.org/10.1111/sjos.12016

Greenspoon, P. J., & Saklofske, D. H. (2001). Toward an integration of subjective well-being and psychopathology. *Social indicators research*, *54*(1), 81-108.

Gudiño, O. G., Lau, A. S., Yeh, M., McCabe, K. M., & Hough, R. L. (2009). Understanding racial/ethnic disparities in youth mental health services: Do disparities vary by problem type? *Journal of Emotional and Behavioral Disorders*, *17*(1), 3–16. https://doi.org/10.1177/1063426608317710

Harper, S. R. (2012). Race without racism: How higher education researchers minimize racist institutional norms. *The Review of Higher Education*, *36*(1S), 9–29. https://doi.org/10.1353/rhe.2012.0047

Howard, T. C. (2001). Telling their side of the story: African American students' perceptions of culturally relevant pedagogy. *Urban Review*, 33, 131-149.

Hendriks, T., & Graafsma, T. (2019). Guidelines for the Cultural Adaptation of Positive Psychology Interventions. *Caribbean Journal of Psychology*, *11*(1).

Hendriks, T., Schotanus-Dijkstra, M., Hassankhan, A., Sardjo, W., Graafsma, T., Bohlmeijer, E., & de Jong, J. (2020). Resilience and well-being in the Caribbean: Findings from a randomized controlled trial of a culturally adapted multi-component positive psychology intervention. *The Journal of Positive Psychology*, *15*(2), 238-253.

Hernandez, R., Cheung, E., Carnethon, M., Penedo, F. J., Moskowitz, J. T., Martinez, L., & Schueller, S. M. (2018). Feasibility of a culturally adapted positive psychological intervention for Hispanics/Latinos with elevated risk for cardiovascular disease. *TBM*, 2018 (8), 887-897. doi: 10.1093/tbm/iby045

Huebner, E. S. (1991). Initial development of the student's life satisfaction scale. *School Psychology International*, *12*(3), 231-240. https://doi.org/10.1177/0143034391123010

Huey Jr, S. J., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child & Adolescent Psychology*, *37*(1), 262-301.

Khanna, P., & Singh, K. (2019). Do all positive psychology exercises work for everyone? Replication of Seligman et al.'s (2005) interventions among adolescents. *Psychological Studies*, *64*(1), 1-10. https://doi.org/10.1007/s12646-019-00477-3

Kurtz, K. D., Pearrow, M., Battal, J. S., Collier-Meek, M. A., Cohen, J. A., & Walker, W. (2021). Adapting Social Emotional Learning Curricula for an Urban Context via Focus Groups: Process and Outcomes. *School Psychology Review*, 1-15. https://doi.org/10.1080/2372966X.2021.2021782

Larson, S., Chapman, S., Spetz, J., & Brindis, C. D. (2017). Chronic childhood trauma, mental health, academic achievement, and school-based health center mental health services. *Journal of school health*, *87*(9), 675-686. https://doi.org/10.1111/josh.12541

Laurent, J., Catanzaro, S. J., Joiner, T. E., Jr., Rudolph, K. D., Potter, K. I., Lambert, S., Osborne, L., & Gathright, T. (1999). A measure of positive and negative affect for children: Scale development and preliminary validation. *Psychological Assessment, 11*(3), 326–338. https://doi.org/10.1037/1040-3590.11.3.326

Lenz, A. S., Gerlach, J., Dell'Aquila, J., & Pester, D. (2020). A Mixed-Methodological Evaluation of a Subjective Well-Being Intervention Program With Elementary-Age Students. *Journal of Counseling & Development*, *98*(2), 200-206.

Lyons, M. D., Huebner, E. S., & Hills, K. J. (2013). The dual-factor model of mental health: A short-term longitudinal study of school-related outcomes. *Social Indicators Research*, *114*(2), 549-565.

Lyubomirsky, S., Sheldon, K. M., & Schkade, D. (2005). Pursuing happiness: The architecture of sustainable change. *Review of General Psychology*, *9*, 111–131. doi:10.1037/1089- 2680.9.2.111

MacLeod, K. B., & Brownlie, E. B. (2014). Mental health and transitions from adolescence to emerging adulthood: developmental and diversity considerations. *Canadian Journal of Community Mental Health*, *33*(1), 77-86. https://doi.org/10.7870/cjcmh-2014-007

Madubata, I., Spivey, L. A., Alvarez, G. M., Neblett, E. W., & Prinstein, M. J. (2019). Forms of racial/ethnic discrimination and suicidal ideation: A prospective examination of African American and Latinx Youth. *Journal of Clinical Child & Adolescent Psychology*, 1–9. Advance online publication. https://doi.org/10.1080/15374416.2019.1655756

Marziali, E., Munroe-Blum, H., & McCleary, L. (1997). The contribution of group cohesion and group alliance to the outcome of group psychotherapy. *International Journal of Group Psychotherapy*, *47*(4), 475–497. https://doi.org/10.1080/00207284.1997.11490846

Neblett, E. W., Rivas-Drake, D., & Umaña-Taylor, A. J. (2012). The promise of racial and ethnic protective factors in promoting ethnic minoritized youth development. *Child Development Perspectives*, *6*(3), 295–303. https://doi.org/10.1111/j.1750-8606.2012.00239.x

Palermo, T. M., Bromberg, M. H., Beals-Erickson, S., Law, E. F., Durkin, L., Noel, M., & Chen, M. (2016). Development and initial feasibility testing of brief cognitive-behavioral therapy for insomnia in adolescents with comorbid conditions. *Clinical Practice in Pediatric Psychology*, *4*(2), 214. https://doi.org/10.1037/cpp0000140

Priest, N., Paradies, Y., Trenerry, B., Truong, M., Karlsen, S., & Kelly, Y. (2013). A systematic review of studies examining the relationship between reported racism and health and well-being for children and young people. *Social Science and Medicine*, *95*, 115–127. https://doi.org/10.1016/j.socscimed.2012.11.031

Pumariega, A. J., Jo, Y., Beck, B., & Rahmani, M. (2022). Trauma and US Minority Children and Youth. *Current Psychiatry Reports*, 1-11.

Raudenbush, S. W., & Bryk, A. S. (2002). *Hierarchical linear models: Applications and data analysis methods* (Vol. 1). Sage.

Roth, R. A., Suldo, S. M., & Ferron, J. M. (2017). Improving middle school students' subjective well-being: Efficacy of a multicomponent positive psychology intervention targeting small groups of youth. *School Psychology Review*, *46*(1), 21–41.

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. Field methods, 15(1), 85-109. https://doi.org/10.1177/1525822X02239569

Santiago-Rosario, M. R., Whitcomb, S. A., Pearlman, J., & McIntosh, K. (2021). Associations between teacher expectations and racial disproportionality in discipline referrals. *Journal of School Psychology*, *85*, 80-93. https://doi.org/10.1016/j.jsp.2021.02.004

Seaton, E. K., Caldwell, C. H., Sellers, R. M., & Jackson, J. S. (2008). The prevalence of perceived discrimination among African American and Caribbean Black youth. Developmental Psychology, 44(5), 1288–1297. https://doi.org/10.1037/ a0012747

Seligman, M. E. P, & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*, 5-14.

Shalabi, N. M. (2014). Toward inclusive understanding and practice of diversity: Directions for accommodating Muslim and other religious minoritized students on university campuses. Journal of Critical Thought and Praxis, 2(2). https://doi.org/10.31274/jctp-180810-19

Shoshani, A., & Steinmetz, S. (2014). Positive psychology at school: A school-based intervention to promote adolescents' mental health and well-being. *Journal of Happiness Studies*, *15*(6), 1289–1311.

Sinclair, J., Hansen, S. G., Machalicek, W., Knowles, C., Hirano, K. A., Dolata, J. K., Blakely, A.W., Seeley, J., & Murray, C. (2018). A 16-year review of participant diversity in intervention research across a selection of 12 special education journals. *Exceptional Children*, *84*(3), 312-329. https://doi.org/10.1177/0014402918756989

Snyder P. A., Hemmeter M., Fox L. (2015). Supporting implementation of evidence-based practices through practice-based coaching. *Topics in Early Childhood Special Education*, *35*(3), 133–143. https://doi.org/10.1177/0271121415594925

Substance Abuse and Mental health Services Administration. (2022, July 23). *Results from the 2020 National Survey on Drug Use and Health: Mental Health Findings*. 2020 National Survey of Drug Use and Health (NSDUH) Releases. https://www.samhsa.gov/data/release/2020-national-survey-drug-use-and-health-nsduh-releases

Suldo, S. M. (2016). *Promoting student happiness: Positive psychology interventions in schools*. Guilford Publications.

Suldo, S. M., Savage, J. A., & Mercer, S. H. (2014). Increasing middle school students' life satisfaction: Efficacy of a positive psychology group intervention. *Journal of Happiness Studies*, *15*(1), 19–42.

Suldo, S. M., & Shaffer, E. J. (2008). Looking beyond psychopathology: The dual-factor model of mental health in youth. School Psychology Review, 37(1), 52–68.

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International journal of medical education*, *2*, 53. doi: 10.5116/ijme.4dfb.8dfd

Tejada-Gallardo, C., Blasco-Belled, A., Torrelles-Nadal, C., & Alsinet, C. (2020). Effects of school-based multicomponent positive psychology interventions on well-being and distress in adolescents: A systematic review and meta-analysis. *Journal of Youth and Adolescence, 49*, 1943–1960. https://doi.org/10.1007/s10964-020-01289-9

Thomas, J. F., Temple, J. R., Perez, N., & Rupp, R. (2011). Ethnic and gender disparities in needed adolescent mental healthcare. *Journal of Health Care for the Poor and Underserved, 22*, 101–110.

Wegmann, K. M., Powers, J. D., Swick, D. C., & Watkins, C. S. (2017). Supporting academic achievement through school-based mental health services: A multisite evaluation of reading outcomes across one academic year. *School Social Work Journal, 41*(2), 1–22.

Whitaker, K., Nicodimos, S., Pullmann, M. D., Duong, M. T., Bruns, E. J., Wasse, J. K., & Lyon, A. R. (2018). Predictors of disparities in access and retention in school-based mental health services. School Mental Health, 10(2), 111–121. https://doi.org/10.1007/s12310-017-9233-4

Wintersteen, M. B., Mensinger, J. L., & Diamond, G. S. (2005). Do Gender and Racial Differences Between Patient and Therapist Affect Therapeutic Alliance and Treatment Retention in Adolescents? *Professional Psychology: Research and Practice*, *36*(4), 400–408. https://doi.org/10.1037/0735-7028.36.4.400

Wolf, K. C., & Kupchik, A. (2017). School suspensions and adverse experiences in adulthood. *Justice Quarterly*, *34*(3), 407–430 . https://doi.org/10.1080/07418825.2016.1168475

Wood, P. A., Yeh, M., Pan, D., Lambros, K. M., McCabe, K. M., & Hough, R. L. (2005). Exploring the relationship between race/ethnicity, age of first school-based services utilization, and age of first specialty mental health care for at-risk youth. *Mental Health Services Research, 7*(3), 185-196.

Appendix A: Active Parent Consent Letter

Study ID: STUDY001065_MOD000005
Date Effective: 9/7/2022

Dear Parent or Guardian:

This letter tells you about a study called "Promoting Well-Being in Middle School Students." The study is being done at your child's school by researchers from the University of South Florida (USF) and the University of Massachusetts Amherst (UMass). The research team is called Project SOAR, which stands for Strengths, Optimism, Achievement, and Relationships. We are doing this study to evaluate the Well-Being Promotion Program (WBPP). The WBPP is a program offered at school to increase personal well-being. Greater well-being, in turn, enhances students' readiness to learn and academic success. Earlier in the school year, your child took part in a screening to examine students' emotional well-being (life satisfaction, and frequency of positive and negative moods). The next step in this project is to offer extra support to students whose survey responses indicate room for growth in well-being; some students will participate in the WBPP this year and others the next year. This study will determine the effect of the WBPP on students' emotional well-being and school performance. The following information is shared to help you and your child decide whether you would like to join the research study.

✓ Who We Are: Project SOAR is led by USF and UMass Professors Shannon Suldo and Sarah Fefer. Our research team includes graduate students and school psychologists from our Colleges of Education. We are doing the study in collaboration with the district and school administrators to ensure the study provides information that will be helpful to students, educators, and families.

✓ Why We are Requesting You and Your Child's Participation: We are doing this study to evaluate a promising program created to increase middle school students' emotional well-being. Findings from the study will help educators know more about activities that increase well-being in youth, and how well-being links to school success. The study is funded by the Institute of Education Sciences. We are requesting your child's participation because of their responses on a recent survey of emotional well-being. Your child's responses indicated room for growth in their life satisfaction. This is not unusual, most youth are not fully satisfied with their life across multiple domains. Your child is invited to take part in the WBPP that is intended to increase students' well-being, including from "mostly satisfied" to "delighted" with life. You are being asked to participate because you are one of the child's parents, caregivers, or legal guardians.

✓ What Your Child's Participation Requires: Children with permission to participate will be randomly assigned to one of two groups: *program now* and *program later*. There is a 50/50 chance of being assigned to either group. Students in the *program now* group will begin the WBPP in the next few weeks. Students in the *program later* group will be offered the WBPP or other positive activities that promote life satisfaction the next school year, after this study ends. Note: students in both groups will still receive existing supports provided by the school.

All students in the *program now* and *program later* groups will be asked to complete several surveys on four occasions over two years: near the beginning, middle, and end of this school year, and the middle of the next school year. These surveys will ask about your child's attitudes towards learning, classroom behavior, personal strengths, relationships, and emotional well-being (life satisfaction, as well as emotional and behavioral problems). Completion of surveys is expected to take about 45-60 minutes on each occasion. On each of these four occasions, one of your child's teachers will be asked to independently and privately complete short surveys about your child's behavior at school.

Additionally, students in the *program now* group will participate in the WBPP, and be invited to participate in two 30-minute interviews to provide feedback on the program and their use of various skills learned in the meetings. The WBPP starts with 10 weekly meetings. Your school's mental health team will meet with small groups of students once per week for 30-45 minutes. Meetings will consist of

lessons about ways of thinking and behaving that are related to emotional well-being. Students will complete activities intended to evoke positive moods and strengthen relationships and complete homework to practice these activities. After the 10 weekly meetings, students will take part in follow-up meetings about once per month, up to five meetings, to review topics and activities learned earlier.

All research activities (survey completion, WBPP meetings, and feedback) will be during regular school hours and scheduled to be minimally disruptive to your child's academic course schedule. In the event of student absences or a school closure, your child may complete portions of the study online using technology arranged with the school for meetings and/or survey completion. In total, participation will take no more than 4 hours for students in the *program later* group and 15 hours for students in the *program now* group during the study period. All but one hour of that time will be during this school year, and the remaining hour will be during next school year.

Another part of participation involves a confidential review of your child's school records. District employees will provide the research team with your child's: demographic features (gender; race/ethnicity; eligibility for discounted school meals; identification as an English Language Learner or a student with an exceptionality; date of birth); district student ID number; student email address (district assigned account); as well as student academic achievement (grades in each course, and scores on district/state assessments of academic skills) and school behavior (attendance, number of office referrals) during the two year study period and the year prior.

✓ What Your Participation Requires: For all students (*program now* and *program later* groups), one parent/caregiver per child participant will be asked to complete brief surveys of your child's behavior on four occasions over two years: near the beginning, middle, and end of this school year, and the middle of the next school year. These surveys will ask about your child's emotional well-being (life satisfaction, as well as emotional and behavioral problems) as demonstrated at home. Completion of the surveys is expected to take about 15 minutes on each occasion. If your child is assigned to the *program now* group, you will be asked to attend one 30-minute information meeting about the WBPP in the next few weeks. There will be multiple times and options for how to attend this meeting, such as in person at your child's school, join a remote meeting electronically, or watch a pre-recorded session online. We will provide food and childcare at in-person meetings. The time, date, and location options for the meeting will be shared with you through the contact method you provide on the next page. In this meeting for families, we will describe the WBPP activities and answer any questions. You will be asked to share feedback on the meeting after you participate. Throughout the program, you will receive one-page handouts that describe what your child did during each meeting at school, in order to support your child in practicing the WBPP activities at home. It should take about 15 minutes per week to review and discuss the handout with your child. When your child has finished the 10 weekly meetings, we will ask you to complete a 30-minute survey to gather your feedback on the WBPP and your use of activities at home.

All research activities (survey completion, family information meeting, and feedback) will be at your convenience, outside or during school hours based on your preference. Surveys will be completed online with links sent through email; surveys can be completed in hard copy (paper-and-pencil) or over the phone upon request. In total, participation will take no more than 1 hour for parents of students in the *program later* group and 4.5 hours for parents of students in the *program now* group during the study period. All but 15 minutes of that time will be during this school year, and the remaining 15 minutes will be during next school year.

✓ Why You and Your Child Should Participate: The WBPP is intended to help students develop skills linked to personal well-being, as well as social and academic success. Prior studies with middle school students found participation in the WBPP caused gains in life satisfaction and positive feelings, and reductions in negative feelings. Thus, your child may experience an increase in well-being due to taking part in the WBPP. More research evidence for the effectiveness of activities to increase well-being may allow children in the future to take part in such programs at school. Group-level results of the study will be shared with school counselors, teachers, and leaders, to increase their knowledge of activities that promote student well-being. Please note you and your child will not be paid for participation in the study. However, all students who return this permission form will receive a small gift in the form of a school supply (even if you indicate your child can not participate). All students who complete the surveys about their thoughts, feelings, and behaviors will receive a $5 gift card or gift of the same value after each time they complete surveys (up to four occasions). Students in the *program now* group who provide feedback on the WBPP will receive a $5 gift card or gift of the same value each time they provide feedback in an interview (up to two occasions). All parents who provide ratings of their child's emotional well-being will receive a $10 gift card after each time they complete surveys (up to four occasions). Parents of students in the *program now* group who provide feedback on the WBPP will receive a $25 gift card.

✓ Please Note: You and your child's participation is voluntary. You are free to allow your child to participate in this research study or to withdraw them at any time. Your child has the right to withdraw their assent

or discontinue participation at any time without penalty. If your child indicates a wish to discontinue, you will be contacted to be kept aware of your child's participation. Any decision to participate, not participate, or withdraw participation at any point during the study will in no way affect your child's student status, their grades, or your relationship with your child's school, school district, USF/UMass, or any other party. Your child does not have to participate in any part of this research. You or your child have the right to inspect the survey instruments before they are administered, if a request is made within a reasonable amount of time. The surveys will be available at your school prior to the survey administration.

✓ Confidentiality of Responses and Study Risks: This research is considered minimal risk. Minimal risk means that study risks are the same as the risks you face in daily life. There are no known additional risks to those who take part in this study. Your child will receive no guaranteed benefits by participating in this research study. Your and your child's privacy and research records will be kept confidential to the extent of the law. Authorized research personnel, employees of the Department of Health and Human Services, the USF Institutional Review Board and its staff, and other individuals acting on behalf of USF may inspect the records from this research project. However, your and your child's individual responses will not be shared with school system personnel or anyone other than us and our research assistants. Your child will be assigned a study code number to protect the privacy of information from students, parents/caregivers, teachers, and school records. Only approved study staff will have access to the password-protected files and locked file cabinets stored at USF/UMass that will contain records linking code numbers to participants' names, and data gathered from school records. Your child's responses during some research activities will be digitally audio recorded, and then assigned the study code number to protect the confidentiality of their statements. Consenting for your child to participate in this project also indicates your consent for your child to be audio recorded. For students in the *program now* group, we cannot guarantee that what your child says during group meetings will not be repeated by other students who take part in the same group. But, we will encourage children to respect privacy and not repeat what is said in the meetings to others. No names will be attached to stored surveys or audio files. All records from the study will be destroyed five years after the study is completed. These records include completed surveys, activity forms completed during group meetings, and information from students' school records. A de-identified version of the electronic dataset that includes your de identified records could be used for secondary analyses in future research studies conducted by USF/UMass and by other investigators. Your and your child's specific responses and comments will not be shared with school staff. However, if you or your child indicate that your child intends to harm themself or someone else, we will contact your school counselor or other district mental health staff. Those individuals will follow district procedures for ensuring the safety of your child and others and follow up with parents and guardians about concerns for student well-being. Please note that if you, your child, or your child's teacher complete portions of the study online (such as complete surveys electronically), it is possible, although unlikely, that unauthorized individuals could gain access to responses. Confidentiality will be maintained to the degree permitted by the technology used. No guarantees can be made regarding the interception of information sent via the Internet. However, your participation in this study using electronic surveys or meeting methods involves risks similar to a person's everyday use of the Internet. Please note that due to the COVID-19 pandemic, face to-face interactions with study staff may pose a risk of transmission of the novel coronavirus. Study staff will adhere to all district health and safety measures for individuals entering schools, such as use of facial coverings.

✓ What We'll Do With Your and Your Child's Responses: We plan to use information from this study to determine the effectiveness of school programs intended to increase student well-being. Study findings will inform educators about activities that promote emotional well-being in middle school students, and the link between well-being and school success. Results from data collected during this study may be published. However, the data obtained from you and your child will be combined with data from other people in the publication. We expect a total of about 1170 children and 1340 adults (parents, teachers, and school mental health staff) will take part in this study across Florida and Massachusetts schools. The published results will not include any information that would in any way identify you or your child.

✓ Questions? If you have questions about this study, contact Dr. Suldo at (813) 974-2223 or Dr. Fefer at (413) 545-0211. If you have questions about your rights as a person who is taking part in a research study, contact a member of the USF Division of Research Integrity and Compliance at (813) 974-5638. Refer to Study # 001065.

✓ Want to Participate? To permit you and your child to take part in this study, check "YES" and complete the consent form below (titled "Consent to Participate… in this Research Study"). Provide your contact information (phone numbers, email address, how to reach you via text). If you complete the form electronically via DocuSign, download and keep a digital form for your records. If you complete the form in hard copy, ***have your child return the green paper with the completed form to their designated teacher.*** Sign and keep the other copy of this letter (on gold paper) for your records.

Sincerely,
Shannon Suldo, Ph.D. (Professor) Sarah Fefer, Ph.D. (Associate Professor) School Psychology Program, College of Education School Psychology Program, College of Education University of South Florida University of Massachusetts Amherst

Consent to Participate and Parental Permission for My Child to Participate in this Research Study

☐ YES, I freely give my consent to take part and give permission for my child (_____) to take part in this study. I understand that by signing this form I am agreeing to take part and to let my child take part in research. I have received a copy of this form for my records.

☐ NO, I do not give permission for my child (_____) to take part in this study.

_____ _____
_____ **Signature of parent Printed name of parent Date** ----------
---------- ***If you checked "YES" above to permit your child to take part in the study, please provide the information requested below:***

_____ _____ _____
Printed name of child Child's date of birth Parent email address(s)

Parent phone numbers: (cell/text): _____ (home or office): _____

Preferred method of communication, to get weekly updates on the Well-Being Promotion Program? *Check all that apply:* ____ text ____ phone call ____ email ____ other (describe: _____)

Do you want to attend a **parent information meeting** about the Well-Being Promotion Program? **What format** do you prefer? ____ yes (in person, face-to-face) ____ yes (remote: live online meeting) ____ yes (remote: pre-recorded video) ____ yes, other (describe: _____) ____ no

If yes for an in-person *or* live online information meeting, what **time of day** do you prefer? ____ morning ____ afternoon (during school hours) ____ afternoon (after school hours) ____ evening (6pm or later)

Preferred language for communication: ___English ___Spanish ___other (describe: _____)
Preferred language for parent information meeting: ___English ___Spanish ___other (describe: _____)

(Portion for USF or UMass to complete): **Statement of Person Obtaining Informed Consent** I certify that participants have been provided with an informed consent form that has been approved by the University of South Florida's Institutional Review Board and that explains the nature, demands, risks, and benefits involved in participating in this study. I further certify that a phone number has been provided in the event of additional questions.

_____ _____ _____
Signature of person obtaining consent Printed name of person obtaining consent Date

Appendix B: Recruitment Flyer

Students, you're invited to Project SOAR!

What is Project SOAR?

- Project SOAR is a research project taking place at your school in partnership with researchers from the University of South Florida and UMass Amherst. SOAR stands for strengths, optimism, achievement, and relationships.
- Students who join Project SOAR will take part in the Well-Being Promotion Program during the school day either this school year or next school year. Nothing else at school would change.

How would you describe the Well-Being Promotion Program?
"A program where we do activities where we try to understand how we can make our lives better by helping others, or doing kind things for others for ourselves and thinking about the kind of things we can do in the future or the present."

Why am I being invited?

Middle school can be a challenging time, and there are lots of things outside of our control that can cause us to feel less than delighted about how things are going at home, at school, or with friends. We are inviting all students who, on the recent well-being survey, said that they were anything less than "mostly satisfied" on average to participate in Project SOAR. We know from past research that middle school students can learn positive activities to increase their satisfaction across multiple areas of life, which is why we are bringing Project SOAR to your school.

Why might participating in this project matter for me?

The Well-Being Promotion Program teaches middle schoolers about positive activities that they can do to enhance well-being. Research has shown that engaging in positive activities can help middle schoolers to:

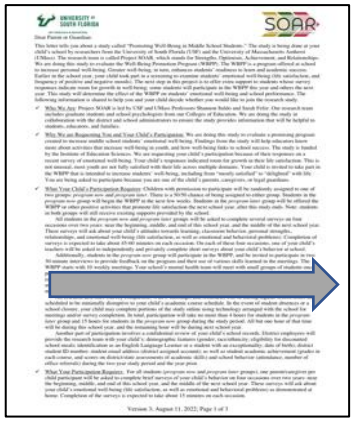
- improve performance in school
- enhance friendships and other relation
- manage challenging situations
- have a positive outlook on life

What did you like best about the program?
"You see the effects have definitely changed my mindset with anything else. Definitely think more positively than I did before the program. Definitely socialize a whole lot more."

Do I have to participate in this project?

Your participation in this project is voluntary. If you start and change your mind, you can stop participating at any time, and we will let your parent/caregivers know about your choice. If you choose not to participate or stop participating, no one will be upset, and nothing will change.

What should I do next?



1. Let your parent/caregiver know that you have been invited to Project SOAR. Share this flyer with them, and your thoughts about whether you may want to participate.
2. Give your caregiver the green and yellow permission forms and ask them to fill them out to indicate whether you will be participating in this project.
3. Bring the completed green permission form back to school to get a prize! You will also get a prize if your caregiver fills out a digital form sent to them via email. You will get a prize regardless of whether they say that you can participate.

If my parent/caregiver and I decide to participate, then what happens?

- First, the research team will double check that you would like to participate in the study and ask you to complete an assent form (like a student permission form for yourself).
- Then, you will be asked to complete an online survey during the school day and receive a $5 gift card as a thank you.
- Next, you will find out if you will participate in the Well-Being Promotion Program during this school year or next school year.

If you have any questions, please ask your counselor at school!

Parents/Caregivers, You and Your Child are invited to Project SOAR!

What is Project SOAR?

- Project SOAR (Strengths, Optimism, Achievement, Relationships) is a research study funded by the Institute of Educational Sciences taking place at your child's school this year. It is in partnership with a team led by Dr. Shannon Suldo from the University of South Florida and Dr. Sarah Fefer from UMass Amherst.
- This study evaluates the Well-Being Promotion Program (WBPP), a program offered at school to increase well-being. Greater well-being, in turn, enhances students' readiness to learn and academic success.
- This flyer tells a bit more about the WBPP, with quotes from families who recently completed the program.
- The 3-page green permission form describes the study in greater detail.

Why might participating in this project matter for my child?

The WBPP is intended to help students develop skills linked to personal well-being, as well as social and academic success. Prior studies with middle school students found participation in the WBPP led to gains in life satisfaction and positive feelings, and reductions in negative feelings.

What did you like best about the WBPP?
"The small group setting for my child. The activities and lessons he learned. The opportunity to get to know his counselor better."

What would my child's participation entail?

- Student participants will be randomly assigned to one of two groups: *program now* and *program later*.
    - Students in the *program now* group will begin the WBPP in the next few weeks.
    - Students in the *program later* group will be offered the WBPP or other positive activities that promote life satisfaction the next school year, after this study ends.

> *"This was a great opportunity for mental health education for middle schoolers. I am very glad and grateful that my child could participate and learn more about these topics."*

- Participation in this project will not change your child's access to any academic, behavioral, or social-emotional supports in school.
- All students in the *program now* and *program later* groups will complete several surveys on four occasions over two years. Students receive a $5 gift card on each occasion.

What would be my role in this study?

- For all students, one caregiver per child participant will be asked to complete brief surveys of your child's behavior on four occasions over two years. You will receive a $10 gift card on each occasion as a thank you.
- If your child is randomly assigned to the *program now* group:
    - In the next few weeks, you will be invited to attend a 30-min information meeting about the WBPP.
    - Throughout the program, we ask that you support your child's at-home practice of the WBPP activities by reviewing a one-page handout that describes what your child did during each meeting.

> **What did you like best about the WBPP?**
> *"It gave my child the opportunity to learn about other ways of thinking. She really enjoyed the optimistic thinking topics, and it allowed her to hear about positive ways to think and live from someone other than her family members."*

- *Please note:* You and your child's participation are voluntary, and you are free to allow your child to participate in this research study or to withdraw them at any time. Your child has the right to withdraw their assent or discontinue participation at any time without penalty, and our team will inform you if this occurs.

What should I do next?

1. Talk with your child about Project SOAR to decide whether you and they may want to participate.
2. Review and complete the green permission form brought home by your child to indicate whether or not you and your child will be participating in this study. If you would prefer to complete a digital form, please email wellbeingstudy@usf.edu (FL) or wellbeingstudy@umass.edu (MA) to request a DocuSign version.

If you have any questions or would like to discuss this invitation further, please reach out to Dr. Suldo at USF (suldo@usf.edu) or Dr. Fefer at UMass (sfefer@umass.edu) for more information.

Appendix C: Passive Consent Form

Year 1

Recruiting Students for Study Participation

Dear School Mental Health Provider,

We are requesting your assistance to recruit students for participation in a research study designed to evaluate the Well-Being Promotion Program (WBPP). The WBPP is an extra support grounded in positive psychology and develops students' skills in increasing personal happiness. This extra support is offered only to students whose ratings of their subjective well-being in the recent happiness screening were ≤ the 25th percentile. Participating students at your school will be randomly assigned to one of two conditions: WBPP during the *current* school year, or extra support during the *next* year. This 10-week program is provided to small groups of students, and the meetings last about one class period and are held once per week. To minimize loss of instructional time, meetings can be held on a rotating schedule, elective period, or lunch. The exact meeting times and places will be selected by the school leadership team. Student participation in the WBPP involves completing various tasks as laid out in the WBPP manual, during and outside of the small group meetings. We are asking all students who are in the study to take part in the evaluation of the WBPP by completing surveys before and after the student program is implemented in the *current* year, so that we may track students' social-emotional and academic outcomes. Survey completion is expected to take about 45-60 minutes on each occasion (before and after the program). We will administer the surveys during regular school hours to students who have caregiver permission to participate. Please follow the steps below to recruit students for participation in this study, through brief individual meetings with all students identified as ≤ 25th percentile on subjective well-being. In these meetings, you will privately communicate to the student that they are being asked to participate in the WBPP because of their responses in the screening. Please take measures to reduce potential stigma attached to the intervention. Specifically, explain that lots of students feel that at least one area of their life could be improved, explain the intervention targets and purpose, and let them know that many students in their school are also being invited. Then, distribute two copies of the caregiver consent/permission forms to the student. Ask them to keep the gold copy of the form for their family's records; the green copy should be completed by the caregiver and returned to you, whether or not the caregiver chooses for the child to participate. Please note that participation by students is completely voluntary; their decision to participate (or not) should not impact their grades nor their relationship with USF/UMass, you, or anyone at their school. Please do not use any coercion or undue influence in recruiting participants. This study's procedures have been approved by USF IRB (Study # 001065).

Please say to students:

Hello, I'm [introduce self and affiliation to school]. *I am working with a research team at USF/UMass that is conducting a study to evaluate a program created to improve students' happiness. It is called the Well-Being Promotion Program. Your school counselors/psychologists/ social workers, including myself, will be leading the 10-week program. We will meet with small groups of students once a week during the school day. These meetings will take about 45 minutes. We will do activities that teach you ways to think and act that are related to feeling happy. We will practice grateful thinking. We will do nice things for others. And we will find out our*

personal strengths. After the program is done, the small groups will get together about once per month to keep practicing the happiness activities.

We think you may be interested in this program, and are inviting you to join the study, because of surveys you filled out recently during the happiness screening. Your answers to some questions showed that you have some room for growth in your satisfaction with life. You are not alone; many students at your school feel that one or more areas of life could be going better. That's why we teach students ways of thinking and acting that make them feel happier with their families, friends, school, and self. We aim for all students to feel delighted with their lives, so we are inviting many students in your grade to take part in this program.

Participation in this study is voluntary; it is your choice whether or not you want to participate. If you decide to take part in the project, you can still change your mind later. No one will be upset if you stop the study. If you join the project, we would be very excited to work with you! However, if you don't join, nothing will change. Students who join this study will do a few things. They will fill out several surveys about their current thoughts, feelings, and behaviors, up to 4 times during the study (3 times this school year, 1 time next year). Students will receive a $5 gift card [specify to where] *or gift worth that much after each time they complete the surveys. Some of the students will start the Well-Being Promotion Program this year. Other students will start next school year. Students who start the Well-Being Promotion Program this year will receive the $5 gift card or gift each time they share their thoughts about the program, up to 2 times this year.*

Only students with permission from their caregiver at home- such as a parent, grandparent, or legal guardian- can join the study. Bring these permission forms home to your caregiver. Your caregiver should keep the gold copy and then they should complete the other copy, printed on green paper. Return the green copy completed by your caregiver to me as soon as you can, whether or not your caregiver chooses to allow you to participate. Would you like a version that is written in Spanish?

We are collecting signed permission forms that will allow students to take part, or tell us whether a caregiver has indicated they do not want their child to take part. Each student who returns a form will get a small gift to use at school, such as a highlighter or pen [show students the pen, fidget, eraser, etc. they can choose]. *You will still get the gift if your caregiver writes on the form that you can't take part in the project. Caregivers can also complete the form electronically. If you would prefer I email this to your caregiver, I'd be glad to. Just tell me their name and email address, whether to send in English or Spanish, and when you'd like for me to send the email. For instance, perhaps tomorrow morning after you've had a chance to talk with them about it? Or should I send it today?*

Do you have any questions for me? If you think of some later, or your caregivers have any questions about this research study, the phone numbers for the researchers and the USF Division of Research Compliance are listed on the caregiver permission form. Refer to Study # 001065. Please note that in-person interactions with any extra people put you at increased risk of getting COVID-19. The researchers from USF/UMass who visit your school will follow health and safety measures like using facial coverings, social distancing, and checking temperatures. Despite taking such steps to protect your health, it cannot be guaranteed that you will not be exposed to the virus.

Please place the signed consent forms back into this envelope. Completed envelopes will be collected by a member of the USF/UMass research team. Thank you!

Sincerely,

Shannon Suldo, Ph.D.
School Psychology Program, College of Education
University of South Florida

Sarah Fefer, Ph.D.
School Psychology Program, College of Education
University of Massachusetts Amherst

Appendix D: Year 2 Student Recruitment

Dear School Mental Health Provider,

We are requesting your assistance to recruit students for participation in a research study designed to evaluate the Well-Being Promotion Program (WBPP). The WBPP is an extra support grounded in positive psychology and develops students' skills in increasing personal happiness. This extra support is offered only to students whose ratings of their subjective well-being in the recent happiness screening were ≤ the 25th percentile. Participating students at your school will be randomly assigned to one of two conditions: WBPP during the *current* school year, or extra support during the *next* year. This 10-week program is provided to small groups of students, and the meetings last about one class period and are held once per week. To minimize loss of instructional time, meetings can be held on a rotating schedule, elective period, or lunch. The exact meeting times and places will be selected by the school leadership team. Student participation in the WBPP involves completing various tasks as laid out in the WBPP manual, during and outside of the small group meetings. We are asking all students who are in the study to take part in the evaluation of the WBPP by completing surveys before and after the student program is implemented in the *current* year, so that we may track students' social-emotional and academic outcomes. Survey completion is expected to take about 45-60 minutes on each occasion (before and after the program). We will administer the surveys during regular school hours to students who have caregiver permission to participate. Please follow the steps below to recruit students for participation in this study, through brief individual meetings with all students identified as ≤ 25th percentile on subjective well-being. In these meetings, you will privately communicate to the student that they are being asked to participate in the WBPP because of their responses in the screening. Please take measures to reduce potential stigma attached to the intervention. Specifically, explain that lots of students feel that at least one area of their life could be improved, explain the intervention targets and purpose, and let them know that many students in their school are also being invited. Then, distribute two copies of the caregiver consent/permission forms to the student. Ask them to keep the gold copy of the form for their family's records; the green copy should be completed by the caregiver and returned to you, whether or not the caregiver chooses for the child to participate. Please note that participation by students is completely voluntary; their decision to participate (or not) should not impact their grades nor their relationship with USF/UMass, you, or anyone at their school. Please do not use any coercion or undue influence in recruiting participants. This study's procedures have been approved by USF IRB (Study # 001065).

Please say to students:

Hello, I'm [introduce self and affiliation to school]. *I am working with a research team at USF/UMass that is conducting a study to evaluate a program created to improve students' happiness. It is called the Well-Being Promotion Program. Your school counselors/psychologists/ social workers, including myself, will be leading the 10-week program. We will meet with small groups of students once a week during the school day. These meetings will take about 45 minutes. We will do activities that teach you ways to think and act that are related to feeling happy. We will practice grateful thinking. We will do nice things for others. And we will find out our personal strengths. After the program is done, the small groups will get together about once per month to keep practicing the happiness activities.*

We think you may be interested in this program, and are inviting you to join the study, because of surveys you filled out recently during the happiness screening. Your answers to some questions showed that you have some room for growth in your satisfaction with life. You are not alone; many students at your school feel that one or more areas of life could be going better. That's why we teach students ways of thinking and acting that make them feel happier with their families, friends, school, and self. We aim for all students to feel delighted with their lives, so we are inviting many students in your grade to take part in this program.

Participation in this study is voluntary; it is your choice whether or not you want to participate. If you decide to take part in the project, you can still change your mind later. No one will be upset if you stop the study. If you join the project, we would be very excited to work with you! However, if you don't join, nothing will change. Students who join this study will do a few things. They will fill out several surveys about their current thoughts, feelings, and behaviors, up to 4 times during the study (3 times this school year, 1 time next year). Students will receive a $5 gift card [specify to where] *or gift worth that much after each time they complete the surveys. Some of the students will start the Well-Being Promotion Program this year. Other students will start next school year. Students who start the Well-Being Promotion Program this year will receive the $5 gift card or gift each time they share their thoughts about the program, up to 2 times this year.*

Only students with permission from their caregiver at home- such as a parent, grandparent, or legal guardian- can join the study. Bring these permission forms home to your caregiver. Your caregiver should keep the gold copy and then they should complete the other copy, printed on green paper. Return the green copy completed by your caregiver to me as soon as you can, whether or not your caregiver chooses to allow you to participate. Would you like a version that is written in Spanish?

We are collecting signed permission forms that will allow students to take part, or tell us whether a caregiver has indicated they do not want their child to take part. Each student who returns a form will get a small gift to use at school, such as a highlighter or pen [show students the pen, fidget, eraser, etc. they can choose]. *You will still get the gift if your caregiver writes on the form that you can't take part in the project. Caregivers can also complete the form electronically. If you would prefer I email this to your caregiver, I'd be glad to. Just tell me their name and email address, whether to send in English or Spanish, and when you'd like for me to send the email. For instance, perhaps tomorrow morning after you've had a chance to talk with them about it? Or should I send it today?*

Do you have any questions for me? If you think of some later, or your caregivers have any questions about this research study, the phone numbers for the researchers and the USF Division of Research Compliance are listed on the caregiver permission form. Refer to Study # 001065. Please note that in-person interactions with any extra people put you at increased risk of getting COVID-19. The researchers from USF/UMass who visit your school will follow health and safety measures like using facial coverings, social distancing, and checking temperatures. Despite taking such steps to protect your health, it cannot be guaranteed that you will not be exposed to the virus.

Please place the signed consent forms back into this envelope. Completed envelopes will be collected by a member of the USF/UMass research team. Thank you!

Sincerely,

Shannon Suldo, Ph.D.
School Psychology Program, College of Education
University of South Florida

Sarah Fefer, Ph.D.
School Psychology Program, College of Education
University of Massachusetts Amherst

Appendix E: Procedures for Exit Interviews with Students

(keep to < 30 minutes)

Instructions

- Share purpose of discussion:
  - *We're interested in learning more about your experiences in the Well-Being Promotion Program. We want your feedback on the program activities and materials, in part so that we can improve the program before using it with other students. There are no right or wrong answers – we want your honest opinions.*
- *Your specific responses will not be shared. We are recording this session only as a tool to capture all information. After what was said during this session has been typed, you will not be identified by name.*
- *You have previously given your written consent/assent to take part in this discussion. As a reminder, you are free to stop participating at any point.*

Student Discussion, in individual interviews to be held ideally within a week of intervention conclusion

- *Let's start with your overall or big picture thoughts on the Well-Being Promotion Program, then I will ask some more specific questions. As a reminder, here's an overview of the topics and activities covered throughout the 10 weeks of the Well-Being Promotion Program.*
  - [show visual reminder of 10 week schedule of topics and activities in the WBPP]

1. *What did you think about the program? (e.g., handouts, activities, topics covered, take home challenges)*
   - Follow-up: *What did you like the best about the program?*
   - Follow-up: *What did you like least about the program?*
   - PROBE: If not mentioned, ask: *Did your caregivers get involved in the program, for instance by attending the initial information session, engaging with any of the weekly handouts, or talking with you about what you did in group?*
     - If yes: *How did they get involved? Did you talk to them about the program or did they bring it up?*
     - If no: *What kept your caregivers from getting involved?*

2. *What was it like to participate in the program at your school (e.g., when and where groups met, length of meetings, pace, group size)?*
   - PROBE: If not already answered, ask: *What worked well? What didn't work well?*
   - PROBE: If not mentioned, ask:
     - *Do you have anything else to share on when or where groups met?*
     - *Length or pace of meetings?*
     - *Group size?*

3. *How would you explain this program to your friends?*
   - Follow-Up: *Would you recommend this program to your friends?*

The next questions ask about your feelings about the goals and outcomes of the program

[show handouts from Session 1 as visual reminder of determinants of happiness (pie chart)]

As a reminder, the goal of the WBPP is to teach positive activities to improve life satisfaction and overall well-being for middle school students.

[review handouts from Session 1 as visual reminder of intent of program to teach skills in purposeful behaviors that evoke happiness, through positive activities that focus on your past-present-future]

4. *Do you think that this goal is important for all middle school students? Why?*
    - Follow-up: *Is this goal important to you personally? Why?*

5. *What are some of the most important things you learned in the program?*
    - Follow-up: *Why are these things important to you?*
    - Follow-up: *Describe an example of something in your life that you think changed based on what you learned in this program (e.g., at school, with your family, with friends?)*
        - PROBE: If not discussed across multiple domains, ask if the program impacted the other domains not yet mentioned.

    Follow-up: *Do you think you can increase/change your happiness? Why/why not?*

6. *Which activities that you learned do you think you will use in the future? Why?*
    - Follow-up*: What settings do you think you will be able to use what you've learned (family, friends, schools)?*
        - PROBE: If not discussed across multiple settings, ask if the program is applicable across the other settings not yet mentioned or why not those settings.

The next questions will focus on your perspectives on relationships in the group – with leaders and with other students.

7. *How would you describe your relationship with your group leaders?*
    - Follow-up: *Did the relationships with the group leader(s) change from the time the group started until now?*
        - PROBE: *What session(s) did you notice you felt this way?*
    - Follow-up: *What about your leaders contributed to that relationship?*
        - PROBE, if not mentioned: *What did the leaders do to build relationship?*
    - Follow-up: *Did your group leaders try to understand what it's like to be you? How?*
    - Follow-up: *What was a memorable moment for you with your leader(s) in this group?*
8. *How would you describe your relationship with the other students in your group?*
    - Follow-up: *Did the relationships with other students in the group change from the time the group started until now?*
        1. PROBE: *What session(s) did you notice you felt this way?*
        2. PROBE: *What about this group and the people in it helped you feel closer to other students in the group?*
    - Follow-up: *How did your relationships with other students influence your overall experience in the group?*
    - Follow-up: *What was a memorable moment for you with other students in this group?*
9. *How do you think that you contributed to the experience of the group?*

The next questions will focus on how the program fits with your culture, identity, and unique life experiences. There are a variety of racial groups, like Black, Asian, White, Hispanic or Latino. In addition to race and ethnicity, there are other aspects of your identity that make you who you are. Next I will ask about how the program matched up with your culture, identity, and unique life experiences.

10. *How would you describe your culture or identity?*
    - *PROBE: What other aspects of your identity are important to you?*

11. *Describe whether or not the program activities easily related to your own life.* (if student appears confused, reword with: *in other words, did program activities feel relevant to you, clicked with you, matched up with what's important to you?*)
    - PROBE*: Which discussions, examples, or activities did you feel were relatable to you?*
    - PROBE: *Which didn't feel like they were relatable to you?*

1. *Describe whether or not your group leaders incorporated your culture, identity, and unique life experiences into the discussions and activities?*

   Reword if confused: *Did you feel like group leaders incorporated anything that you identify with or things that make you unique?*
    - Follow-up: How did they incorporate your identity OR How could leader incorporate your identity more?
    - Follow-up: *Anything to add about how group leaders attended to your...* [culture/identity/ unique life experiences... whatever wasn't covered already by student but mentioned by student as a salient part of their identity [question 10]

12. *How did group leaders show that they understood your unique life experiences? OR What made you feel like they did not understand your unique life experiences?*
13. *Describe whether or not you felt accepted, safe, and comfortable during the sessions.*
    - PROBE*: What session activities or interactions in the group made you feel accepted, safe, comfortable sharing?* OR
    - *Why did you feel uncomfortable or like you couldn't share?*
14. *Describe whether or not you felt like you fit in with the other members of your group?*
    - PROBE*: Please describe what made you feel connected OR what made you feel different from the group?*
    - If they felt different from the group probe further*:*
        - PROBE*: Do you think this had anything to do with your culture or identity? If so, why?*
15. *What advice would you give group leaders to help all students feel accepted, safe, comfortable, and respected?*

For this final question we want you to reflect back on all of your experiences in the program.

16. *What changes would you make to the program?*
    - Follow-up: *What suggestions do you have to improve the program?*

[Summarize responses] *is that correct? Please take a moment to think if there is anything else you might want to add.*

Appendix F: Procedures for Exit Interviews with Interventionists

(schedule for 45 minutes, aim for < 30 minutes)

Instructions

- Share purpose of discussion:
  - *We're interested in learning more about your experiences leading the Well-Being Promotion Program. We want your feedback on the program activities and materials as well as your experience delivering the WBPP at your school. There are no right or wrong answers – we want your honest opinions.*
- *Your specific responses will not be shared. We are recording this session only as a tool to capture all information. After what was said during this session has been typed, you will <u>not</u> be identified by name.*
- *You have previously given your written consent/assent to take part in this discussion. As a reminder, you are free to stop participating at any point.*

School Mental Health Provider discussion, to be held ideally within a week of intervention conclusion.

We will start with your <u>overall or big picture thoughts</u> on the Well-Being Promotion Program (the intervention goals and methods), then I will ask some more specific questions about your experiences bringing the WBPP to your school (the logistics of delivering it). Starting with the WBPP, here's an overview of the topics and activities covered throughout the 10 weeks of the core program.

- [show visual reminder of 10-week schedule of topics and activities in the WBPP and visual reminder of session materials]

1. *Please share your thoughts about the Well-Being Promotion <u>Program</u> (e.g., everything from the intervention manual you received, such as meeting and homework activities, as well as caregiver and student handouts).*
   - FOLLOW-UP: *What did you like best about the program? Least?*
   - PROBE: If not mentioned, ask:
     - *Please share your thoughts specifically about the caregiver components (e.g., information session and weekly caregiver engagement).*

The next questions ask about your perspectives on the <u>intervention goals</u>, so we wanted to remind you of the specific goals of the WBPP. You may remember this from our professional development.

- [show visual with intervention goals – goal of promoting complete mental health/bolstering well-being]
- Summarize: *The WBPP is a Tier 2 intervention grounded in positive psychology to provide early intervention for students with low subjective well-being—vulnerable and troubled students—by evoking positive emotions and building relationship.*

2. *How do the goals of this program fit with your own goals related to mental health service delivery*?
   - PROBE: If clarification is needed, ask: *How do the goals of this program this align with your approach or preferred way of practice as a counselor/psychologist/[state role]*

3. *How do the goals of this program align with your current role in the school?*

The next questions ask about your perspectives on the <u>outcomes</u> of the WBPP.

4. *What do you see as the outcomes of participating in this program? For you? For the students?*
   - FOLLOW-UP: *Please share an example of an outcome and why you think it is a result of participation in this program (i.e., what evidence have you seen or heard?)*
   - PROBE: If not stated, ask: *Do you think your students increased their happiness? Why/why not? What role do you think you played in this change, if any? If yes, how?*
5. *Are these outcomes important for you? For students? Why or why not?*
   - PROBE: If not stated, ask: *Describe how these outcomes can help students.*
   - PROBE: If not stated, ask: *Describe how these outcomes can help you and your practice.*

The next questions ask about your <u>experiences bringing the WBPP to your school this year</u>, including the training, setting up the screening, inviting eligible students, delivering the program, and evaluating the WBPP. We'll start with delivering the WBPP, then the activities that led up to and supported that delivery.

6. *Describe your experience <u>delivering</u> the Well-Being Promotion Program at your school this year. (e.g., frequency and timing, pace, working with co-leader)*
   - PROBE: If not already answered, ask:
     - *What worked well about the delivery?*
     - *What didn't work well?*
   - PROBE: If not mentioned, ask:
     - *Do you have anything else to share on working with a co-leader to deliver the program?*
     - *Do you have anything else to share about the frequency or timing of the program sessions?*
     - *Do you have anything else to share about the pace of the session?*

The next questions focus on <u>engaging all students</u> in your group, and the <u>cultural relevance</u> of the intervention.

7. *Describe your experiences ensuring that all students were engaged with the program content and activities?*
   - PROBE: What specific approaches or strategies did you use?

8. *Describe your experiences ensuring that all students felt welcomed and safe in the group?*
   - PROBE: What specific approaches or strategies did you use?

9. *Describe your experiences building and maintaining relationships with and among students in the group?*
   - PROBE: What specific approaches or strategies did you use to address and/or repair relationships?

7. *How did you incorporate students' cultures and unique life experiences into the discussions and activities during the WBPP sessions?*
   - PROBE: *Was it difficult to incorporate students' cultures and unique life experiences into the intervention, why or why not?*
     - *OR*
   - PROBE: *What prevented you from incorporating students' cultures and unique life experiences into the sessions?*

10. *<u>If they indicate that they DID incorporate students' cultures and lived experiences into the sessions, then ask</u>: Which of the approaches/methods were most well-received by the students in your opinion?*

- PROBE: *What was the reaction of the students when you used this strategy?*
- PROBE: *What strategies did not work as well?*

The next questions focus on the <u>professional development supports</u> (summer training, weekly coaching meetings).

12. *What are your thoughts about the initial professional development you received from our team?*
    - FOLLOW-UP: *What did you like best/find most beneficial? What did you like least/find least helpful?*
    - PROBE: If they did not talk about preparation for delivery of the program, ask: *In what ways did it help you to prepare to deliver the WBPP?*
13. *What are your thoughts about the weekly coaching meetings?*
    - PROBE: If content/fidelity not mentioned, ask: *How did coaching contribute to your understanding of WBPP content?*
    - PROBE: If group dynamics not discussed, ask: *How did coaching contribute to the group counseling process (e.g., engagement, relationships, session flow, cultural humility)?*
14. *Describe the relationship that you had with your coach.*
    - PROBE: *How comfortable did you feel in sharing and/or problem solving with them?*
    - PROBE: *How did you feel when receiving their feedback?*
15. *What do you think it would be like to implement WBPP in your school without this coaching support?*

The next questions focus on the <u>screening and recruitment</u> to enroll students in the WBPP.

16. *Thinking back to when we did a schoolwide screening of student life satisfaction, describe your experiences with identifying students for the WBPP?*
17. *Describe your experiences with inviting and enrolling those who met screening criteria?*
18. *How did providing the WBPP as Tier 2 support for students with low subjective well-being fit within your school's multi-tiered system of supports for student mental health?*
19. *Thinking about all of your experiences bringing the WBPP to your school this year, how will this experience influence your future practice?*
    - PROBE: If not mentioned, ask: *Are there aspects of the program that you will continue to use on your own? If so, which ones, and why?*
    - PROBE: If not mentioned, ask: *Are there aspects of the program that you will continue to use with students? If so, which ones and why?*

Thanks so much, we have just a few <u>wrap-up questions</u> to conclude.

20. *What suggestions do you have to improve delivery of the program, in terms of content and process?*
    - PROBE: *Ideally what resources and supports would help you deliver the sessions as described in the manual/FOI checklists?*
    - PROBE: *Ideally what resources and supports would help you engage all students in your group, such as by building and maintaining relationships and incorporating unique life experiences like culture and gender identity into the sessions?*
    - FOLLOW-UP: *Given some of the challenges you brought up earlier about ____, what would be some specific suggestions for improvement?*
21. (time permitting, if < 50 minutes): *This is the last question. Please tell me about your experiences as a participant in the research process.*
    - PROBE: *The research process includes the data collection with students and interventionists, interactions with the USF/UMass research team, audio-recording sessions, extra attention to fidelity, and being part of a scientific study*

intended to determine how well a school mental health intervention works and costs. Any reactions positive or negative to those components?

[Summarize responses] *is that correct? Please take a moment to think if there is anything else you might want to add.*

Appendix G: Procedures for Exit Interviews with Coaches

(schedule for 60 minutes, aim for < 45 minutes)

Instructions

- Share purpose of discussion:
  - *We're interested in learning more about your experience coaching school mental health providers who are implementing the Well-Being Promotion Program. We want your feedback about the coaching model and how you think coaching supported the implementation of the Well-Being Promotion Program. There are no right or wrong answers – we want your honest opinions.*

Coach discussion, *to be held ideally within a week of intervention conclusion*

- Let's start with your overall or big picture thoughts on your role as a coach for the Well-Being Promotion Program, then I will ask some more specific questions.

1. *Describe your experience coaching WBPP interventionists (group leaders) this year.*
   - FOLLOW-UP: What did you like most about being a coach*?*
   - FOLLOW-UP: What did you like least about being a coach*?*
2. *How would you describe your relationships with the interventionist(s) you coached?*
   - FOLLOW-UP: *Did your approach to relationship building and/or coaching differ across the interventionists you coached? If so, how and why?*
3. *Describe the ways that you supported interventionist delivery of content from the WBPP manual.*
   - FOLLOW-UP*: In what ways did you see fidelity of implementation stay high or change as a result of coaching? What role do you think you played in this?*
4. *Describe the ways that you supported interventionist group process (i.e., engagement, relationships, session flow, cultural humility)?*
   - FOLLOW-UP*: In what ways did you see group process stay strong or change as a result of coaching? What role do you think you played in this?*
5. *Did you provide any implementation supports (e.g., modified protocols, specific checklists) beyond those provided to all leaders during the coaching process?*
   - FOLLOW-UP*: If so, what supports, why did you provide them, and what was the result?*
6. *Describe a time when an interventionist did not meet expectations for either content or process. How did you address this during coaching?*
   - FOLLOW-UP: *How did the interventionist react to your approach? What was the result?*
7. *Did you feel prepared to coach for content and process for the WBPP?*
   - FOLLOW-UP*: If yes, what contributed to you feeling prepared? If no, what resources or supports would you need to feel prepared?*
   - PROBE: If not mentioned, ask: *What are your thoughts on the coaching supervision meetings?*
8. *Do you think that coaching achieved the goal of higher quality implementation of WBPP in schools? Why or why not?*
   - FOLLOW-UP: *In what ways did you use motivational interviewing strategies to meet this goal?*
   - FOLLOW-UP: *In what ways did you use strategies aligned with positive psychology to meet this goal?*

- FOLLOW-UP: *In what ways did you use behavioral skills training to meet this goal?*

9. *What aspects of the coaching procedures (e.g., audio recording, coaching notes, zoom meetings) worked well for you? For the individuals you coached?*
    - FOLLOW-UP*: What aspects did not work well for you? For the individuals you coached?*

10. *What are your thoughts about the significance of coaching for efforts to bring promising mental health interventions to schools? Why?*
    - FOLLOW-UP: *What do you think it would be like to implement the WBPP in schools without this coaching support?*

11. *Describe any outcomes you saw in the individuals that you coached.*
    - FOLLOW-UP: *Do you think that these outcomes are important? What role do you think you played in this?*

12. *Describe any barriers to coaching that you experienced. What did you do to problem solve these barriers? What was the results?*
    - PROBE: If not mentioned, ask: *Did you have any attendance problems?*

- The last 3 questions focus on the cultural relevance of the intervention and approaches used to increase cultural relevance.

13. *Describe how your background and unique life experiences influenced your approach to coaching and your relationship(s) with interventionist(s).*
14. *Describe whether or not coaching included discussions around cultural humility as well as incorporating students' cultures and unique life experiences into the sessions.*
    - PROBE*: What approaches did interventionists use to incorporate students' cultures and unique life experiences into the sessions?*
    - PROBE: If not mentioned, ask: *How did the group process form impact these discussions?*

15. *Describe any approaches/methods used by you or the interventionist(s) you coached that you feel contributed to students feeling welcome, understood, and safe in the group.*
16. *Ideally what resources and supports do you think would be helpful to coaches and interventionists seeking to incorporate student and leader's unique life experiences like culture and gender identity into the sessions?*

[Summarize responses] *is that correct? Please take a moment to think if there is anything else you might want to add.*

Appendix H: Group Process Check-In

Please consider the Well-Being Promotion Program (WBPP) session(s) you led/co-led this past week. Rate each domain on a scale from 1 to 5, where: 1 = *Not at all*, 2 = *A Little*, 3 = *Somewhat*, 4 = Quite a bit, to 5 = *Totally*.

Student Engagement	
To what extent did the session <u>facilitate student engagement</u>? *Did you....* 1. *Ask open-ended questions as much as you can?* 2. *Provide multiple opportunities to respond using a variety of methods?* 3. *Affirm students' effort in engaging in positive activities, whether it was planned or unplanned?* 4. *Reflect on students' sentiments to make sure you understand them?*	1 2 3 4 5
Relationship Enhancement	
To what extent did the session <u>enhance relationships</u>? *Did you....* 5. *Convey a positive, accepting demeanor?* 6. *Make a personal connection with each student?* 7. *Encourage students to interact with each other?* 8. *Reinforce students' efforts and plans to include caregivers in positive activities?*	1 2 3 4 5
Session Flow	
To what extent did the session <u>flow</u>? *Did you....* 9. *Deliver the manualized content seamlessly (e.g., move between topics and activities smoothly)?* 10. *Readily provide personal examples to illustrate ideas and content in the manual?* 11. *Monitor when to adjust pacing (moving through more quickly or slow down)?* 12. *Provide individualized assistance for students who appeared disengaged or confused?*	1 2 3 4 5
Cultural Humility	
To what extent did the session <u>reflect practicing cultural humility</u>? *Did you....* 13. *Examine how your own beliefs and cultural identity influenced how you facilitated the session?* 14. *Invite and appreciate students' diverse lived experiences?* 15. *Use examples that were relevant to students in the group?* 16. *Align session content with the goals and values of students in the group?*	1 2 3 4 5

<u>Tools in Your Toolbox</u>

Leader Tools	Group Tools	Student Tools
Establish routines and structure	Establish norms	Have 1:1 conversation

Provide opportunities to respond	Arrange the environment	Consider “why” of behavior
Show care	Seek student input	Provide choices
Meet students where they are	Revisit the “why”	Catch them being good – a lot

Appendix I: BMSLSS

BMSLSS

For each statement, circle a number from (1) to (7), where (1) means you feel *terrible* about that area of life and (7) means you are *delighted* with that area of life.

During the past several weeks…	Terrible	Unhappy	Mostly Dissatisfied	Mixed *(about equally satisfied & dissatisfied)*	Mostly Satisfied	Pleased	Delighted
1. I would describe my satisfaction with my *family life* as:	1	2	3	4	5	6	7
2. I would describe my satisfaction with my *friendships* as:	1	2	3	4	5	6	7
3. I would describe my satisfaction with my *school experience* as:	1	2	3	4	5	6	7
4. I would describe my satisfaction with *myself* as:	1	2	3	4	5	6	7
5. I would describe my satisfaction with *where I live* as:	1	2	3	4	5	6	7
6. I would describe my satisfaction with my *whole life* as:	1	2	3	4	5	6	7

*Permission to reprint not needed as measure is available for free in the public domain.

Appendix J: SLSS

SLSS

For each statement, circle a number from (1) to (6), where (1) means you *strongly disagree* with the statement and (6) means you *strongly agree* with the statement.

During the past several weeks…	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. My life is going well	1	2	3	4	5	6
2. My life is just right	1	2	3	4	5	6
3. I would like to change many things in my life	1	2	3	4	5	6
4. I wish I had a different kind of life	1	2	3	4	5	6
5. I have a good life	1	2	3	4	5	6
6. I have what I want in life	1	2	3	4	5	6
7. My life is better than most kids	1	2	3	4	5	6

*Permission to reprint not needed as measure is available for free in the public domain.

Appendix K: PANAS-C-10

PANAS-C-10

This scale consists of a number of words that describe different feelings and emotions. Indicate to what extent you have felt this way in the past few weeks.

Feeling or emotion:	Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
1. Sad	1	2	3	4	5
2. Happy	1	2	3	4	5
3. Scared	1	2	3	4	5
4. Miserable	1	2	3	4	5
5. Cheerful	1	2	3	4	5
6. Proud	1	2	3	4	5
7. Afraid	1	2	3	4	5
8. Joyful	1	2	3	4	5
9. Mad	1	2	3	4	5
10. Lively	1	2	3	4	5

*Permission to reprint not needed as measure is available for free in the public domain.

Appendix L: Beliefs About WBPP Survey

Please select the number that best indicates how you feel about the Well-Being Promotion Program (WBPP)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I find the Well-Being Promotion Program to be an acceptable way to increase my own happiness/well-being.	1	2	3	4	5
2. I would be willing to use the program again if I wanted to increase my happiness.	1	2	3	4	5
3. I would recommend the program to a friend who wanted to feel happier.	1	2	3	4	5
4. I like the activities in the program.	1	2	3	4	5
5. I believe this program is likely to be effective.	1	2	3	4	5
6. I experienced discomfort during the program.	1	2	3	4	5
7. I believe this program is likely to result in lasting improvements for me.	1	2	3	4	5
8. I was willing to carry out the activities within the program.	1	2	3	4	5
9. Overall, I have a positive reaction to this program.	1	2	3	4	5

*****Modified and adapted from the Treatment Evaluation Inventory-Short Form (Kelley, Heffer, Gresham, & Elliott, 1989)