

2014

Creating Opportunities for Personal Empowerment for Adolescent Students in a Rural High School

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Doctor of Nursing Practice Capstone Projects. 3.
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Creating Opportunities for Personal Empowerment for Adolescent Students in a Rural High
School

Submitted in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice
at Eastern Kentucky University

By

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Richmond, KY

April 28, 2013

Abstract

BACKGROUND: With the incidence of 3% of children and 6% of adolescents diagnosed with depression, treatment appropriate for this population is needed. Provision of mental health care is limited due to barriers of access such as transportation, parental consent, and availability of services in the adolescent's environment such as the school setting. **OBJECTIVES:** To decrease the depressive symptoms and increase the self-confidence perceptions of adolescents in a high school setting utilizing a cognitive-behavioral skills enhancing, seven-session intervention called COPE (Creating Opportunities for Personal Empowerment).

STUDY DESIGN: The project was an evidence-based nurse practitioner project utilizing pre- and post- intervention assessment tools (Beck Youth Inventory II and Healthy Lifestyle Beliefs Scale). The project intervention was based on Cognitive Behavior therapy (CBT) principles of the relationship between thinking, feeling, and behavior. A program (COPE TEEN) was the framework for the interventions implementing CBT principles for adolescents.

RESULTS: A majority of the adolescent students reported positive outcomes from the study in reducing their depressive symptoms and increasing their perception of self-confidence. The project did not show a statistically significant difference but did demonstrate clinically significant improvement in behavior and perception of self-confidence by the adolescents.

CONCLUSIONS: The COPE TEEN program provides tools for the adolescent to learn effective coping skills to demonstrate clinical improvement in depressive symptoms and effective coping skills.

Keywords: adolescents, depression, anxiety, self-esteem, coping skills, treatment, evidence-based practice, cognitive-behavioral therapy, school-based treatment programs

Acknowledgements

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Creating Opportunities for Personal Empowerment in Adolescent Students in a Rural High School

Background and Significance of the problem

Mental health diagnoses in adolescents represent significant portions of the pediatric (child and adolescent) diagnoses. The Surgeon General (2007) indicated a 20.9% prevalence rate for mental health disorders in individuals 9-17 years of age. The presence of significant impairments due to mental health disorders affects four million individuals in this age group (Surgeon General, 2007). For example, 3% of children and 6% of adolescents are diagnosed with depression (Williams, O'Conner, Eder, & Whitlock, 2009). Depression leads to significant morbidity in children and adolescents. Williams et al. (2009) indicated that depression is associated with "... decreased school performance, and impaired work, social, and family functioning during young adulthood" (p. 2). In addition to the difficulties related to mental health disorders, such as depression and anxiety, there also exist difficulties in coping with stressors of life such as death, serious illness in family member(s) or friends, and the potential of experiencing both direct and indirect life trauma. Zimmer-Gembeck and Skinner (2008) cited that 25% of adolescents experience at least one significant life event that can act as a significant stressor. An adolescent's response to these life events and stressors contributes to the potential for mental health and behavioral problems. Addressing the mental health issues that arise during adolescence from life events and/or stressors require incorporating adolescent developmental stages into interventions and implementing evidenced-based programs that address the specific needs of the adolescent.

Provision of an evidence-based, developmentally appropriate intervention to meet the mental health needs of adolescents is only part of improving the delivery of mental health

services in the adolescent population. Interventions must also improve access to care and reduce barriers to provision of health care that create challenges to healthcare organizations.

Adolescents reported barriers to health care utilization as including: a) gaining access to care, (b) difficulty with transportation, c) lack of parental consent, d) cost of care, e) stigma, and f) availability of mental health services (Samargia, Saewyc, & Elliott, 2006). These barriers can be reduced by providing mental health care services in the school setting. Additionally, the studies considered access to care for adolescents as a perceived barrier in receiving mental health services.

When contemplating a treatment program for adolescent mental health issues, consideration of the developmental stages of adolescence and how to implement programs or interventions in such a way that they address the specific needs of the adolescent population is needed. The developmental stages of adolescence include the Erikson's (1968) stage of identity versus role confusion during which the adolescent is developing the virtue of competence and answering the questions necessary to succeed in a world of people and things. Failure to appropriately complete the stage of industry versus inferiority may result in the child developing a sense of inferiority (Erikson, 1968). The adolescent population is challenged by identity versus role confusion. During the adolescent stage, the adolescent is developing the value of fidelity and answering the questions of who they are and what they can achieve or become (Erikson, 1968). Erikson (1968) identified that failure to develop an identity can result in an inability to create strong, enduring bonds and a satisfying sense of personal identity. Erikson (1968) summarized the task of adolescence with the statement "...in the jungle of human existence there is no feeling of being alive without a sense of identity" (p. 130). An understanding of the developmental stages is required to identifying and implementing evidence-based mental health

programs and interventions that are effective in the adolescent population (Zimmer-Gembeck & Skinner, 2008).

The Agency for Healthcare Research and Quality (AHRQ, n.d.) validated the need for assessing the mental health needs of adolescents and the necessity of providing treatment to adolescents in their guideline statements that outlines the best evidence and practice parameters of child and adolescent mental health care in community systems (AHRQ, 2010a). AHRQ (2010a) guidelines identified the need to screen for mental health issues in adolescents and provide appropriate interventions that address the specific mental health disorders of the adolescent population with validated, developmentally appropriate therapies such as cognitive behavioral therapy (CBT) and school-based delivery systems. The American Academy of Pediatrics (AAP, 2004) and the American Academy of Child and Adolescent Psychiatry (2007) further supported the need for appropriate interventions for mental health issues in the adolescent population with consideration of appropriate interventions and in settings that are conducive to access of the intervention.

Improving access to care for mental health services for rural adolescents requires supporting the school system/organization to act as a delivery system for adolescent mental health services. Samargia et al., (2006) identified one of the barriers to mental health care as being lack of transportation. The utilization of mental health services within the school system does not present within the “normal” scope of mental health services (Adelsheim, & Wrobel, 2007; Melnyk et al., 2009; Swartz et al., 2007; Weist, Rubin, Moore, Adelsheim, & Wrobel, 2007). Usually, adolescents receive mental health services in a traditional clinic setting. However, providing mental health services within the school setting encourages adolescents to

utilize mental health services and reduces barriers such as transportation, stigma of mental health care, and availability of services (Samargia et al., 2006).

The adolescent patient presents a special challenge to the nurse practitioner when considering mental health issues. The adolescent is faced with life stressors with which he/she may not have the ability to cope thus complicating the normal developmental tasks of establishing the adolescent's own individuality (Williams et al., 2009). Identification of mental health disorders is becoming more prevalent in the adolescent population (AHRQ, 2010a). Reaching adolescents is a concern because of multiple barriers impeding care (Samargia et al., 2006). Barriers included both structural and nonstructural aspects. Structural barriers included not knowing where to seek services, financial, lack of transportation, and lack of parental or guardian involvement. Nonstructural barriers included hoping problems would go away, not wanting parents/guardians to know, finding the time, afraid of connection with a mental health stigma, and fear of what the therapist would say (Samargia et al., 2006). Provision of care in the school system removes some of these barriers such as access and transportation to treatment. The following discussion presents a preventive intervention using an evidence-based practice (EBP) model of CBT in the school setting designed to target and educate at-risk population group and diminish access to care barriers for mental health services in an adolescent population.

Problem Statement

Adolescence is a vulnerable time for children. The adolescent is neither a child nor an adult. During this time, adolescents are particularly vulnerable to the stressors of life because thought processes and coping skills are not fully mature (Williams et al., 2009). Additionally, mental health concerns commonly make their initial presentation during adolescence when hormone fluctuations affect the balance of neurochemical and structural brain changes (Spear,

2000; Zimmer-Gembeck & Skinner, 2008). Many adolescents do not understand what is happening to them and do not seek appropriate intervention which leads to mental health difficulties such as poor coping skills, anxiety and or depression. To complicate matters, many adolescents do not have adequate access to mental health services or adequate support systems (Samargia et al., 2006). Therefore, adolescence becomes a very complicated time for many adolescent patients, their families, and school personnel.

Relationship of Project to Advanced Practice Nursing

The role of the doctor of nursing practice (DNP) prepared nurse is to translate research and knowledge into evidence-based practice (Dreher & Glasgow, 2011). Creating Opportunities for Personal Empowerment TEEN (COPE TEEN) is an EBP intervention used to educate the adolescent in effective coping skills. Implementing this program in a rural Central Kentucky High School enhances the use of mental health services in a population that has traditionally been plagued by access to care issues. The COPE TEEN program emerged through the foresight and ingenuity of advanced practice nurses in an effort to identify unique practice areas and teach adolescent population groups to learn and utilize effective coping skills and improve depressive symptoms and improve self-esteem. This project epitomizes the benefits of advanced practice nursing and the DNP preparation in affecting positive health outcomes by providing a developmentally appropriate, reliable, valid, evidence-based intervention such as the COPE TEEN program, in a rural school setting that reduces barriers to care.

Evidence of Support of Identified Practice Setting

When contemplating a lasting change, evaluation of the need for change, an identification of a specific problem or difficulty, and the willingness of the facility personnel for change are critical. In order to sustain the change, support from the facility personnel must either identify or

agree with the need for a change and view the change as beneficial and potentially feasible for long term change. Additionally, the personnel that will benefit both directly and indirectly must be involved in the planning of change.

A Need of Change within the System

A successful change begins with the identification of the need for a change. Conjunctly a though assessment is also necessary. Nationally, the mental health needs of the adolescent are not being met as evidenced by the AHRQ (2010a) report. The AAP (2004) identified that the mental health needs are significant and “(u)ntreated mental health disorders lead to higher rates of juvenile incarcerations, school dropout, family dysfunction, drug abuse and unemployment” (p. 1839). Consulting with the school stakeholders validated this concern and confirmed the need for an intervention. The school counselors voiced a concern for the behavioral and mental health issues of their student population (Cornelius, personal communication, September 10, 2010). In a subsequent meeting (Cornelius, personal communication, February 14, 2012), counselors requested behavioral interventions for adolescents with identified mental health/behavioral difficulties. The need was clearly identified to implement an evidenced-based intervention such as the COPE TEEN program in the rural high school setting.

Identification of the Problem

The incidence of 3% of children and 6% of adolescents being diagnosed with depression (Williams et al., 2009) was lower than the practice of mental health at the principle investigator’s clinical practice. Of the 730 patients ages 11 to 20 seen at the medical clinic where the principle investigator (PI) practices, 167 (23%) were seen at the mental health clinic and had a mental health diagnosis of depression, behavioral issues, and/or mood disorders for the year 2011.

Additionally school counselors had identified a need for mental health services for the adolescent students and the limited availability of mental health services in the county.

Prior to the discussion with counselors about the project, the Chief Executive Officer of Horizon Healthcare, A. Giles, met with the counselors and the School Superintendent, T. Floyd. Horizon Healthcare (DBA Paragon Family Practice) is a primary care organization that provides healthcare by advanced practice registered nurses (APRN). Mr. Floyd identified unmet needs of mental health services as one of great concern to the school (Giles, personal communication, August 25, 2010). Following this interaction, a meeting was held on September 10, 2010 between Central Kentucky Behavioral Health (part of Horizon Healthcare) and the school system. The meeting included of A. Giles, CEO, the Psychiatric/Mental Health Nurse Practitioner (PI), C. Cornelius, head of school counselors, counselors within the school system, and school nurses. During the meeting, various mental health concerns were discussed. Identified concerns included difficulty with availability of services for students, available space/location for mental health services, available resources and the significant need for mental health services for the students identified by the counselors (Cornelius, personal communication, September 10, 2010). A solution to some of mental health service concerns was presented by an agreement to provide a mental health clinic in the rural school setting offering individual appointments with the mental health nurse practitioner. A mental health clinic was opened in the school building in August 2010 with the mental health nurse practitioner providing mental health care for students.

Support from Individuals in Practice Setting

As the mental health clinic grew, the need for additional services became obvious. In September 2010, school counselor involvement was initiated to enhance mental health services

for the Madison County School System (Cornelius, personal communication, September 10, 2010). After discussion and literature review, the COPE TEEN project was selected as the EBP model to address adolescent mental health issues in the rural school system. Encouragement for the COPE TEEN intervention proposal had been voiced since September 2011 (Cornelius, personal communication, September, 2011). Support was reaffirmed from counselors within the counseling services at the rural high school for the COPE TEEN project (Cornelius, personal communication, February 14, 2012). School counselors voiced appreciation of this exciting endeavor. The project coordinator (PI) established an ongoing relationship and trust with the stakeholders within the school system since establishing the mental health clinic in the school in August 2010. Finally, meeting with the D. Gilliam, Principal of Madison Southern High School provided additional administrative support for the COPE TEEN intervention (Gilliam, personal communication, May 8, 2012).

Identified Stakeholders for Project

Stakeholders for the project include adolescents, parents, school counselors, the principal at Madison Southern High School, the APRN (PI) and the Madison County community. The stakeholders for change in the school setting include the school administration, teachers, school counselors, students, parents, and healthcare professionals. Building a relationship with these individuals is critical to the development of trust that sets up a culture for behavioral change. Fullan (2001) identified that change is a slow and deliberate process, not a rapid, end product of a crisis. Inherent in facilitating long lasting change is establishing a collective understanding among the stakeholders about the nature of the change process. Accomplishing the collective understanding by sharing power with each member of the team and regarding the members as full participants essential to promoting change within a complex system

Benefit of Project to Clinical Area

School personnel benefit directly when the adolescents demonstrate effective coping skills and reduction of disruptive behavior (Fossum, Handegard, Martinussen, & Morch, 2008; Lusk & Melnyk, 2011; Melnyk et al., 2009; Merry et al., 2004; Puskar et al., 2009; Swartz et al., 2010; Weisz, Jensen-Doss, & Hawley, 2006). Reduction of depressive symptoms while increasing effective coping skills leads to improved self-esteem and self-confidence which can translate to improved school performance (Merry et al., 2004). Improved daily functioning can enhance self-confidence in dealing with future stressors, difficulties, and challenges.

The clinical practice of mental health benefits in the translation of the evidence-based intervention to the practice setting. This process will enhance the preventive mental health intervention concept for adolescents. An additional benefit to the COPE TEEN project will be validation of the concepts of cognitive behavioral therapy (CBT) and the COPE TEEN program for adolescents. If adolescents learn to have effective life skills then they grow up to be well adjusted adults (Erikson, 1968).

Theoretical and Process Framework

One theoretical framework and one change model (process) were utilized for the project. The theoretical framework was Beck's CBT framework (Beck, Beck, Jolly, & Steer, 2005; Creed, Reisweber, & Beck, 2011) and the change model was Rosswurm & Larrabee's (1999) process framework for facilitating the change in the delivery of service in the school setting. Providing effective intervention or therapy for the adolescent in the school system must incorporate evidence-based therapy (COPE TEEN) and a process to make the intervention readily accessible to students. Both must be present to support a change within the existing system.

Cognitive Behavioral Therapy Framework

CBT is framework used as an intervention to recognize the relationship between what is thought, the feelings elicited, and the resultant behavior (Beck et al., 2005). In exploring what an individual perceives (thinks) about a situation, changes can occur in their thinking process to redefine how one then feels and behaves. Choices are made to reflect an interactive or thoughtful response to a situation rather than a reactive response (Creed et al., 2011). By learning methods of making positive choices, the individual's coping skills improve which enhances their self-confidence and self-esteem. Utilization of CBT for adolescents has been found to be an effective mechanism for positive change (Calear, Christensen, Mackinnon, Griffiths, & O'Kearney, 2009; Fok & Wong, 2005; Kaufman, Rohde, Seeley, Clarke, & Stice, 2005; Kellett, Clarke, & Matthews, 2007; Kolko, Brent, Baugher, Bridge, & Birmaher, 2000; Lusk & Melynck, 2011; Melnyk et al., 2009; Merry et al., 2004; Puskar, Sereika, & Tusaie-Mumford, 2003; Swartz et al., 2010).

CBT framework was used for this project in identifying how an individual (cognitive) perceives a situation that influences how they feel (affective) and then determine how they behave (psychomotor) (Beck et al., 2005). The connection of these different domains is important to understand. The CBT framework was used to education the adolescent students in using effective problem solving skills to influence the choices they make resulting in positive and socially acceptable behavior.

Rosswurm and Larrabee's Model for Change

Essential for the translation of evidenced-based knowledge to practice is a process for the information to be implemented or changed. "To avoid becoming just another unheard or unheeded recommendation, strategies for such awareness (prevention research) raising need to

be practical, and information needs to be tailored to those who will receive it” (Tashman et al., 2000, p. 105). An appropriate framework for strategic change is Rosswurm and Larrabee’s (1999) model for evidenced-based practice translation. This model maps the translation process in a series of six steps: a) assess, b) link, c) synthesize, d) design, e) implement and evaluate, and f) integrate and maintain (Rosswurm & Larrabee, 1999). Effective utilization of the Rosswurm and Larrabee (1999) model for change has been validated for use in the clinical area (DePalma, 2005; DePalma, 2008; Facchiano, Snyder, & Nunez, 2011).

First stage of Rosswurm and Larrabee’s change process.

Identification or assessment of the need for a change is the first step of the Rosswurm and Larrabee’s (1999) process. Once the problem is identified then effective change can begin. Currently, the mental health needs of the adolescent are not being met as evidenced by the AHRQ (2010b) report. Consulting with school stakeholders validated this concern and need for an intervention (Cornelius, personal communication, September 10, 2010). In particular, the school counselors described several behavioral and mental health issues identified in the student population. The counselors then requested an intervention for adolescents with identified mental health or behavioral difficulties (Cornelius, personal communication, February 14, 2012). Further discussion identified a mechanism by which school counselors would identify adolescent students who would benefit from cognitive behavioral interventions.

Second stage of Rosswurm and Larrabee’s change process.

The goal of the second step of Rosswurm and Larrabee’s (1999) model is to link the difficulty with an appropriate intervention. A meta-analysis of direct comparison of cognitive behavioral interventions supported the benefit of the COPE TEEN intervention in comparison to the usual mental health care (Weisz et al., 2006). Additionally, interventions provided in a group

setting appropriately benefit the developmental stage of the adolescent as peer influence is strong for this population (Erikson, 1968). Specifically, the COPE TEEN model was studied and found to be effective in improving symptoms of depression and an increased use of coping skills for adolescents (Lusk & Melynk, 2011; Melnyk et al., 2009).

Third stage of Rosswurm and Larrabee's change process.

Synthesizing the best evidence is the third step of Rosswurm and Larrabee's (1999) model. The step also includes determining the intervention and identifying the desired outcomes. Studies utilizing cognitive behavioral interventions have confirmed benefits (Lusk & Melynk, 2011; Melnyk et al., 2009; Merry et al., 2004; Puskar et al., 2009). Intervention outcomes include improvement (decrease of symptoms) in depression, anxiety, anger, disruptive behavior and coping skills (more effective use) in the adolescent population. School counselors in the high school in which the COPE TEEN pilot intervention was implemented anticipated the improvement of adolescent behavior coupled with an improvement in school performance. The organization will benefit from improved adolescent behavior including less staff time for behavioral management and successful academic progress toward graduation.

Fourth stage of Rosswurm and Larrabee's change process.

The fourth step of the Rosswurm and Larrabee's (1999) model is designing a specific intervention to address the need. Melnyk et al. (2009) created and tested a specific intervention called COPE TEEN for treatment of adolescents in a school setting. The intervention has a specific process that involves a one hour, seven-week, guided (manual) group session that meets the identified needs of adolescents with mental health and/or behavioral difficulties. Sessions are structured to define the connection between thinking, emotions, and behavior by addressing effective coping skills, problem solving techniques, relaxation techniques, and positive self-talk.

Discussion with the Madison Southern High School counselors of the specific COPE TEEN intervention resulted in verbalized support (Cornelius, personal communication, February 14, 2012).

Fifth stage of Rosswurm and Larrabee's change process.

Implementing and evaluating the change in practice is the fifth step of the Rosswurm and Larrabee's (1999) model process. Implementation involves the practitioner providing the COPE TEEN intervention strategies. Evaluation of the COPE TEEN intervention involves participation of student, nurse practitioner, and the school stakeholders. The adolescent students participate by completing the post-intervention Beck Youth Inventory II (Beck et al., 2005). The school counselors and administrator provide input into the evaluation process by including their perceptions of the benefit of the program and evidence of improvement in adolescent behavior through a post intervention survey. Both surveys will be analyzed using a paired *t*-test in an effort to validate program success with an improvement in depressive symptoms and self-confidence.

Sixth stage of Rosswurm and Larrabee's change process.

The last step in Rosswurm and Larrabee's (1999) change process is the integration and maintenance of the change. This step follows the evaluation of the program/intervention and entails incorporating the program into the school program of instruction. Incorporation of the COPE TEEN intervention as part of the curriculum will be explored following the completion of the project and evaluation of the effectiveness of the intervention. The intent is to offer the program to all freshmen students as an effort to enhance their self-confidence and prevent mental health and behavioral difficulties.

Project Description

The project addressed the elements of self-confidence issues, depressive symptoms, disruptive behavior, and difficulty in the school system as identified by the school staff. Goals of the project were to decrease depressive symptoms and increase self-confidence as perceived by the adolescent. The purpose of the intervention was to provide an evidence-based intervention (COPE TEEN) to educate the adolescent students in learning effective coping skills.

The project was conducted as a pilot utilizing pre-intervention and post-intervention measurements. The two scales used were the Beck Youth Inventory II (Beck et al., 2005) and Healthy Lifestyle Beliefs Scale by Melynck (2009). The components of the Beck Youth Inventory II used for this project were the Beck Self-Concept Scale and the Beck Depression Scale.

Adolescent students were identified by the school staff as potentially benefitting from an intervention addressing effective coping skills. The sessions were offered during school time and in the school setting. A meeting with students was held to explain the program and to obtain permission for the project. Parents/legal guardians provided consent and adolescents provided assent. After obtaining the sign consents/assents, each student was evaluated to determine feasibility of benefiting from the group experience.

Appraisal of the Evidence

Several studies evaluated the effectiveness of a cognitive-behavioral intervention for adolescents in a school setting with positive results (Lusk & Melynck, 2011; Melnyk et al., 2009; Merry et al., 2004; Puskar et al., 2003; Puskar et al., 2009; Swartz et al., 2010). The studies addressed interventions with adolescents focused on using cognitive-behavioral theory as a

preventive measure. To reduce barriers of access to mental health services, the studies were conducted in the school setting.

Puskar et al. (2003) used mixed methods to investigate a 10-week program on teaching self-esteem, stress management, and coping skills. Outcome measures were assessed by using the Reynolds Adolescent Depression scale and the Coping Response Inventory–Youth to determine the presence of depressive symptoms and the coping skills necessary for dealing with stressful life events. These measures included both positive and avoidance behaviors. The study consisted of a 624 volunteer sample who were primarily white adolescent females (average age of 16). Results indicated an improvement in the intervention group for depression. Analysis of the data was completed by *t*-test, Mann Whitney U-test, and chi square. No significant differences were found between the groups for coping styles except that the intervention group used less cognitive avoidance behaviors.

A study by Puskar et al. (2009) used cognitive-behavioral interventions with adolescents (age range of 14-18) in the school setting. Data analysis was conducted by use of the two-tailed Student's *t*-test. The results of the interventions were clinically significant in terms of improved usage of effective coping skills; however, the results were not statistically significant.

A quantitative study conducted by Swartz et al. (2010) supported the effectiveness of a school-based adolescent education program or intervention. The intervention was Adolescent Depression Awareness Program (ADAP) which focused on teaching the illness aspects of depression, decreasing the stigma associated with depression, and promoting a more accepting attitude towards recognizing what it means to have depression. Participants were students in six high schools in a large public school district in Maryland. Pre- and post-test data was collected using a paired *t*-test to evaluate the significance of the differences for the mean scores. Results

of the intervention were positive for the identification of the symptoms of depression and mania and a more accepting attitude towards mental illness. By providing the intervention in a school setting, the adolescents had access to the intervention and demonstrated an improvement in their knowledge of mental illness.

Melnyk et al. (2009) conducted a randomized controlled pilot study utilizing a cognitive-behavioral approach called COPE Healthy Lifestyles TEEN (thinking, emotions, exercise and nutrition). The COPE Healthy Lifestyles TEEN program expected outcomes included: creating a healthy lifestyle, building self-esteem, effective stress management, goal setting, effective communication, nutrition, and physical activity. The Beck Youth Inventory II (BYI-II) was used to measure depressive symptoms, anxiety symptoms, anger, disruptive behavior, and self-concept (Beck et al., 2005). Demographic characteristics of the sample included: (a) adolescents (mean age 15.67 for the experimental group and 15.28 for the control group) and (b) in high school. Data analysis used the paired *t*-test to assess depressive and anxiety symptoms and coping (choices) skills. The intervention group showed a decrease in depressive symptoms, a decrease in anxiety symptoms and an increase in commitment to make healthy choices. Data indicated improvement in scores; however, the *p* value was $\leq .10$ for anxiety and making healthy choices which does not indicate statistical significance (possibly due to low number of participants).

Lusk and Melnyk (2011) conducted a quasi-experimental study that validated the effectiveness of cognitive behavioral interventions using of the mental health portion of the COPE Healthy Lifestyles TEEN concept previously used by Melnyk et al. (2009). The COPE TEEN intervention included activities to help the student make the connection between thinking, feeling, and behavior. It also targeted activities to facilitate coping with stress, problem solving,

dealing with emotions in healthy ways, and putting it all together. The research instruments used to measure intervention success included: (a) Personal Beliefs Scale – Teens, which measures beliefs/confidence about the ability to manage stress and to cope with various stressors, (b) the Beck Youth Inventory II which measures depression, anxiety, anger, destructive behavior and self-concept, and (c) the post-COPE TEEN program evaluations for the teens and parents. The sample population consisted of adolescents (age 12-17) from a community mental health center in a western rural community. Data analysis was completed using paired sample *t*-tests, to determine the difference between the pre-and post-COPE intervention scores. The results demonstrated a statistically significant decrease of depression scores. The Beck Youth Depression Inventory mean score indicated an improvement with a decrease in depressive symptoms, anxiety symptoms, anger symptoms, and destructive behavior. Furthermore, the results indicated an increase in self-concept and beliefs to manage stress, and success with learned CBT skills. These results indicate a significant improvement in response to the cognitive-behavioral intervention of COPE TEEN program.

The effectiveness of a school-based depression prevention program was evaluated in a randomized trial by Merry et al. (2004). Merry et al., (2004) used a specific program for teaching self-esteem, stress management, and coping skills to adolescents. The research instruments used were the Reynolds Adolescent Depression scale and the Beck Depression Inventory (BDI II). The sample consisted of adolescents (mean age 14.2) from two high schools in Auckland, New Zealand; one school was from a lower socioeconomic urban area and the second school was from a middle-class, rural district. Research used a one-tailed, independent-sample *t*-test that compared the difference between baseline scores and the scores at the different

intervals (post-intervention, 6 months, 12 months, and 18 months) to evaluate data. A Chi-square analysis was used to evaluate the changes between the BDI-II categories. The statistical analysis revealed an improvement depression scores over beginning scores after an 18 month period. The mean difference for the intervention group was 1.55 (SD= 1.03) and 1.31 (SD – 1.02) for the placebo group.

Support for the long term benefits of cognitive-behavior interventions with adolescents was illustrated by Puskar et al. (2003). The study followed the participants for 12 months. Additionally, a study by Merry et al. (2003) identified persistent positive effects of the intervention for depressive symptoms even after 18-months. While the study by Puskar et al. (2009) did not show statistically significant improvement using CBT, it did show clinical significance or symptom improvement over a period of 1 year. A meta-analysis of 32 randomized trials by Weisz et al. (2006) confirmed the benefit of evidence-based therapies in the treatment of adolescents.

Another concern for adolescent mental health services was the accessibility of mental health services for the adolescent. Samargia et al. (2006) identified barriers to health care as reported by youth to include “gaining access to care because of waiting lists, lack of parental consent, or transportation problems” (p. 18). Other barriers identified by the study were stigma of mental health issues and parental perception that the adolescent’s health problem was not important.

Limited resources for mental health services reduce compliance during treatment which is a concern for mental health providers. Removing barriers to health care can promote use of resources and thus improve mental health service success. Gampetro, Wojciechowske, & Amer (2012) conducted a qualitative study where findings indicated that adolescents identified the use

of a school- based clinic as meeting their needs and removing barriers to mental health care. Data were analyzed through content analysis and four common concerns or themes emerged: (a) adolescent's concerns, (b) resource needs, (c) helpful resources, and (d) barriers to resources. The last three themes were related to the care received from the school-based clinic. Students indicated the importance of the identification of resource needs and the availability of services in the school based clinic. The students also identified that "if the clinic did not identify their needs for mental health care, they would most likely have not received services" (p. 29). This is a significant finding and supports the provision of mental health services within a school-based clinic to facilitate quality mental health care.

Project Objectives

The objectives of COPE TEEN intervention project are 1) to reduce depression symptoms and 2) to improve self-confidence of adolescents in a rural high school. The objectives were achieved by empowering a group of adolescents through learning and utilizing effective life coping skills. The COPE TEEN project objectives dovetailed with the mission of Madison Southern High School, to teach, to empower, to aspire, and to motivate (TEAM).

Project Design

The project was designed to identify and address mental health issues among adolescent high school students in a specific Central Kentucky High School. Through the implementation of COPE TEEN project a decrease of depressive symptoms and an increase of self-confidence through the use of effective coping skills are the goals for the participants. The use of interventions was based on CBT, specifically designed to help the adolescent identify the relationship between thoughts, feelings, and behavior (Beck et al., 2005). The program outcome measures include the use of the Beck Youth Inventory II (Beck et al., 2005) to detect evidence

of improvement in depressive symptom and improved self-confidence through better knowledge and utilization of coping skills as measured by the Healthy Lifestyles Belief Scale for Teens (Melnyk et al., 2009). Self-confidence will be measured by the Beck Youth Inventory II self-confidence index section and the Healthy Lifestyles Belief Scale for Teens. Post-intervention improvement in scores on these measures indicated that the adolescent's ability to cope with stress and daily life choices has been enhanced by the CBT intervention. Evaluations by students, parents/guardians, school counselors and the school principal would identify improvement in the adolescent's mood, behaviors and perceptions of self-confidence.

A common understanding of the vital language, concepts, definitions, and theories that provide the foundation for the project enhanced the understanding and success of the COPE TEEN project implementation. Working with adolescents encompasses unique developmental, behavioral, and mental health concepts, and language. The following is a discussion of pertinent definitions, concepts, and theories necessary for appropriate understanding and success of the project implementation.

Cognitive behavioral theory.

A foundation for the implementation of this project was the CBT theory. CBT theory identifies the relationship between what a person thinks and translates that relationship into; first, how one feels and, then, into how one behaves (Beck et al., 2005). By understanding this relationship, the adolescent can understand how what one thinks influences how one behaves in a situation. With appropriate education, the adolescent incorporates this new knowledge to choose to respond to a situation that is appropriate/socially acceptable rather than reacting to the situation in a non-productive manner. Correlating the relationship between thought and behavior, interventions can be developed to teach positive coping skills to adolescents who have

not had opportunities to develop them previously. Beck et al. (2005) was the first to utilize the theory of CBT as the basis for an intervention for adolescents. Later, Melnyk et al. (2009) developed a program known as the Creating Opportunities for Personal Empowerment (COPE) TEEN program that serves as the foundational intervention for this project.

COPE TEEN program.

The COPE TEEN program was developed by Melnyk et al. (2009) specifically to address the coping skills of the adolescent. The program addresses the developmental needs of the adolescent by utilizing CBT interventions that facilitate adolescent understanding and practice of effective coping skills. The original program consisted of a fourteen-session intervention/therapy that addressed the basic concepts of CBT, providing situations applicable to adolescents and utilizing CBT concepts and healthy nutritional instruction. The program is presented in a structured approach with instruction utilizing examples designed specifically for the adolescent population and weekly homework to practice concepts presented in the lesson. As a pilot project for the school system, this project will utilize the seven sessions that focus on the mental health concepts.

Mental health issues in adolescents.

The third aspect is mental health issues among adolescents. Mental health issues are identified as any mental health issue that interferes with the adolescent's functioning in the social and school setting. These may include depression, anger, and disruptive behavior. The behavior must meet the diagnostic criteria as listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV TR; American Psychiatric Association {APA}, 2000). For the purpose of this project, only measures for depression symptoms and the acquisition of coping skills will be

evaluated. Exhibitions of anger and disruptive behaviors will be considered as evidence of depression and ineffective coping skills as defined by the DSM, IV TR (APA, 2000, p. 356).

Project Timeline

The project proposal was presented to the Capstone Committee and the school board for review in August, 2012. After completing recommended revisions and receipt of approval from the Capstone Committee and the legal advisor for the school board, the project was submitted to the Eastern Kentucky University Institutional Review Board (IRB) for approval. Additional revisions as requested by the IRB and the Capstone Committee were made. Approval from Eastern Kentucky University IRB was received on October 18, 2012. On November 7, 2012, a meeting was held between the school counselors, school administrator, and the principle investigator to review the project and identify the roles of each member.

Review of potential participants began on November 29, 2012, and the process of the COPE TEEN intervention was established. School counselors recruited participants by alerting school faculty of the program and discussing the potential benefits of the program. Counselors and school faculty then identified students who would potentially benefit from the intervention and scheduled a meeting with the principle investigator. The principle investigator met with potential participants (students) to explain the program and answer questions on November 20, 2012. For students who were unable to attend the meeting, school counselors talked with the students and provided the contact information for the principle investigator. Upon determining the adolescent's willingness to participate in the project, both program information and consent forms were given to the adolescents. The forms included the parents/guardians consent forms and assent forms for the adolescents. The principle investigator started screening interviews for appropriateness to participate in the project on November 29, 2012. In January 2013, additional

students were identified by the school counselor and staff to potentially benefit from the intervention. The students met with the principle investigator to discuss the program and packets were given to those who expressed interest in participating in the program. Interviews were conducted in a private office and the counseling office to facilitate confidentiality and ease of accessibility for the student.

The COPE TEEN project began on January 17, 2013. There were seven (7) weeks of program interventions. An eighth session was held on March 7, 2013 to complete the post-intervention surveys and program evaluations.

Data, consents, assents, and scales will be housed in the Capstone Chairman's office under lock and key. The principle investigator and committee members had full access to the data. A code book was generated to identify the student with an assigned number in order to facilitate anonymity and confidentiality. All scales and data for the students were identified by a number and no names appeared on the written material. School counselors held the code book until the end of the project and reviewed the initial completion of the Beck Youth Inventory Scale to identify any potential self-harm statements. Following the review by the school counselors, the principle investigator transported the completed scales to the Capstone Committee chair's office to be stored in a locked cabinet. Following the completion of the project, the data will remain in the Capstone Committee chair's office for three years as required by the university. After the three years' time period, the data will be destroyed by shredding.

Resources

The project required support from the school in terms of physical space and support for the delivery of the program. Financial support was also needed for the project. The school provided a meeting room, allowed students to attend during the regular school hours without

negative consequences of missing class, counselors maintained the code book, and referred any questions from the parents or guardians to the principle investigator. Financial aspects included: licensing fee for the COPE TEEN program (\$250), purchase of the Beck Inventory tool and forms (\$292), and reproduction of the COPE TEEN manuals (\$600). The principle investigator absorbed the cost of the materials and licensing fee. There was no cost incurred by the students/participants. An initial evaluation was completed to determine the adolescent's ability to participate in group sessions. Referrals were made to mental health services if needed. Insurances were billed for the initial evaluation but no additional charge was incurred by the participants. An agreement with the mental health clinic was made to absorb the cost not covered by insurance so there would be no cost to the participants.

Feasibility of Sustainability

Sustainability is feasible based on previous research data (Lusk & Melynk, 2011; Melynk et al., 2009) and the support by the school personnel. Support from the school during the project included support from the school counselors for the concepts and actual program. Discussions with A. Hayes, Vice-Principal for Curriculum, resulted in verbalization of program support and the potential for future endeavors including incorporating the intervention process into the school curriculum (Hayes, personal communication, November 20, 2012). A potential endeavor is to present the program in freshman health class through a grant. This would incorporate teaching the COPE TEEN program to the school staff.

Methods

The purpose of the project was to improve depressive symptoms (self-reported) and improve of self-confidence by utilizing a program (COPE TEEN) to facilitate effective coping skills for adolescents. The COPE TEEN program is a structured, seven-week intervention that

addresses the relationship between thinking, emotions, and behavior. The setting was a rural high school in Kentucky. The two goals were to improve depressive symptoms and improve self-confidence by improving effective coping skills.

Approval for the project was obtained from Eastern Kentucky University's full Internal Review Board. Approval for the project within the high school was obtained from R. Pepper, Chief Academic Officer of the county and D. Gilliam, Principal at the high school following review by the county school's legal counsel. Consents from the parents or guardians and assent from the adolescent students were obtained prior to evaluation for participation in the program.

Procedure

Counselors and faculty employed by the high school identified students with behavioral, emotional, or family difficulties for participation in the program. Counselors then scheduled a meeting with each student and the principle investigator (PI) to explain the program and answer questions. In December 2012 student expressing interest in the program were given packets (consent forms for parent/guardian and assent form for the student) to take home for signatures. For students who had not returned a packet, a second meeting was held in January 2013 to confirm interest in the program and answer questions. Additional students were identified by the school counselor and staff as potentially benefitting from the intervention. An individual meeting was held by the principle investigator to discuss the program and provide packets for those students who expressed interest in participating in the program. Once consent from the parent/guardian and assent forms from students was received, the PI interviewed each student to assess appropriateness to participate in the project. Interviews were conducted in a private counseling or administration office at the high school to assure confidentiality and ease of accessibility for the student. Students were excluded from participation if interviews revealed

limited cognitive ability, disruptive behavior, and psychosis. Following completion of the interview, students assessed as appropriate for the project were scheduled for pre-assessment and initial session.

The COPE TEEN program included seven 30-35 minute sessions scheduled weekly. Sessions times differed to avoid students being absent from the same class period for seven consecutive weeks. Classroom teachers of the participants were contacted via phone just prior to each program session and asked to send the student to the school office. This further assured confidentiality.

Conceptual and operational definitions were established to include depressive symptoms and self-confidence. The conceptual definition of depressive symptoms is those feelings experienced by the adolescent identified feeling down, low energy, feelings of sadness and lack of motivation or hope. The Operational definition would reflect the score on the Beck Depression Index (Beck, 2005). Self-confidence is how the student perceives themselves and their ability to handle stress and difficulty situations. Feeling confident and believing that they can handle new and stressful situations would constitute the operational definition for self-confidence for the adolescent student. The operational definition of self-confidence is the score on both the Beck Self-Confidence Index (Beck, 2005) and the Healthy Lifestyle Beliefs Scale (Melynk, 2009).

Design

A pre-experimental one group design was utilized with a pre- and post-intervention assessment. After the completion of evaluations by the principle investigator (for appropriateness of group involvement) and baseline measurements (pre-intervention scales), the

seven 30-35 minute group sessions were conducted with the adolescents. The sessions followed the COPE TEEN program manual for the adolescents. See Table 1 for Session content.

Table 1 COPE TEEN Program Content

Week	Topic
Week 1	Thinking, Feeling , and Behaving Triangle
Week 2	Self-esteem, positive thinking, Self-talk
Week 3	Goal setting and problem solving
Week 4	Stress and coping
Week 5	Emotional and behavioral regulation
Week 6	Effective communication
Week 7	Barriers to goal progression

Post-intervention scales for the BSCI, BDI, Healthy Lifestyle Beliefs, and course evaluations were completed after the last session of the program.

Sample

A total of 39 students were recommended by the counselors/staff at the high school as potentially benefiting from the intervention. Students were selected based on life situation, or mood and behavior observed by the counselors/staff. Twenty-seven students indicated an interest in participating in the project. Twelve students returned the signed consents/assents for the project. One of the twelve students was excluded following the initial interview/assessment and referred to individual counseling. Exclusion criteria included limited mental ability, presence of psychosis, and behavior that would interfere with the group process such as potential for violence either through previous experience or verbalization by the student. One student withdrew after the second session due to not perceiving a need to continue in the project. An additional student withdrew after the fourth session due to her father being ill. Two students

missed one session each due to absence from school and one student missed two sessions due to illness. A total of nine students completed the COPE TEEN project and pre and post assessments.

Demographics of Population

Table 2 represents the demographics of the sample. The majority of the sample was Caucasian and almost evenly distributed between male and female. Students' age ranged from 14 years – 17 years and grade in school ranged from 9 – 11. All of the participants reported some previous mental health diagnosis.

Table 2 Demographics

		<i>n</i>	%
Gender	Male	5	55
	Female	4	45
Ethnic orientation	Caucasian	8	89
	Hispanic	1	11
Age	14	1	11
	15	5	55
	17	3	33
Grade in High School	9	3	33
	10	4	45
	11	2	22
Previous Mental Health Diagnosis	Yes	9	100
	No	0	0
	Depression	6	67
	ADHD	2	22
	Asperger's	1	11

Instruments

Beck Youth Inventory II was used to measure depressive symptoms and self-confidence. The measure is a nationally recognized tool that measures outcomes of the COPE cognitive behavioral therapy interventions and is designed for the second grade reading level (Beck et al., 2005). The scale has been used in studies with adolescents for pre and post intervention

assessments (Lusk & Melnyk, 2011; Melnyk et al., 2009; Merry et al., 2004). The results demonstrated improvement depressive symptoms and self-concept following cognitive behavioral intervention. Cronbach's alpha coefficients for the depressive scale ranged from .91 to .96 for adolescents between 15 and 18 years of age (Beck, 2005). It is expected that the intervention will demonstrate improvement in coping skills and reduced symptoms of depression

The range for Beck's BDI (depressive symptoms index) scores is: 70+ extremely elevated, 60-69 moderately elevated, 55-59 mildly elevated and less than 55 is average (Beck et al., 2005, p. 19). The goal of the intervention is a decrease of scores which indicated an improvement of symptoms of depression has as self-reported by the adolescent student. The Beck's BSCI (self-confidence index) score range is: greater than 55 is above average, 45-55 is average, 40-44 is lower than average, and less than 40 is much lower than average (Beck et al., 2005, p. 19). Intervention will increase the score to indicate a greater self-reported perception of self-confidence by the adolescent student.

A second instrument was the Healthy Lifestyle Beliefs Scale (Melnyk et al., 2009). This instrument addresses the adolescent's perceptions of his/her ability and confidence to cope with various stressors and manage their stress. The 10-item instrument utilizes a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). The range for test scores is 16 to 80 with higher scores indicating the adolescent's belief of his/her ability to manage stress. (See appendix A.) The highest score possible for the Healthy Lifestyle Beliefs Scale is 80 which indicate the adolescent's perception of self-confidence and belief of their ability to handle stress and life situations in a healthy, positive manner. The intervention will focus on increasing the score for the Healthy Lifestyle Beliefs Scale which will demonstrate a perception by the adolescent student that they are more confident to handle stress and use effective coping skills.

Results

Data were analyzed using a two-tailed paired *t*-test to identify differences in mean score on the Beck Youth Inventory II and the Healthy Lifestyle Beliefs Scale. Scores on the BSCI and the BDI were used from the Beck Youth Inventory II. SPSS software version 19 was used for all analysis. Table 3 represents outcomes of all analysis.

The scores of the BSCI of the nine adolescent students 6 (66%) showed improvement in their scores ranging from 48% to 14%. Three adolescents (33%) demonstrated a decrease in scores ranging from 1% to 33%. Data were analyzed using the paired-samples *t*-test, two-tailed to evaluate the effectiveness of the COPE TEEN intervention on the adolescent students' scores for their self-confidence. There was not a statistically significant increase in the pre intervention scores ($M = 44.89$, $SD = 9.35$) to post-intervention scores ($M = 46.56$, $SD = 6.23$), $t(-.536) = 3.11$, $p \geq .05$ (two tailed). The mean increase in self-confidence scores was 1.67 with a confidence interval ranging from -8.84 to 5.50. The improvement was clinically significant but failed to reach statistical significance.

Table 3 Pre and Post Intervention Scores

Measure	Pre-Intervention Mean \pm <i>SD</i> (range)	Post Intervention Mean \pm <i>SD</i> (range)	<i>t</i>	df	Sig, (2-tailed)
BSCI	44.89 \pm 9.35 (32-58)	46.56 \pm 6.23 (37-56)	-.536	8	.606
BDI	56.67 \pm 8.17 (46-72)	57.00 \pm 9.11 (41-72)	-.152	8	.883
HLBS	55.11 \pm 9.92 (43-65)	65.22 \pm 13.84 (43-80)	-1.817	8	.107

The BDI scores reflect the pattern of the BSCI results which showed an improvement (reduction of depressive symptoms) ranging from 1% to 10% for 6 adolescents (66%). There were three (33%) of the student that identified an increase of depressive symptoms ranging from

3% to 27%. The range for Beck's BDI scores is: 70+ extremely elevated, 60-69 moderately elevated, 55-59 mildly elevated, ≤ 55 average (Beck et al., 2005, p. 19).

The two-tailed paired *t*-test was used to analyze the data to evaluate the effectiveness of the COPE TEEN intervention on the adolescent students' scores of their perceptions of symptoms for depression. There was not a significant decrease in the pre intervention scores ($M = 56.56, SD = 8.33$) to post-intervention scores ($M = 56.44, SD = 9.98$), $t(.049) = 2.26, p \geq .05$ (two tailed). The mean decrease in depressive symptom scores was .11 with a confidence interval ranging from -5.11 to 5.33. The improvement failed to reach statistical significance.

Healthy Lifestyle Beliefs Scale post intervention demonstrated an increase of belief in their ability to make healthy life choices for 6 students (66%) and 3 students (33%) showed a decrease in scores demonstrating a reduction of belief by the three students. To evaluate the effectiveness of the COPE TEEN intervention on the adolescent students' scores of their perceptions of healthy lifestyle beliefs in their self-confidence and their ability to cope with stress the paired-samples *t*-test was used to analyze the data. There was not a significant decrease in the pre intervention scores ($M = 55.11, SD = 9.91$) to post-intervention scores ($M = 65.22, SD = 14.02$), $t(-1.71) = 5.91, p .13$ (two tailed). The mean increase in self-confidence scores was 10.11 with a confidence interval ranging from -23.75 to 3.53. Statistical significance for the improvement of self-confidence was not reached.

Qualitative data was obtained through program evaluation surveys from the adolescents, parent, one counselor and the administrator. The evaluation used open-ended questions to elicit responses. The themes of responses included: dealing with anger, thinking before acting, learning coping skills, and improved self-confidence. Seven (78%) of the nine student's evaluation surveys resulted in a positive perception of the COPE TEEN program with viewed the

program as helpful. Responses included 78% of the adolescents indicating improved coping skills as the COPE TEEN being helpful as evidenced by statements of “just deal with my anger”, “coping”, “to think about my anger”, “I can think more clearly and not be intimidated by other”. Negative responses included “therapy doesn’t help me”. When asked about the students liked best about the COPE TEEN program, responses included (67% positive, $N=9$) “it helped me chill out”, “being able to talk about things” “the feedback from other students” and “getting to know new people”. In identifying the least liked part of the program, students related “having to talk”, “getting interrupted by the teacher/guide person”, “some of the lessons and homework”, and “the program was generally ridiculous and unhelpful”. Positive change in their perceptions and behavior was identified by 78% of the students and 67% identified that they planned to continue to use the skills they had learned in the COPE TEEN program. When asked if they thought all teens should participate in a COPE TEEN program, 44% responded yes, 33% no and 22% did not respond. The reasons for their responses included: “not everyone needs it”, “it can help you”, “it really helps”, and “because it’s just inadequate”. The majority of the students thought they had learned new ways to deal with their thoughts and behaviors (56 %). Identifying new ways to deal with their feelings was 44% with 22% giving no response.

The Parent COPE TEEN program evaluation forms were given to the nine adolescent students and one (11%) was returned. The response was positive and indicated an improvement in the adolescent’s behavior had improved “seems a little more patient”, “deals with anger a little differently most times”, and “was taught imagery as a coping method/tool and that it was helpful”. An additional comment identifying benefits of the program was that it was “during school times and at different times” (different periods during the school day).

Counselor evaluation identified the COPE TEEN program as helpful for the students by helping “students develop coping skills and increased logical thinking”. The counselor related that the program “helped students develop real life skills” and was evidenced by “they have fewer behavior problems”. On the question of whether all teens should attend the COPE TEEN program, the counselor related “every teen doesn’t need it, but there are many who do”. Additional comments given were “I appreciate the value of this group and its availability to our students”.

Administration/school principal responses mirrored the responses by the school counselor. Benefits of the COPE TEEN program included that it “gave students an opportunity to talk with someone and someone to listen to them” and “the small group session that allowed open dialogue among participants. The school principal was able to identify that “the students seem to have more self-confidence and more self-esteem” and the most helpful topic was “making wise choices” because “students had to reflect on their personal characteristics when considering choices/decisions”. An identified change was “students seemed to have more strategies for dealing with stressful situations”. A topic identified as needing more time with the program was “accepting and understanding responsibilities”. The principal also related that the program was “not for everyone”.

Discussion

Results from the project indicated that the majority of the students found the program to be helpful and demonstrated an improvement in scores to support their perceptions of self-confidence and decreased depressive symptoms. Improvement in depressive symptoms and an improvement in self-confidence were achieved by a majority of the participants. While the project did not achieve statistical significance, the value of clinical improvement is important.

The project data mirrored study results by Puskar (2009) which demonstrated long-lasting clinical improvement with no statistical significance. Melynk (2009) and Lusk (2011) reported positive results for depressive and self-confidence with the COPE TEEN program. Another CBT program (TKC) by Puskar et al. (2003) demonstrated an improvement in depressive symptoms and effective coping skills. Merry (2004) related that improved school performance can result from reduction of depressive symptoms and improved self-esteem and self-confidence by increasing effective coping skills. Student participation in the group sessions was active and interaction among the adolescents was beneficial. Participation in the COPE TEEN session was consistent with two students missing one session each and one student missing two sessions due to absence from school.

Of the nine participants, six achieved improvement on their scores. By reports from the parent, school counselor and administrator, all participants demonstrated improved coping skills/ self-confidence and improved depressive symptoms. Additionally during the session, examples were given that demonstrated more effective coping skills such as walking away from a situation which previously would have resulted in physical altercation, practicing relaxation skills, and identifying options to situations that demonstrated problem solving techniques. One student's evaluation related negative comments about the program but demonstrated improvement in their scores for depressive symptoms and improved self-confidence.

With clinical improvement in behavior and self-confidence, it is questionable if the difference between the pre and post scores is a true reflection of the individual. As the student's awareness increased, a more accurate assessment may have been made at the post-intervention assessment. A second possibility is that as the adolescent became comfortable with the group setting, they were confident to answer the post intervention questions more honestly. With the

developmental task of identity versus role confusion (Erikson, 1968), adolescents are striving to accomplish their own unique identity while being very aware of their peers. By increasing their self-confidence, the adolescent would advance in this developmental task and be able to respond in a more honest manner in the post-intervention tools.

With the two students who scores represented a decrease of self-confidence and an increase of depressive symptoms, an improvement of behavior was evident by both interaction in the group setting and feedback from school personnel. School staff related that on several occasions one of the students validating that the group would be conducted prior to the primary investigator arriving. Participation was 100% for this individual. Clinically depressive symptoms may increase prior to perceived improvement of depressive symptoms even with improvement in behavior (First & Tasman, 2004). With this situation, clinical improvement demonstrated benefit for both students from the intervention.

Providing the intervention in the school setting reduced some barriers to health care as identified by Samargia (2006). Transportation and accessibility were eliminated by providing the session in the school and during school times. Parental involvement (consent forms and evaluation form) was limited and identified in Samargia (2006) as one of the barriers to adolescents seeking mental health care. Returning of paperwork was an issue whether due to the student or parent/guardian. Students reported in the group session that they forgot paperwork and was the reason for lack of completion of paperwork. Intervention in the school setting is a positive alternative for the provision of mental health services as it reduces many of the barriers that impede the utilization of mental health services by adolescents. Participation in the group located in the school proper also reduced the potential for stigma of mental health issues which was identified as a barrier to seeking mental health help by Samargia (2009).

Securing the support of the facility was important in the success of the intervention. Utilizing a practice friendly approach such as Rosswurm and Larrabee's (1999) model for change was beneficial to ensure involvement in the change process by the facility and school personnel. Long lasting change has to include all as part of the team approach for the intervention and demonstrate a collective understanding of the change process. When the supporting facility and individuals are involved in the change, the feasibility of sustaining or facilitating further change is enhanced.

Limitations

The major limitation with the project was the small sample size ($N=9$). Because of the limited number of participants, the opportunity to conduct a control group was not available. The diversity of the group participants were limited and would not support the generalization of finding to a diverse population.

The limited involvement by parents/guardians was a concern as was evident in the returning of consent evaluation forms. Parental questions were answered by the school counselor and parents were encouraged to talk with the principle investigator. Additionally there were two students who requested to participate in the program but parents would not sign the consent forms.

Each of the students identified for the program had displayed either emotional or behavioral concerns for the school staff which may have influenced their perception of the program and thus their responses. Important to evaluate in further studies would be the attention received in the small group setting verses the actual program. Many times the presence of individualized attention can influence change. Previous therapy experience may have also

influenced the student's expectations of the group session and influenced their responses on the scales.

The length of the evaluation measures was a consideration and took approximately 25 minutes. This may have influenced the completion of the forms. The scales consisted of 106 items and the program evaluation was detailed and resulted in non-completion by 33% of the participants. A shorter and more concise evaluation form may have produced more information.

Implications

Implementing a CBT based intervention specifically for adolescents is beneficial on a clinical base. Even with the limitations and lack of statistical significance, the clinical improvement is important to a venerable population of adolescence. As related by the studies by Lusk (2011), Melynk (2009), Puskar (2009), and Swartz (2007), the improvement of depressive symptoms and improvement of effective coping skills were enhanced by a CBT intervention. The short term (seven sessions) group interventions addresses the need to provide intervention in a time limited manner due to focus ability and the busy lives of the adolescent individual.

Providing the interventions in a non-threatening environment is conducive for the adolescent to utilize the mental health services. Melynk (2009), Merry (2004), Samargia (2006), and Swartz (2007) addressed the benefits of offering mental health services in the school setting. By providing the services in the school setting, many barriers are removed. Barriers that are removed include reduction of transportation issues, stigma of mental health services, and provision of services in a familiar setting. Provision of the intervention in a group setting addresses the developmental issues of adolescence and indirectly provides feedback that the adolescent is not alone in their self-perceptions of their difficulties.

Provision of both intervention and preventive projects would be helpful in the school setting. Future projects could expand the participant sample to be able to generalize the benefit of the project to a wider population. On an individual basis, the improvement of self-confidence has the possibility of reducing difficulty behavior and depressive symptoms which can enhance productivity and school success.

Summary/Conclusion

COPE TEEN program is a feasible CBT intervention that has the potential to benefit adolescents. Even with the limitations of the study and the lack of statistical significance, clinical improvement was demonstrated by the perceptions of the participants and observations of the parent, counselor, and principal of the school. Providing the intervention in the school setting is beneficial to the adolescent and can enhance their self-confidence perception. Additional benefits of providing the intervention in the school setting is the removal of barriers to health care services which limit the accessibility of services. The enhanced self-confidence can have lifelong benefit as the student increased believe in their ability to handle stress and life situations.

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Appendix A

Healthy Lifestyle Beliefs Scale

Healthy Lifestyles Belief Scale for Teens

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Below are 16 statements that relate to your overall health and well-being. Please circle the number that best describes your agreement or disagreement with each statement. There are no right or wrong answers

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1	I am sure that I will do what is best to lead a healthy life	1	2	3	4	5
2	I believe that exercise and being active will help me to feel better about myself	1	2	3	4	5
3	I am certain that I will make healthy food choices	1	2	3	4	5
4	I know how to deal with things in a healthy way that bother me	1	2	3	4	5
5	I believe that I can reach the goals that I set for myself	1	2	3	4	5
6	I am sure that I can handle my problems well.	1	2	3	4	5
7	I believe that I can be more active	1	2	3	4	5
8	I am sure that I will do what is best to keep myself healthy	1	2	3	4	5
9	I am sure that I can spend less time	1	2	3	4	5

	watching TV					
10	I know that I can make healthy snack choices regularly.	1	2	3	4	5
11	I can deal with pressure from other people in positive ways.	1	2	3	4	5
12	I know what to do when things bother or upset me.	1	2	3	4	5
13	I believe that my parents and family will help me to reach my goals	1	2	3	4	5
14	I am sure that I will feel better about myself if I exercise regularly	1	2	3	4	5
15	I believe that being active is fun	1	2	3	4	5
16	I am able to talk to my parents/family about things that bother or upset me.	1	2	3	4	5

Appendix B
Evaluation Forms

ADMINISTRATION COPE PROGRAM EVALUATION FORM

Please answer the following questions.

Date:

- 1) Did you find the COPE program helpful for the student? ___yes ___no
- 2) If you found the COPE program helpful, in what ways did it help the student?
- 3) If you do not think the COPE program was helpful, please describe why it was not helpful?
- 4) What did you think was best about the COPE program?
- 5) What did you think was least helpful about the COPE program?
- 6) What, if anything, have you seen a change in the student since starting the COPE program (attitude, behavior, self-confidence, etc.)?
- 7) What was the most helpful topic for the student in the COPE program?
- 8) Why was this topic helpful?
- 9) What topic in the COPE program would you have liked to see more time spent on?
- 10) What topic in the COPE program would you have liked to see less time spend on?
- 11) Was there a change in the student when dealing with stress, concerns or things that worry them? _____yes, _____no
12. If there was a change, what was the change?
- 13) What would you suggest to change about the COPE program?
- 14) Were you aware of the homework in the COPE program? ___yes ___no
- 15) Was the homework helpful for the student? __yes, __no,__ don't know
- 16) If the homework was helpful, how was it helpful?
- 17) If the homework was not helpful, why did you think it was not helpful?
- 18) Do you think all teens should get the COPE program? ___yes (why?) ___no (why?)

- 19) What were barriers for the student attending all of the COPE sessions? (for example, absent from school, illness, influence from peers, etc.)
- 20) What else would you like to share about this C.O.P.E. experience?

Thanks so much for completing this evaluation of the COPE program!

CONSELOR COPE PROGRAM EVALUATION FORM

_____Code Number DATE: Please answer the following questions.

- 1) Did you find the COPE program helpful for the student? ___yes ___no
- 2) If you found the COPE program helpful, in what ways did it help the student?
- 3) If you do not think the COPE program was helpful, please describe why it was not helpful?
- 4) What did you think was best about the COPE program?
- 5) What did you think was least helpful about the COPE program?
- 6) What, if anything, have you seen a change in the student since starting the COPE program?
- 7) What was the most helpful topic for the student in the COPE program?
- 8) Why was this topic helpful?
- 9) What topic in the COPE program would you have liked to see more time spent on?
- 10) What topic in the COPE program would you have liked to see less time spend on?
- 11) Was there a change in the student when dealing with stress, concerns or things that worry them? _____yes, _____no
12. If there was a change, what was the change?
- 13) What would you suggest to change about the COPE program?
- 14) Were you aware of the homework in the COPE program? ___yes ___no
- 15) Was the homework helpful for the student? ___yes, ___no,___ don't know
- 16) If the homework was helpful, how was it helpful?
- 17) If the homework was not helpful, why did you think it was unhelpful?
- 18) Would you have liked to have joined the student for the COPE sessions? ___yes ___no
(why?)

19) Did the student discuss the information he/she learned in the COPE sessions or the COPE homework with you? _____yes _____no

20) Do you think all teens should get the COPE program? ___yes ___no (why?)

21) What were barriers for the student attending all of the COPE sessions? (for example, absent from school, illness, influence from peers, etc.)

28) What else would you like to share about this C.O.P.E. experience?

Thanks so much for completing this evaluation of the COPE program!

PARENT COPE PROGRAM EVALUATION FORM

DATE: _____ Code Number

Please answer the following questions.

- 1) Did you find the COPE program helpful for your child? ___yes ___no
- 2) If you found the COPE program helpful, in what ways did it help your child?
- 3) If you do not think the COPE program was helpful, please describe why it was not helpful?
- 4) What did you think was best about the COPE program?
- 5) What did you think was least helpful about the COPE program?
- 6) What, if anything, have you seen a change in your child since starting the COPE program?
- 7) What was the most helpful topic for your child in the COPE program?
- 8) Why was this topic helpful?
- 9) What topic in the COPE program would you have liked to see more time spent on?
- 10) What topic in the COPE program would you have liked to see less time spend on?
- 11) Was there a change in your child when dealing with stress, concerns or things that worry them? _____yes, _____no
12. If there was a change, what was the change?
- 13) What would you suggest to change about the COPE program?
- 14) Were you aware of the homework in the COPE program? ___yes ___no
- 15) Was the homework helpful for your child? _____yes, _____no
- 16) If the homework was helpful, how was it helpful?
- 17) If the homework was not helpful, why did you find it unhelpful?
- 18) If your child did not complete all of your homework assignments, why did they not complete them?
- 19) Would you have liked to have joined your child for the COPE sessions? ___yes ___no (why?)
- 20) Did you discuss the information your child learned in the COPE sessions or the COPE homework? _____yes _____no
- 21) What would you tell a friend about the COPE program?

22) Do you think all teens should get the COPE program? ___yes ___no (why?)

23) What were barriers for your child attending all of the COPE sessions? (for example, absent from school, illness, etc.)

28) What else would you like to share about this C.O.P.E. experience?

Thanks so much for completing this evaluation of the COPE program!

COPE PROGRAM ADOLESCENT EVALUATION FORM

Please answer the following questions. _____ Code Number

- 1) Did you find the COPE program helpful? ___yes ___no
- 2) If you found the COPE program helpful, in what ways did it help _____ you?
- 3) If you do not think the COPE program was helpful, please describe why it was not helpful?
- 4) What did you like best about the COPE program?
- 5) What did you like least about the COPE program?
- 6) What, if anything, have you changed since starting the COPE program?
- 7) What was the most helpful topic in the COPE program?
- 8) Why was this topic helpful?
- 9) What topic in the COPE program would you have liked to spend more time on?
- 10) What topic in the COPE program would you have liked to spend less time on?
- 11) What new or different thoughts do you have about dealing with stress, concerns or things that worry you?
- 12) What things that you learned in the COPE program do you plan to continue to use?
- 13) What would you change about the COPE program?
- 14) Was the homework in the COPE program helpful to you? ___yes ___no
- 15) If the homework was helpful, how was it helpful?
- 16) If the homework was not helpful, why did you find it unhelpful?
- 17) If you did not complete all of your homework assignments, why did you not complete them?
- 18) Did you like the length of the COPE sessions -45 minutes?
___yes (if yes, why?) ___no (if no, why?)

19) Did you and your parent/guardian discuss the information you learned in the COPE sessions or the COPE homework? _____yes _____no

20) What would you tell a friend about the COPE program?

21) Do you think all teens should get the COPE program? ___yes (if yes, why?)
____no (if no, why?)

22) Did you learn new ways to deal with your thoughts? _____yes _____no

23) Did you learn new ways to deal with your feelings? _____yes _____no

24) Did you learn new ways to deal with your behaviors? _____yes _____no

25) What were barriers for your coming to all of the COPE appointments? (for example, not being in school)

26) What else would you like to share about this C.O.P.E. experience?

Thanks so much for completing this evaluation of the COPE program!