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An Applied Mental Health Course and Student Well-Being

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ABSTRACT

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Addressing mental health concerns and promoting well-being is imperative for university students to function optimally and to succeed academically. The demand for mental health care is exceeding the capacity of traditional counseling center resources at universities, suggesting the need for innovative interventions that can serve a broader scope of students. There is emerging evidence suggesting that mental health can be addressed, and well-being improved through psychoeducation and applied skills taught in classroom settings. *Objectives:* To examine a Mental Health and Well-Being course at a large, private religious university and its relationship to students' well-being. This will be measured by assessing two well-being constructs: thriving and satisfaction with life. *Method:* Student volunteers were recruited from three sections of a Mental Health and Well-Being course and a control group from the general student body. Students were assessed on two measures of well-being, the Satisfaction with Life Scale, and the Thriving Quotient, at the beginning of the semester, mid-semester, end of semester and one month after the conclusion of the semester. *Results:* A Split-Plot ANOVA was used to assess the interaction between group membership (treatment v control) and time. The interaction between time and treatment was not significant. However, well-being (Thriving Quotient) did increase as a mean effect overtime for all participants. *Discussion:* Being enrolled in the Mental Health and Well-Being class did not significantly predict improved well-being compared to students not enrolled in the class. However, there was a general improvement in student well-being among both the treatment and control group, suggesting other situational or environmental factors may have been playing a significant role. Further research on potential interventions for university student well-being, including those that could be offered in the classroom setting could be valuable using a larger sample of students and measuring other variables as well.

Keywords: well-being, psychoeducation, thriving, flourishing

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DESCRIPTION OF DISSERTATION STRUCTURE AND CONTENT

This dissertation, *An Applied Mental Health Course and Student Well-Being*, is written in a hybrid format which integrates traditional dissertation requirements and journal publication formats. In line with these requirements, the literature review is included in Appendix A. Appendix B includes the Institutional Review Board Approval, Appendix C contains the study's instruments. Appendix D is the syllabus used for each section of the course taught, and Appendix E includes the fidelity checklist used in order to enforce teacher reliability. This dissertation format contains two reference lists; the first contains references included in the journal-ready article, while the second includes all citations used in Appendix A.

Introduction

The impetus for this dissertation comes from the increasing demand for mental health care services and the lack of sufficiently accessible and adequate resources. The repercussions of these insufficiencies in mental health care are profound, economically and more significantly in the loss of human lives. In addition to increasing mental health care resources for mental illness, there is also evidence that society and individuals could benefit from resources aimed at improving psychological well-being. University and college campuses are one place that could potentially benefit from additional, innovative mental health resources.

Inadequate Mental Health Care

There is a significant discrepancy between society's need for mental health care and the care individuals actually receive, and the cost of this discrepancy is significant. According to the National Alliance on Mental Illness (NAMI, 2019), one in five U.S. adults experience mental illness each year. In a given year, it is estimated that the majority, 56.5%, of adults with a mental illness receive no treatment (Mental Health America, 2017). In fact, the average delay between the onset of mental illness symptoms and treatment is 11 years (NAMI, 2019).

Even when individuals begin seeking treatment, accessing that care often remains an obstacle. For example, while estimates of how long individuals spend on a waiting list before being seen by a mental health care provider vary, research suggests that it can frequently range between 2–3 weeks and 2–3 months (Peipert et al., 2022). A 2021 survey from the American Psychological Association (2002) further reported that 65% of psychologists were reporting no openings for new patients at all. Further, almost half of the U.S. population knows someone who has had to drive more than an hour round trip to seek needed psychological treatment (National Council for Mental Wellbeing, 2018). Additionally, in one study, almost two-thirds of primary

care physicians reported difficulty accessing mental health services for their patients, a rate at least twice as high as reported for other health services (Cunningham, 2009). These physicians reported shortages of mental health care providers as an *important barrier* to mental health care (Cunningham, 2009).

Effects of Inadequate Care

The effects of insufficient and untimely care are immense. For instance, depression and anxiety cost the global economy 193.2 billion in lost earnings each year, and depression is a leading cause of disability worldwide (NAMI, 2019; Vos et al., 2017). Additionally, 20.1% of people experiencing homelessness in the U.S. have a serious mental health condition, and the rate of unemployment is higher for those with mental illness (NAMI, 2019).

Beyond the fiscal cost, the mental health care crisis is costing human lives. Suicide is the tenth most common cause of death in the U.S., and the second leading cause among individuals aged 10–34 (Hedegaard & Warner, 2021). While 90% of people who die by suicide are found in psychological autopsies to have had symptoms of mental health conditions, only 46% of those individuals had been diagnosed with a mental health condition during their lives (NAMI, 2019). These statistics suggest that many of those dying from suicide do not receive appropriate diagnoses for mental health concerns, let alone sufficient care. Human lives are at stake as long as proper care is not provided to those in need.

Well-Being

When considering how to provide adequate care, it is important to note that improving psychological well-being may constitute an important goal in addition to the traditional focus on alleviating symptoms of mental illness and distress. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the

absence of disease or infirmity" (World Health Organization, 1995, p.1). Their statement illustrates that psychological well-being is a key piece of overall health and is more than the absence of mental illness.

Psychological well-being, also referred to as good mental health or *flourishing*, consists of both subjective well-being and positive functioning (Keyes, 2002). Similarly to how a diagnosis of mental illness, such as a depressive disorder, necessitates the presence of certain symptoms such as anhedonia and impaired functioning, it is proposed that mental health requires the presence of positive *symptoms*, such as emotional vitality, adaptive functioning, engagement in fulfilling relationships, and an ability to cope with and adapt to adversity (Keyes, 2005; United States Public Health Service, 1999). A holistic view of mental health includes symptom reduction, improved functioning, as well as the experience of well-being and increased life satisfaction.

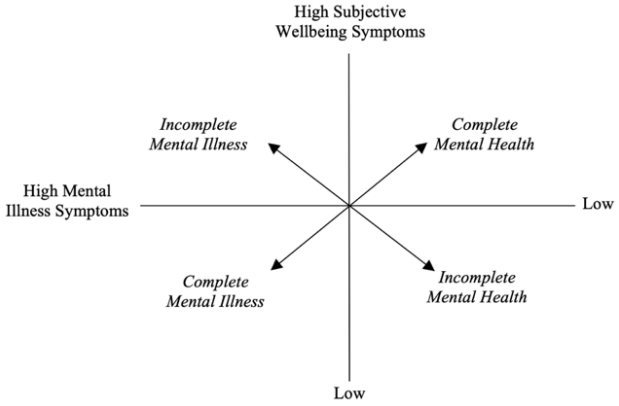
Instead of psychological well-being existing on the same continuum as mental illness, as its polar opposite, research in the area of psychological well-being argues that well-being and mental illness exist on two separate but related continua (Keyes & Lopez, 2002). In the two-continua model, mental illness lies on a spectrum that ranges from absent to present, and well-being exists on another spectrum ranging from low to high (Keyes & Lopez, 2002). This is supported by findings that mental illness and well-being correlate at only -0.50, suggesting that only 25% of the variance between their latent factors is shared, a much smaller correlation than would exist if mental health was guaranteed by the absence of mental illness (Keyes, 2005).

Keyes (2005) argues that these continua can be conceptualized as intersecting perpendicularly to form four quadrants. Figure 1 illustrates these four quadrants: present mental illness and low well-being, present mental illness and high well-being, absent mental illness and

high well-being, and absent mental illness and low well-being (Keyes & Lopez, 2002). This illustrates how the absence of mental illness does not necessitate high levels of mental health.

Figure 1

Mental Health and Mental Illness: The Complete State Model



Note. Two continua model of mental health (Keyes & Lopez, 2002, p. 50).

The WHO's declaration about mental health alludes to the importance and benefits of psychological well-being for individuals and their communities, arguing that mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 1995, p. 1).

Additionally, research findings show that individuals who are flourishing, or who have high well-being, miss fewer days of work, demonstrate higher levels of prosocial functioning, and have higher levels of functional goals than those with low well-being (Keyes, 2007). This remained true even when flourishing individuals were compared to non-flourishing individuals who were not experiencing mental illness (Keyes, 2007). This suggests that high psychological

well-being positively predicts important aspects of functioning, beyond those predicted by the absence of mental illness.

Mental Illness and Health in Higher Education

One population in need of additional mental health resources is university campuses. Universities are not immune to the difficulties related to mental health and access to care seen in the general population. In fact, college-aged individuals experience mental health concerns at higher rates than other age populations, with about half of individuals reporting experiencing mental illness in the past year (Blanco et al., 2008). Young adults aged 18–34 have been found to report the most significant increases in anxiety prevalence of any cohort, and between 2005 and 2017 suicide-related outcomes increased by 60% among young adults aged 18–25 (Goodwin et al., 2020; Twenge et al., 2019).

Treatment rates for college-aged individuals are low both for non-students and college attenders (Blanco et al., 2008; Han et al., 2016). The majority of college students with mental health problems do not receive treatment each year. For example, Auerbach et al. (2016) found that only 16.4% of students with 12-month disorders received any 12-month healthcare treatment for their mental disorders.

Not all students with mental health concerns seek help, but access to care is a problem even for students who do so. The Center for Collegiate Mental Health found that the number of students seeking counseling services increased 50% between 2015 and 2016 (Locke et al., 2016). On some campuses the number of students seeking mental health services has been found to be increasing four times more quickly than the student population itself (Xiao et al., 2017).

Those working in college counseling centers are noticing this increase in demand. In 2018, 57% of college counseling center directors reported that in order to meet students' needs,

they would need more hours of psychiatric services than they had available (LeViness & Bershad, 2018). This discrepancy is evident in a national study that found that the number of counselors available in college counseling centers compared to the number of students they serve is very small, on average, with just 1 counselor for every 2081 students (Gallagher & Taylor, 2015).

In addition to being important for mental health, access to treatment is important for college students' academic success. For example, students who receive counseling tend to have lower attrition rates (Lee et al., 2009). Additionally, 65% of college counseling center clients reported that counseling helped them to stay enrolled at their institutions, and 64% indicated that counseling had helped with their academic performance, even when it was unlikely to be their reported reason for seeking treatment (Gallagher & Taylor, 2015).

Well-Being in College Students

It is clear that greater psychological resources would benefit and are needed on college campuses. It is important that the efforts to better address college student mental health concerns also include addressing well-being in addition to the traditional focus on treating mental illness, since well-being is predictive of positive outcomes that are valuable to both universities and their students. Psychological well-being is positively associated with student academic performance (Rodríguez-Muñoz et al., 2021). Research suggests that college students with very high life satisfaction demonstrated improved academic performance over those with average life satisfaction, in terms of greater student engagement, academic self-efficacy, and approach-oriented achievement goals and lower academic stress (Antaramian, 2017).

Counseling centers and other traditional modes of mental health care are important. However, evidence suggests that college counseling centers are not able to fully meet student

demand for support relying on individual and group counseling modalities. Students are asking for and interested in more resources, including students who may not be recommended to traditional therapy due to their subclinical levels of symptoms. Stepped care models actually advocate a variety of interventions from low to high intensity interventions (Bailey et al., 2022; Cornish et al., 2017)

Interest in New Resources

Evidence suggests that students are interested in well-being and mental health resources from their universities in addition to traditional therapy. One example is Florida State University's Student Resilience Project designed to address student mental health needs and assist students in coping with stress (Oehme et al., 2019). The project is web-based and aims to destigmatize help-seeking behaviors, promote the use of services and resources available through the university, and help students develop resilience through skills such as mindfulness, distress tolerance, and emotional self-regulation (Oehme et al., 2019). Preliminary evidence found 80% of respondents specified they would likely return to the site for additional resources and 70% expressed that they would likely recommend the site to other students (Oehme et al., 2019).

Another example demonstrates students' interest in mental health resources specifically in the format of a college course. When Yale offered the course *Psychology and the Good Life*, which aimed to teach positive psychology principles and real-life applications of those principles, almost 25% of the university's undergraduate students enrolled, with 1,182 students taking the class, becoming the university's most popular class ever offered (Shimer, 2018). The responses of students to both FSU and Yale's mental health and well-being resources suggest that students are interested in resources when their universities make them available. Making resources available that have demonstrated usefulness is the present challenge.

Interventions for Students

Psychoeducation

Research suggests that one type of intervention that may help to protect mental health and prevent mental illness in college students is psychoeducation, particularly psychoeducational interventions geared to facilitate well-being. Lukens and McFarlane define psychoeducation as "a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and education interventions" (2004, p. 206).

An example of one of these well-being-focused psychoeducational interventions at the college was implemented with medical students. A group-level intervention that focused on psychoeducation and stress management skills for these students resulted in a 46.7% decrease in stress prevalence, a significant decrease in anxiety levels, and improved psychological well-being (Bughi et al., 2006).

Another example is a 4-week mental health promotion program for college students that combined psychoeducation and applied mental health skills and exercises (Viskovich & Pakenham, 2020). Results found improvement in students' scores on measures of depression, anxiety, well-being, and life satisfaction compared to students in a waitlist control. These improvements were enduring at a 12-week follow up.

In addition to aiding those with clinical level concerns, research suggests that psychoeducation can benefit those for whom traditional resources such as therapy are not designed primarily for. For instance, in one psychoeducational study, those with mild, subclinical panic attack symptoms experienced significant symptom reduction from psychoeducation alone and were less likely to require one-on-one treatment in the future (Baillie & Rapee, 2004). These findings support the idea that psychoeducation can benefit those without a clinical mental illness

and may decrease the need for those individuals to seek therapy later on, thus decreasing the demand on counseling centers.

Course Format Resources

In terms of mental health resources, it seems that a credit-bearing, psychoeducational college course format may provide distinct benefits on college campuses. For example, a review of research on mental health promotion and prevention programs for higher education students found interventions delivered in a class format to be more effective than those delivered in small groups (Conley et al., 2013).

Additionally, a class formatted approach to meeting mental health needs offers solutions to several of the problems with more traditional efforts and strategies (Howell & Passmore, 2019). For example, stigma poses another potential barrier when attempting to meet mental health needs. The stigma individuals hold significantly, negatively predicts whether students will seek mental health help (Eisenberg et al., 2009; Lally et al., 2013). A class that fulfills a university requirement and is delivered in a format similar to other courses may reduce the impediment created by stigma.

Another barrier to students receiving mental health services is lack of knowledge about resources. Being unaware of services was a significant predictor of not receiving those services in university students, and one study found that as many as half of students were unaware of campus mental health care resources (Dobmeier et al., 2013; Eisenberg et al., 2007). A class can inform students about resources, can be a resource in itself, and can be listed in the course catalog students already use.

Yet another difficulty with using traditional mental health resources alone is the significant rate of attrition in therapy. A meta-analyses of therapy attrition rates found rates

ranged from 18% when measured by a predetermined number of sessions to close to 40% when measured by clinician report (Roseborough et al., 2016). Students may be less likely to discontinue a class they are receiving credit and have paid tuition for than they are to cease therapy. Demonstratively, in one state, withdrawals from college courses were found to be less than 12% of total course enrollments (Florida Department of Education, 2011). This rate is significantly less than that reported for therapy.

Finally, lack of perceived need is a significant predictor of students not receiving mental health care (Eisenberg et al., 2007). Psychoeducation easily offered in a course format may serve to decrease this challenge. Young adults who received just 3 weeks of psychoeducation about mental health concerns demonstrated increased help-seeking attitudes and intentions, suggesting a psychoeducation course could help students in need of further therapy realize their need, as well as helping to meet that need in itself. (Taylor-Rodgers & Batterham, 2014).

In one pilot study, a college course aimed to address aspects of mental health, including depression, anxiety, and self-esteem, through teaching psychoeducational principles and skills and requiring practice of these skills (Schiraldi & Brown, 2001). Researchers found that at the end of the course students had significantly lower depression and anxiety scores and higher self-esteem (Schiraldi & Brown, 2001). An additional study on this course found that the improvements in anxiety and depression scores were greater in this class than the improvements gained in a more traditional stress-management course (Brown & Schiraldi, 2004). However, further studies on this course as well as any widespread implementation of a well-being-focused psychoeducation resource has not occurred, despite the potential benefits it could have.

Statement of the Problem

Many college students need mental health services and university counseling centers frequently struggle to meet increasing demands. Mental health issues impact students emotionally, relationally, and academically. As university counseling tries to adapt to the increasing demand for services, additional methods of intervention, beyond traditional individual therapy, are required to assist students. These additional methods must be less resource intensive yet scaled to meet a larger number of students seeking mental health support.

Statement of the Purpose

Applied mental health classes have been developed recently as a potential solution for broader access to mental health education and intervention. However, research assessing the effectiveness of these classes in addressing student mental health and well-being needs is quite limited. This study aims to evaluate the value of a university mental health course as a method of addressing student mental health needs and increasing well-being. The purpose of the current study is to assess the relationship between an applied mental health course and student well-being.

Research Hypotheses

1. We predict that there will be no significant interaction between time and group membership (treatment vs. control) in terms of Satisfaction with Life Scale scores.
2. If there is no significant interaction between time and group membership, examining the main effect for time only, there will be no main effect for time in terms of Satisfaction with Life Scale scores.
3. If there is no significant interaction between time and group membership, examining the main effect for group only, there will be no significant main effect for group in

terms of Satisfaction with Life Scale scores.

4. We predict that there will be no significant interaction between time and group membership (treatment vs. control) in terms of Thriving Quotient scores.
5. If there is no significant interaction between time and group membership, examining the main effect for time only, there will be no main effect for time in terms of Thriving Quotient scores.
6. If there is no significant interaction between time and group membership, examining the main effect for group only, there will be no significant main effect for group in terms of Thriving Quotient scores.

Method

It is worth noting that the research procedure used in this study is a causal-comparative experimental method and is not considered an experimental design. A causal relationship between independent and dependent variables cannot be concluded solely from this study.

Participants

Participants for the comparison group were recruited from three sections of a mental health and well-being course at a large, private religious university, Winter Semester 2021. Comparison group participants were recruited by flyers on campus and through the SONA research system.

We had a total of 377 responses across all respondents on all four waves. After removing responses with missing data (those who did not complete the survey during at least three of the four waves, including the first wave) we had 139 remaining responses across the four waves and a total of 38 participants. Twenty of these participants were enrolled in the mental health and

well-being course at the time of the study, and 18 were students at the large, private religious university not enrolled in the class.

Twenty-nine participants were female, nine were male, whereas the university's student population is a roughly even split between the sexes 48% of students identifying as female and 52% identifying as male. One participant identified as an international student. Two participants identified as multiethnic, one as Asian, and one as Hispanic, with the other 35 participants identifying as White. This means that 89.7% of our participants were White. A total of 82.3% of the university's student population identifies as White. Thirty-three participants were unmarried, and 6 were married.

The reported number of semesters attended by participants ranged from one to nine semesters; Four students did not answer this question. The mean number of semesters attended was about 4 (3.97). Of the 38 participants, 36 reported being members of The Church of Jesus Christ of Latter-day Saints, one individual reported having an undecided religious affiliation, and one student did not report their religious affiliation. Additionally, 11 participants reported that they were taking prescribed medication(s) for mental health reasons. Further, 19 participants had never received psychological services, clarified as counseling or therapy; 15 were not currently, but had received these services (three within the last four months). Finally, four were currently receiving psychological services (two had been in therapy for over four months, two for less than four months).

Treatment Group

In the treatment group, 15% of participants in the treatment group identified their sex as male and 85% identified their sex as female. In terms of ethnic identity, 85% identified as White, 5% Hispanic, and 10% Multiethnic. Additionally, 80% had never been married and 20% had

been married. The average number of semesters attended at the university by this group was 4.625. Of the students, 35% had never used psychological services, and the other 65% had or currently were using psychological services. Further, 50% of the group reported taking medication for mental health concerns. Finally, 95% identified as members of The Church of Jesus Christ of Latter-day Saints and 5% reported that they were of an undefined denomination. None of the students identified as international.

Comparison Group

In the comparison group, one-third of the participants in the comparison group identified their sex as male, and two-thirds identified their sex as female. A total of 94.4% of comparison group participants identified as White and 5.6% as Asian. Of the comparison group, 89% had never been married; 11% had been married. The average number of semesters attended at the university was 3.38. Two-thirds of these participants had never used psychological services; the remainder had or were currently using psychological services. Of the sample, 5.6% reported taking medication for mental health concerns. All members of the comparison group identified as members of The Church of Jesus Christ of Latter-day Saints. Of the students, 5.6% identified as international.

Measures

This study included two well-being measures: the Satisfaction with Life Scale and the Thriving Quotient.

Satisfaction With Life Scale

The Satisfaction with Life Scale (SWLS) is a five-item scale designed to assess an individual's cognitive judgments about their global life satisfaction (Diener et al., 1985). Psychometrics on this scale has found it to have strong internal reliability, with a coefficient

alpha of .87, and adequate temporal stability, with a two-month test–retest stability coefficient of .82 (Diener et al., 1985). Convergent validity for the Satisfaction with Life Scale is supported by the moderately strong correlation between scores on the SWLS and scores on at least eight other measures of subjective well-being including Cantril's (1965) Self-Anchoring Ladder (r = .62–66), Gurin et al.'s (1960) well-being measure (r = .47–.59), Andrews and Withey's (1976, as cited in Diener et al., 1985) Delighted–Terrible Scale (r = .62 and .68), Fordyce's (1978) single item measure of happiness and (1978) percent of time happy question (r = .57–.58 and r = .58 and .62), Campbell et al.'s, (1976) semantic differential-like scale (r = .57), Bradburn's (1969, as cited in Diener et al., 1985) Affect Balance Scale (r = .50–.51), and Tellegen's (1979, as cited in Diener et al., 1985) well-being scale of his Differential Personality Questionnaire (r = .68) (Diener et al., 1985). Scores on the SWLS also correlated .43 with interviewers' ratings of individuals life satisfaction after hour-long interviews (Diener et al., 1985) Scores on the SWLS correlated .02 with the Marlowe-Crowne Scale of Social Desirability, indicating that the SWLS is likely not evoking a social desirability response set (Diener et al., 1985).

The possible range of scores for the Satisfaction with Life Scale is 5–35 (Diener et al., 1985). As represented in Table 1 below, scores between 5 and 9 indicate extreme dissatisfaction with life, whereas scores between 3 and 35 indicate extreme satisfaction, and 20 represents a neutral point on the scale (Diener et al., 1985).

Table 1

Satisfaction With Life Scale Score Ranges

Score	Level of satisfaction with life
31–35	Extremely satisfied
26–30	Satisfied
21–25	Slightly satisfied
20	Neutral
15–19	Slightly dissatisfied
10–14	Dissatisfied
5–9	Extremely dissatisfied

Note. Range distinctions for the Satisfaction with Life Scale (Diener et al., 1985)

Thriving Quotient

The Thriving Quotient is a 24-item instrument that is grounded in the concept of psychological well-being, or "flourishing" and encompasses elements essential to college student success (Schreiner et al., 2015). The scale focuses on factors most predictive of academic success, institutional fit, satisfaction with college, and graduation (Schreiner, n.d.). The scale is composed of five factors: Engaged Learning, Academic Determination, Positive Perspective, Social Connectedness, and Diverse Citizenship (Schreiner, n.d.).

Research conducted on this measure found it to be highly reliable; its internal consistency was estimated as Cronbach's alpha = .91. Each separate scale also met standards of reliability: Engaged Learning ($\alpha = .85$), Diverse Citizenship ($\alpha = .80$), Academic Determination ($\alpha = .83$), Positive Perspective ($\alpha = .83$), and Social Connectedness ($\alpha = 81$). A confirmatory factor analysis indicated that Thriving was a second-order factor comprising the five latent variables constituting the scales of the instrument (Schreiner, n.d.). Results suggest that this model was a good fit for the data: $\chi 2(260) = 2{,}781.32$ ($p < .001$), CFI = .955, and RMSEA = .042 with 90%

confidence intervals of .040 to .043 (Schreiner, n.d.). No cut off scores were reported for the Thriving Quotient.

Procedures

The semester we collected data, two instructors taught a combined three sections of the mental health and well-being course. One instructor, a licensed clinician PhD, taught two of the sections, and a graduate student studying counseling psychology taught the other. Two of the courses were taught in a two-hour block once a week, and one was taught in a one-hour block twice a week.

The first hour of instruction each week was dedicated to questions from students about class material or student's other questions and to discussing their experience with homework. Students were asked to keep a journal based on their homework experiences. The second hour of class was reserved for the teaching and discussion of new material and the introduction of the next homework assignment.

The goal of the course as explained in the syllabus was to help individuals to identify common mental health challenges in themselves or others. This course aimed to explain stress, anxiety, and depression and give students tools for managing mental health. Psychological flexibility, including openness, awareness, and engagement, were discussed and practiced by students in this course as tools for living one's values in the face of challenges. Homework assignments varied from readings including *The Happiness Trap* by Russ Harris, experiential meditation, and keeping a journal of their experiences while completing assignments. For more details, see the syllabus for the course in Appendix B.

Measures were administered through Qualtrics on a total of four occasions; at the beginning of the semester, mid-semester, at the end of the semester, and one month after the end

of the semester in order to track changes in the listed measures over time. Participants in both the comparison and treatment groups were compensated for each time they completed the measures, for a total of 45 U.S. dollars per participant.

Fidelity Checklist

A fidelity checklist was designed to ensure that core elements of the course were taught in each course and to reduce differences between courses. Each section of the course was attended by a research assistant who completed a fidelity checklist for the course weekly, identifying and demarcating the presence (or absence) of key components of the course. Analysis of the completed fidelity checklists found that 87% of the expected material was covered in each class on average, with a range of 84 to 90% of planned material being covered in any given course. Aspects of course material that were frequently missed were detailed instructions on upcoming homework assignments and "checking in" on student's journal writing at the start of class. At times, content was excluded due to time restraints or, infrequently, as an oversight. We deemed this to be an acceptable level.

Data Analysis

In order to compare the reported change in well-being over time of students enrolled in the mental health and well-being course to the reported change in the control group, we ran a Split-Plot ANOVA. We only kept data belonging to participants who completed at least three of the four waves, including the first wave. Our data was treated as continuous, having five or more populated categories. Our data was not significantly skewed and fit the assumptions required in order to run a Split-Plot ANOVA. To account for missing data, we imputed data for up to one wave of responses for each individual. Split-Plot ANOVA will render three inferential tests; main effect for time, main effect for group membership, and the interaction between the two. The

most important outcome in Split-Plot ANOVA is the interaction between time and group membership. In essence, the inferential test assesses whether there is a significant difference in slopes of change over time between the two groups. Rather than assess differences at any single point in time, it considers the slope of change across all points of time.

Ethical Concerns

The primary ethical concern associated with this study was the potential loss of confidentiality. In order to minimize this risk, researchers and research assistants were trained in upholding the Family Educational Rights and Privacy Act (FERPA). Precautions included deidentifying names, storing email addresses and student ID numbers separately from the rest of the data, and storing survey data on secure networks, with access given only to researchers. Three years after the completion of the survey, data will be deleted.

Another ethical concern was the potential distress associated with answering mental health questions. As a precaution, the survey included contact information for accessing mental health services via suicide hotlines, community resources, and the university's Counseling and Psychological Services.

Since professors were also part of the research team, ethical protections were put in place. Participants in the study were instructed that their participation was voluntary and that participation would not affect their standing in the class and recruitment for the study was conducted by someone not associated with the course.

Results

We ran Split-Plot ANOVAs to determine if there was a significant interaction between time and group membership in terms of scores on the Satisfaction with Life Scale and the Thriving Quotient. Additionally, we looked to see if there were significant main effects for time

and group membership separately. Below are the results of this analysis.

Table 2 below includes descriptive data for each measure administered over the course of the experiment. Figure 2 shows descriptive statistics for SWLS and TQ results.

Table 2

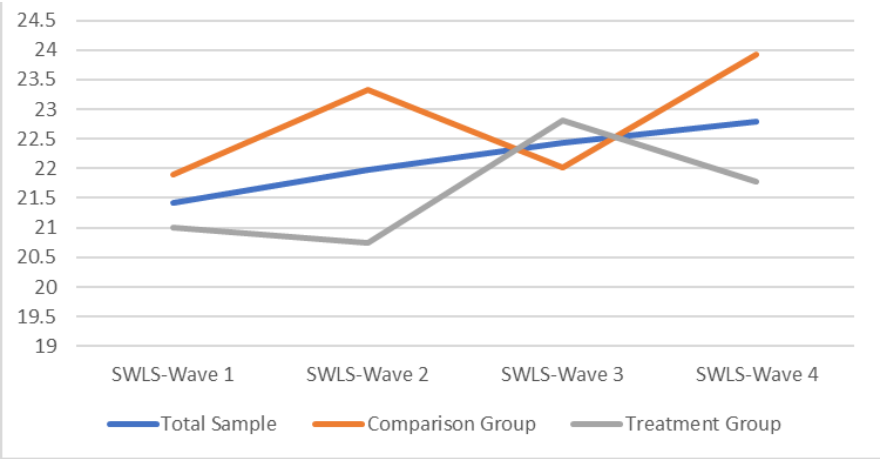
Descriptive Statistics for the Satisfaction With Life Scale and Thriving Quotient Scores

Enrollment	Measure	Time	Mean	Median	Skewness
Comparison group	SWLS	1	21.89	21.00	0.22
N = 18		2	23.33	24.00	-0.37
		3	22.01	22.43	-0.644
		4	22.92	27.00	-0.38
Comparison group	TQ	1	103.67	108.50	-0.81
N = 18		2	101.77	104.50	-0.29
		3	101.29	101.29	-0.13
		4	105.98	105.27	0.16
Treatment group	SWLS	1	21.00	19.00	0.22
N = 20		2	20.75	20.00	0.13
		3	22.81	22.43	-0.03
		4	21.77	21.43	0.21
Treatment group	TQ	1	97.35	96.50	0.01
N = 20		2	97.45	100.00	-0.74
		3	101.27	102.65	-0.62
		4	103.25	103.77	0.73
Total	SWLS	1	21.42	20.50	.088
N = 38		2	21.97	22.50	-0.12
		3	22.43	22.43	-0.45
		4	22.79	22.79	-0.06
Total	TQ	1	100.34	102.50	-0.35
N = 38		2	99.50	102.50	-0.38
		3	101.28	101.29	-0.29
		4	104.54	104.54	0.43

Note. Table 2 shows results from the participants' Satisfaction with Life Scale and Thriving Quotient scores.

Figure 2

Satisfaction With Life Scale ANOVA Results



Note. Figure 2 visually shows ANOVA results from the various groups' Satisfaction with Life Scale responses.

As shown in Table 3, the interaction of linear time and treatment (changes in score over time between treatment v comparison groups) did not yield a significant *p*-value based on the predetermined cut-off of .05 (.952). The main effect for time on Satisfaction with Life Scale scores and the main effect for treatment were also not significant based off of the .05 cut off, at .175 and .577, respectively. The exception was the interaction between group membership and cubic time. As seen in Figure 2 above, the treatment group and the comparison group followed opposite cubic trends over time. The treatment group initially decreased, then increased, then decreased again, but not to the same levels as at Wave 1 or Wave 2. The comparison group means initially increased, then decreased, then increased again. Because the groups followed opposite cubic trends and even crossed at wave-three, the interaction term was significant.

Table 3

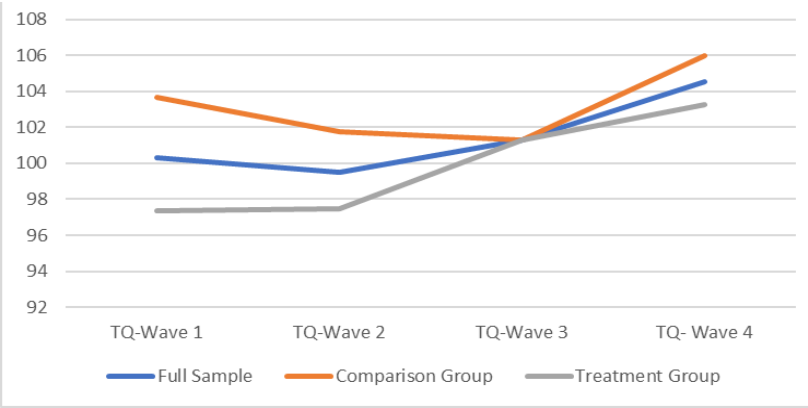
Satisfaction With Life Scale Split-Plot ANOVA Results

		F	*p*
Time x treatment interaction	Linear	0.004	0.952
	Quadratic	0.453	0.505
	Cubic	4.674	0.037
Main effect for time	Linear	1.911	0.175
	Quadratic	0.030	0.863
	Cubic	0.012	0.914
Main effect for treatment		0.318	0.577

Note. Table 3 shows ANOVA results from the various groups' Satisfaction with Life Scale responses.

Figure 3

Thriving Quotient ANOVA Results



Note. Figure 3 visually shows ANOVA results from the various groups' Thriving Quotient responses.

Represented in Table 4, the interaction of linear time and treatment (changes in score over time between treatment v control groups) did not yield a significant *p*-value based on the predetermined cut-off of .05 (.209). The main effect for treatment on Thriving Quotient was also

not significant based on the .05 cut off, at 0.444. There was, however, a significant *p*-value for main effect for time, with a p-value of .023.

Table 4

Thriving Quotient Split-Plot ANOVA Results

		F	*p*
Time x treatment interaction	Linear	1.639	0.209
	Quadratic	1.194	.282
	Cubic	0.788	0.381
Main effect for time	Linear	5.665	0.023
	Quadratic	3.869	0.057
	Cubic	0.029	0.865
Main effect for treatment		0.598	0.444

Note. Table 4 shows ANOVA results from the various groups' Thriving Quotient responses.

Discussion

The purpose of our study was to assess whether a university mental health course could help improve students' well-being. We were looking to see if taking this class (being part of the treatment group) would be correlated with improved well-being as noted on the Satisfaction with Life Scale and Thriving Quotient.

Results

Looking first at the Satisfaction with Life Scale, the linear and quadratic results for the interaction between time and treatment were not significant. The cubic results were significant but did not demonstrate the treatment group consistently improving (nor degrading). The main

effect of time and treatment group were also not statistically significant. Thus, from our study we did not detect significant differences in Satisfaction with Life between the treatment and the comparison groups.

Mean group scores for the total, treatment, and comparison groups on the Satisfaction with Life Scale across all times of measurement fell within the slightly satisfied range. The only exception was the mean score for the treatment group at the second wave, which fell in the neutral range.

Thriving Quotient Scores for the interaction between time and treatment were also not significant, nor was the main effect for treatment. The main effect for time, however, was significant. This suggests the students' thriving may have improved over-all, independent of the classes in which they were enrolled. This trend may be reflective of other factors not assessed by this study, such as the time of year or the impact of the Covid-19 pandemic. Although both the treatment and comparison groups did show improvement over time on the Thriving Quotient scores, there was not measured difference between the groups.

Overall, this research did not find that taking a mental health course significantly improved student well-being. We note the following limitations.

Limitations

A variety of limitations may have impacted the results of our study. The limited sample size likely made it difficult to find significant differences between groups. A limited number of participants reduced the statistical power of our analysis. This may have decreased the ability to detect differences between the treatment and control group and increased the likelihood of a type II error. Another issue was the amount of participant attrition, which contributed to the small sample size and the need to input missing data. Imputing data may lead to underestimation of

variability. This may have impaired our ability to accurately assess the significance of the differences between groups.

Additionally, the comparison, treatment, and total group mean scores in the study already fell within the slightly satisfied range on the Satisfaction with Life Scale at the beginning of the study. As participants were already reporting some level of satisfaction, it may have been more difficult to detect changes than if they reported neutral or unsatisfied scores initially, as there was less room for improvement.

Another important aspect to note is that while there were not significant differences in reported well-being levels between the comparison and treatment groups, we did see differences in the reported use of mental health services and medication for mental health concerns between the groups. Only one third of the comparison group reported ever using psychological services, whereas two-thirds of the treatment group had. Further, only 5.6% of the comparison group reported taking medication for mental health concerns while 50% of the treatment group reported doing so. On both accounts, we saw a higher percentage of mental health resources being utilized previously by individuals who enrolled in the mental health course than we saw in our comparison group. In the case of medication use, utilization was almost 10 times greater in our treatment group than in the comparison.

While we do not know for sure the implications of these group differences, they still may have potentially impacted the results of the study. For example, the tendency of the treatment group to utilize mental health resources more frequently may suggest that they have historically been dealing with a higher level of mental health and well-being concerns than the comparison group. The fact that their well-being scores did not fall significantly lower than those of the comparison group during the course of the semester, which can be a stressful time for students

and potentially take a toll on well-being of those predisposed to difficulties in this area, may suggest that those resources that they are accessing, including the mental health and well-being course, are playing an important role in maintaining their well-being.

It is also possible that if the course had been taken by a group of individuals who had not already frequently been engaging with other mental health resources that we would have seen a more significant impact from the course. Having already received or currently receiving other mental health care may have made it difficult for the course to have a distinct and distinguishable impact. Perhaps those that would benefit most significantly from the course are those not already receiving mental health support elsewhere. Part of the goal of this study was to test whether or not there was statistical support for resources that could reach those who would not otherwise receive care. It remains possible that this course could be beneficial in improving the well-being of those not receiving other treatment but that we were not able to access that demographic with our study.

Further, environmental and situational factors, including time of year may have affected the results, as we see participating students were seeing improving mental health overall, perhaps limiting our ability to clearly identify changes resulting from this specific course. For example, this study began examining student well-being in January and finished in May. Over this period of time, the weather became significantly warmer. This may have had positive impacts on student's well-being through biological factors such as increased Vitamin D and serotonin production, as well as increased potential opportunities for physical activity and social engagement that often accompany warmer weather. Further, over the course of the study students finished the school year and a resulting decrease in academic stress may also have contributed to the general improvement in well-being we saw across groups. Moreover, it is possible that

environmental factors related to the Covid-19 pandemic may have influenced results. The Covid-19 vaccine became available during the semester we collected data, and it is possible that the increased potential for socialization and potential decrease in health anxiety may have contributed to the across-group improvement in well-being seen in our results.

Another factor that may be useful to consider is the content of the course we studied. While the course is called "Mental Health and Wellbeing," many of the aspects of the class were actually geared more towards mental illness. For example, suicide prevention, anxiety and stress tracking, a genogram of familial mental illness, exposure experiences, ACT-based thought defusion, and understanding and managing depression were all part of the core content and focused on mental illness symptoms. Mindfulness, self-compassion, engagement with core-values, and behavioral activation were also part of the class and these factors could be argued as important for improving mental illness and well-being. However, perhaps if more of the class's content focused on mental health and well-being we may have seen higher reports of improved thriving and life satisfaction. Further studies done on the impact of this class did find improvements in mental illness symptoms, suggesting that a greater degree of course content devoted to a given area of focus may be instrumental in producing change.

Implications for Future Research

Further research, with larger sample sizes to account for attrition and administered at varying times of year, will be important to more fully understand the potential benefits a mental health course taught in a college course format may have for students. A more accurate and fuller picture of the potential benefits of such a course may also become clearer if future research considers the level of activity and involvement of the students in the study. In our study, we did not assess or consider how actively student participants were engaging in the course material or

applying what they learned. Much like any college course, the potential benefits of this course likely come from the effort put into learning and applying skills taught, not merely attending the class. It may also be possible to get a clearer view of how a college course could improve psychological well-being if a greater degree of the course content were to be devoted to mental health, rather than to mental-illness. Such a course could include more in-depth psychoeducation and applied exercises related to other factors of well-being, including emotional vitality, adaptive functioning, and engagement in fulfilling relationships.

Moreover, because the larger study our research was a part of was also assessing other aspects of mental health, including changes in depression and anxiety, we had limited space to include measures of well-being when gathering data. Future research may get a clearer picture of the impacts a class geared toward mental health and well-being can have if their assessment includes more measures of well-being. Measures of psychological well-being and flourishing such as the World Health Organization Quality of Life (WHOQOL) questionnaire, Flourishing Scale (FS), PERMA Profiler, Positive and Negative Affect Schedule (PANAS), and the Psychological Well-Being Scale (PWBS) for example could aid in ascertaining a fuller, more accurate picture of changes in well-being in future research.

Seeing as those in our treatment group had accessed or were currently accessing other mental health care resources more often than those in the comparison group, future research may benefit from studying the impact this course could have on the well-being of those who would not otherwise receive care. This does raise the questions of if those less-accessing individuals were taking the course and did not participate in the study or were not enrolled in the class at all. Perhaps in future research it may also be useful to examine ways to increase the knowledge of

and enrollment in such courses by those who are less familiar with services and less likely to use them.

It may also be worth noting that a great amount of psychological research and practice has been focused on reducing symptoms of psychological distress and mental-illness. From reviewing the literature, as well as the general dialogue in the field, it seems comparatively little has been primarily tailored to improving mental health and well-being. It is possible, then, that the interventions for improving mental health and well-being have not been as well-developed and thoroughly explored as those for mental illness.

The inability of this study to definitively offer support about how colleges and universities can aid their students' mental health suggests the need for further creative and innovative efforts to better meet the needs of this population. Previous research suggests that psychoeducation and applied skills, taught beyond just the therapy room, may assist in these efforts.

Conclusion

The data suggest that there was not a significant change in well-being scores, as measured by the Thriving Quotient and Satisfaction with Life Scale, between students enrolled in the mental health and well-being course and students not enrolled in the course. It is possible that these findings may have been limited by the small sample size, rates of attrition, and external factors including the time of the year or the year itself. Using only two measures of well-being and not measuring students' levels of activity and application in the course may also have limited our ability to detect changes in well-being related to class enrollment. Further research that addresses these limitations may allow for a clearer picture of the potential benefits of a mental health and well-being course on student well-being to be ascertained.

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Tables

Table 1

Satisfaction With Life Scale Score Ranges

Score	Level of satisfaction with life
31–35	Extremely satisfied
26–30	Satisfied
21–25	Slightly satisfied
20	Neutral
15–19	Slightly dissatisfied
10–14	Dissatisfied
5–9	Extremely dissatisfied

Note. Range distinctions for the Satisfaction with Life Scale (Diener et al., 1985)

Table 2

Descriptive Statistics for the Satisfaction With Life Scale and Thriving Quotient scores

Enrollment	Measure	Time	Mean	Median	Skewness
Comparison group	SWLS	1	21.89	21.00	0.22
N = 18		2	23.33	24.00	-0.37
		3	22.01	22.43	-0.644
		4	22.92	27.00	-0.38
Comparison group	TQ	1	103.67	108.50	-0.81
N = 18		2	101.77	104.50	-0.29
		3	101.29	101.29	-0.13
		4	105.98	105.27	0.16
Treatment group	SWLS	1	21.00	19.00	0.22
N = 20		2	20.75	20.00	0.13
		3	22.81	22.43	-0.03
		4	21.77	21.43	0.21
Treatment group	TQ	1	97.35	96.50	0.01
N = 20		2	97.45	100.00	-0.74
		3	101.27	102.65	-0.62
		4	103.25	103.77	0.73
Total	SWLS	1	21.42	20.50	.088
N = 38		2	21.97	22.50	-0.12
		3	22.43	22.43	-0.45
		4	22.79	22.79	-0.06
Total	TQ	1	100.34	102.50	-0.35
N = 38		2	99.50	102.50	-0.38
		3	101.28	101.29	-0.29
		4	104.54	104.54	0.43

Note. Table 2 shows results from the participants' Satisfaction with Life Scale and Thriving Quotient scores.

Table 3

Satisfaction With Life Scale Split-Plot ANOVA Results

		F	*p*
Time x treatment interaction	Linear	0.004	0.952
	Quadratic	0.453	0.505
	Cubic	4.674	0.037
Main effect for time	Linear	1.911	0.175
	Quadratic	0.030	0.863
	Cubic	0.012	0.914
Main effect for treatment		0.318	0.577

Note. Table 3 shows ANOVA results from the various groups' Satisfaction with Life Scale responses.

Table 4

Thriving Quotient Split-Plot ANOVA Results

		F	*p*
Time x treatment interaction	Linear	1.639	0.209
	Quadratic	1.194	.282
	Cubic	0.788	0.381
Main effect for time	Linear	5.665	0.023
	Quadratic	3.869	0.057
	Cubic	0.029	0.865
Main effect for treatment		0.598	0.444

Note. Table 4 shows ANOVA results from the various groups' Thriving Quotient responses.

Figures

Figure 1

Mental Health and Mental Illness: The Complete State Model (Keyes & Lopez, 2002, p. 50)

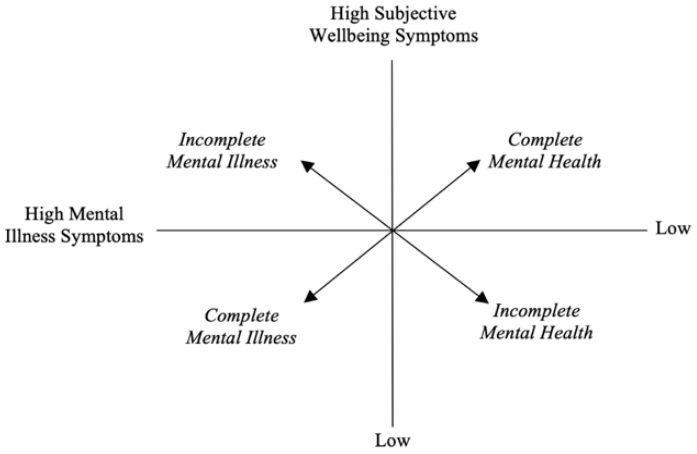


Figure 2

Satisfaction With Life Scale ANOVA Results

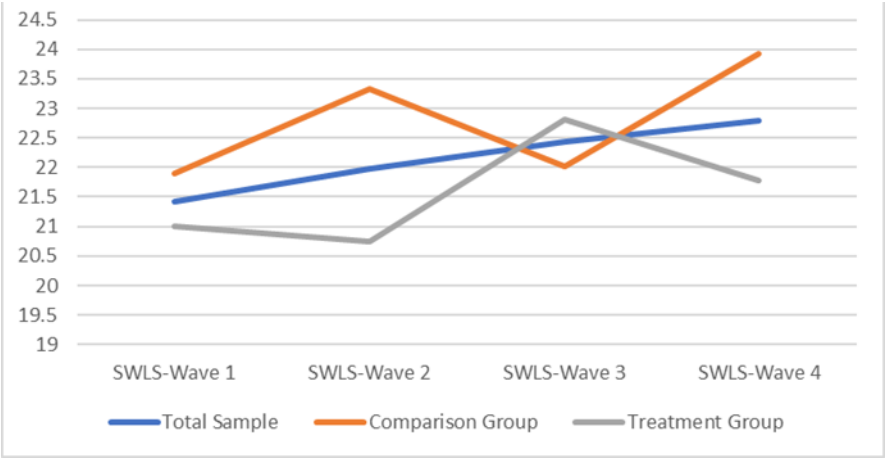
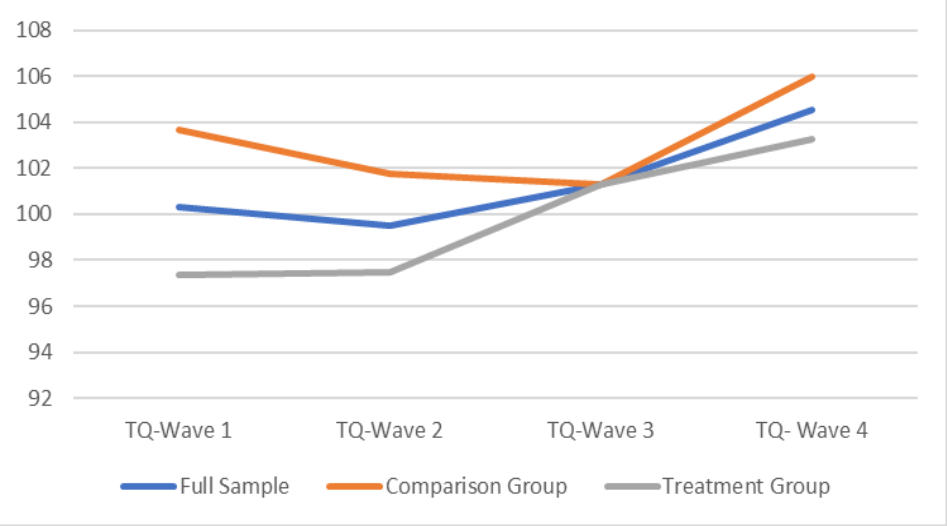


Figure 3

Thriving Quotient ANOVA Results



APPENDIX A

Review of the Literature

Introduction

The impetus for this dissertation comes from the increasing demand for mental health care services and the lack of sufficiently accessible and adequate resources. The repercussions of these insufficiencies in mental health care are profound, economically and more significantly in the loss of human lives. In addition to increasing mental health care resources for mental illness, there is also evidence that society and individuals could benefit from resources aimed at improving psychological well-being. University and college campuses are one place that could potentially benefit from additional, innovative mental health resources.

Inadequate Mental Health Care

There is a significant discrepancy between society's need for mental health care and the care individuals actually receive, and the cost of this discrepancy is significant. According to the National Alliance on Mental Illness (NAMI), one in five U.S. adults experience mental illness each year (NAMI, 2019). In a given year, it is estimated that the majority, 56.5%, of adults with a mental illness receive no treatment (Mental Health America, 2017). In fact, the average delay between the onset of mental illness symptoms and treatment is eleven years (NAMI, 2019).

Even when individuals begin seeking treatment, accessing that care often remains an obstacle. For example, while estimates of how long individuals spend on waiting list before being seen by a mental health care provider vary, research suggests that it can frequently range between 2 and 3 weeks and 2 and 3 months (Peipert et al., 2022). A 2021 survey from the American Psychological Association (2022) further reported that 65% of psychologists were reporting no opening for new patients at all. Further, almost half of the US population knows

someone who has had to drive more than an hour round trip to seek needed psychological treatment (National Council for Mental Wellbeing, 2018). Additionally, in one study, almost two-thirds of primary care physicians reported difficulty accessing mental health services for their patients, a rate at least twice as high as reported for other health services (Cunningham, 2009). These physicians reported shortages of mental health care providers as an *important barrier* to mental health care (Cunningham, 2009).

Effects of Inadequate Care

The effects of insufficient and untimely care are immense. For instance, depression and anxiety cost the global economy 193.2 billion in lost earnings each year, and depression is a leading cause of disability worldwide (NAMI, 2019; Vos et al., 2017). Additionally, 20.1% of people experiencing homelessness in the U.S. have a serious mental health condition, and the rate of unemployment is higher for those with mental illness (NAMI, 2019).

Beyond the fiscal cost, the mental health care crisis is costing human lives. Suicide is the tenth most common cause of death in the U.S., and the second leading cause among individuals aged 10–34 (Hedegaard & Warner, 2021). While 90% of people who die by suicide are found in psychological autopsy's to have had symptoms of mental health conditions, only 46% of those individuals had been diagnosed with a mental health condition during their lives (NAMI, 2019). These statistics suggest that many of those dying from suicide do not receive appropriate diagnoses for mental health concerns, let alone sufficient care. Human lives are at stake as long as proper care is not provided to those in need.

Well-Being

When considering how to provide adequate care, it is important to note that improving psychological well-being may constitute an important goal in addition to the traditional focus on

alleviating symptoms of mental illness and distress. The World Health Organization (WHO, 1995) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p. 1). Their statement illustrates that psychological well-being is a key piece of overall health and is more than the absence of mental illness.

Psychological well-being, also referred to as good mental health or *flourishing*, consists of both subjective well-being and positive functioning (Keyes, 2002). Similarly, to how a diagnosis of mental illness, such as a depressive disorder, necessitates the presence of certain symptoms such as anhedonia and impaired functioning, it is proposed that mental health requires the presence of positive *symptoms*, such as emotional vitality, adaptive functioning, engagement in fulfilling relationships, and an ability to cope with and adapt to adversity (Keyes, 2005; United States Public Health Service, 1999). A holistic view of mental health includes symptom reduction, improved functioning, as well as the experience of well-being and increased life satisfaction.

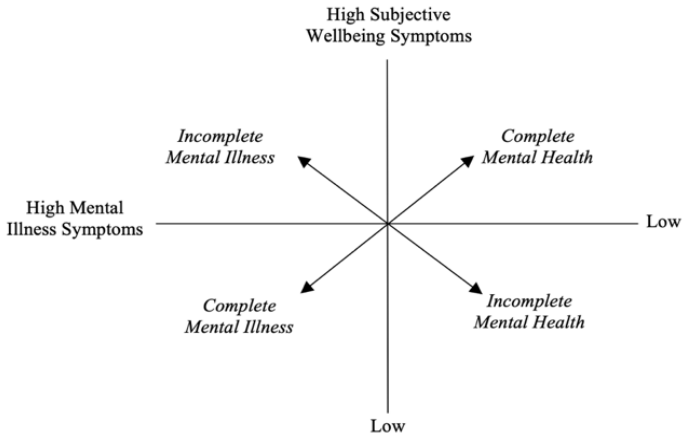
Instead of psychological well-being existing on the same continuum as mental illness, as its polar opposite, research in the area of psychological well-being argues that well-being and mental illness exist on two separate but related continua (Keyes & Lopez, 2002). In the two continua model, mental illness lies on a spectrum that ranges from absent to present, and well-being exists on another spectrum ranging from low to high (Keyes & Lopez, 2002).This is supported by findings that mental illness and wellbeing correlate at only -0.50, suggesting that only 25% of the variance between their latent factors is shared, a much smaller correlation than would exist if mental health was guaranteed by the absence of mental illness (Keyes, 2005).

Keyes argues that these continua can be conceptualized as intersecting perpendicularly to form four quadrants: present mental illness and low wellbeing, present mental illness and high

well-being, absent mental illness and high well-being, and absent mental illness and low well-being (Keyes & Lopez, 2002). This illustrates how the absence of mental illness does not necessitate high levels of mental health.

Figure 1

Mental Health and Mental Illness: The Complete State Model (Keyes & Lopez, 2002, p. 50)



The WHO's (1995) declaration about mental health alludes to the importance and benefits of psychological well-being for individuals and their communities, arguing that mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (p. 1).

Additionally, research findings show that individuals who are *flourishing*, or who have high well-being, miss fewer days of work, demonstrate higher levels of prosocial functioning, and have higher levels of functional goals than those with low well-being (Keyes, 2007). This remained true even when flourishing individuals were compared to non-flourishing individuals

who were not experiencing mental illness (Keyes, 2007). This suggests that high psychological well-being positively predicts important aspects of functioning, beyond those predicted by the absence of mental illness.

Well-Being for Those With Clinical Mental Illness

Improving psychological well-being is important for those experiencing mental illness. Evidence suggests that the presence of mental illness does not necessarily mean the absence of psychological well-being (Keyes, 2005). While someone may experience symptoms of mental illness, such as anxiety or depression, it does not mean that they cannot simultaneously be satisfied with life in general.

Researchers of well-being have argued that the importance of a good life is equally relevant to those with and without mental illness, and that recovery means working towards better mental health regardless of the presence of mental illness (Slade, 2010). Resnick and Rosenheck (2006) similarly argue that because the existence of what is referred to as pathology is not synonymous with weakness and damage, its presence need not rule out the potential of a health focus, but that rather, that the benefits of positive psychology might be even greater for those with severe psychiatric disabilities than those without impairments. Demonstratively, gains in well-being predict declines in mental illness, suggesting just how important positive psychology is for those with clinical level symptoms (Keyes et al., 2010).

Similarly, a focus on improving well-being is consistent with the perspectives on psychological recovery coming from those who have dealt with mental illness, also referred to as consumer perspectives on recovery. While traditional, clinical views of recovery from mental illness have viewed recovery as an outcome to be reached, consumer definitions from those who

have experienced mental illness portray recovery as a nonlinear, personal process, as well as a journey into life, rather than an outcome to be arrived at (Slade, 2010).

Proponents of well-being and consumer focused approaches to mental health interventions argue that if mental health services are to fully support recovery, then interventions need to move beyond the normal deficits-focused, negative approach, and take on an increasingly well-being focused approach. The traditional deficits focus perpetuates the belief that treatment is something that needs to be done before the client gets on with their life, and not as they get on with their lives (Slade, 2010). Literature documenting consumer experience has found this belief, that treatment is something that happens before life goes on, to be unhelpful and that individuals report that the success of services would be better judged by the extent to which they allow individuals to live the lives they want, rather than evaluating them merely by symptom reduction (Slade, 2010). Contrastingly, it is not necessary to wait until mental illness symptoms have been resolved to focus on improving meaningful aspects of individuals' lives, because meaning and well-being can coexist with symptoms.

Moreover, researchers of consumer perspective of recovery have argued that discussion focused on deficits and disease inherently reinforce an illness identity and elicit confirmatory evidence for an illness-saturated view of individuals (Slade, 2010). Conversely, well-being centered approaches focus on an individual's desires, strengths, and capability to work towards goals, rather than their difficulties or dysfunction (Slade, 2010).

Literature on consumer experiences with recovery found four areas to be salient in the recovery process: finding hope, redefining identity, finding meaning in life, and taking responsibility for recovery (Andresen et al., 2003; Bellack, 2006). This literature found that hope is often reported as both a trigger of and an aide in maintaining the recovery process (Andresen

et al., 2003). Psychological well-being is predicted by many of the same factors emphasized as by those recovering from mental health struggles: meaning in life, gratitude, hope, and optimism are all significant predictors of psychological well-being (García-Alandete, 2015; Kardas et al., 2019). Thus, interventions that improve well-being address many of the same factors found useful by consumers of mental health services.

Further evidence to support the importance of a focus on well-being for those with mental illness comes from the findings on post crisis growth that some individuals experience after traumatic events. Research suggests that individuals do not experience post crisis growth as the result of experiencing less anxiety or fewer stressors than those who do not experience growth. Rather, this growth is mediated by the experience of positive emotions associated with well-being, such as joy, hope, pride, and contentment (Fredrickson, 2004; Fredrickson et al., 2003; Fredrickson & Losada, 2005). It then follows that the positive emotions characteristics of well-being are integral to an individual's ability to be resilient in the face of stressors, even if emotional and psychological difficulties occur simultaneously.

Important aspects of mental wellness can coexist with diagnoses and symptoms of mental illness. Coping with a mental illness does not necessarily mean that people cannot be satisfied, resilient, and actually thriving through their challenges, and evidence suggests improving well-being will likely aid individuals in better coping with occurring mental illness. Focusing on improving well-being may likely be both possible and useful for individuals with ongoing mental illness concerns.

Well-Being for Those Without Clinical Mental Illness

Improving psychological well-being is also important to those without mental illnesses. This is in part because individuals without a diagnosable mental illness can still have low levels

of psychological well-being, a state referred to as languishing that an estimated 9.5% of the population is experiencing (Keyes, 2005).

This low psychological well-being, or languishing, is predictive of significant concerns, while high well-being is predictive of positive outcomes. Languishing, or low psychological well-being, has been associated with significant limitations in psychosocial functioning, as well as with significant limitations in daily living, and a high likelihood of a severe number of lost days of work (Keyes, 2002). Additionally, languishing may lend individuals to be more susceptible to the development of mental illness (Keyes, 2005). Languishing adults have been found to be two times more likely to experience a future major depressive episode than moderately mentally healthy adults., and languishing is a better predictor of experiencing mental illness in the future than is even a prior diagnosis of mental illness (Keyes et al., 2010).

Conversely, flourishing, or a high level of well-being, is predictive of positive outcomes. In one study individuals who remained in a flourishing state over time were four times less likely to develop mental illness than those who declined from flourishing to moderate mental health (Keyes et al., 2010). Additionally, flourishing predicts positive outcomes for others and for communities. In a study of flourishing and non-flourishing individuals, those who were flourishing reported being more other-focused, deeply engaged in their work—referring to it as a calling or passion, and motivated towards eudaimonic values that focus on a greater good (Wissing et al., 2021). Flourishing is also associated with higher incidence of volunteering and greater self-regulation and self-control (Garzón-Umerenkova et al., 2018; Klein, 2017; Santini et al., 2019; Tabassum et al., 2016).

Unfortunately, by some estimates, only one-fifth of the U.S. population is flourishing or entirely mentally healthy (Keyes, 2002), suggesting a large percentage of the population has

room for improvement in their levels of well-being. Given the benefits associated with high levels of well-being and the relatively small percentage of the population experiencing these levels currently, it follows that it would be important that mental health resources developed in the future address and aid the development of psychological well-being and that these resources could benefit the vast majority of the population.

Additionally, national research has suggested that less than 40% of individuals seeking therapy have experienced a diagnosable mental illness as stipulated by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in the last year, and around four fifths have never met the criteria for a disorder at all (Druss et al., 2007). This suggests that those seeking help and experiencing distress are not just those with a diagnosable mental illness.

Providing services to individuals who want help but are not experiencing mental illness is important. One reason being that even subclinical depressive symptoms predict serious negative outcomes including suicidal ideation, economic burden, and increased risk of developing major depression (Cuijpers et al., 2008; Cukrowicz et al., 2011). Evidence suggests that interventions for those with subclinical depression may help improve symptoms and decrease the likelihood of those individuals developing clinical depression in the future (Cuijpers et al., 2014). When creating interventions for this sizable group, rather than focusing on treating symptoms of mental illness for those not experiencing one, it makes more logical sense to focus on a factor that is universally relevant such as improving psychological well-being.

Mental Illness and Health in Higher Education

One population in need of additional mental health resources is university campuses. Universities are not immune to the difficulties related to mental health and access to care seen in the general population. In fact, college-aged individuals experience mental health concerns at

higher rates than other age populations, with about half of individuals reporting experiencing mental illness in the past year (Blanco et al., 2008). Young adults aged 18–34 have been found to report the most significant increases in anxiety prevalence of any cohort, and between 2005 and 2017 suicide-related outcomes increased by 60% among young adults aged 18–25 (Goodwin et al., 2020; Twenge et al., 2019).

Treatment rates for college-aged individuals are low both for non-students and college attenders (Blanco et al., 2008; Han et al., 2016). The majority of college students with mental health problems do not receive treatment each year. For example, Auerbach et al. (2016) found that only 16.4% of students with 12-month disorders received any 12-month healthcare treatment for their mental disorders.

Not all students with mental health concerns seek help, but access to care is a problem even for students who do so. The Center for Collegiate Mental Health found that the number of students seeking counseling services increased 50% between 2015 and 2016 (Locke et al., 2016). On some campuses the number of students seeking mental health services has been found to be increasing four times more quickly than the student population itself (Xiao et al., 2017).

Those working in college counseling centers are noticing this increase in demand. In 2018, 57% of college counseling center directors reported that in order to meet students' needs, they would need more hours of psychiatric services than they had available (LeViness & Bershad, 2018). This discrepancy is evident in a national study that found that the number of counselors available in college counseling centers compared to the number of students they serve is very small, on average, with just 1 counselor for every 2,081 students (Gallagher & Taylor, 2015).

In addition to being important for mental health, access to treatment is important for college students' academic success. For example, students who receive counseling tend to have lower attrition rates (Lee et al., 2009). Additionally, 65% of college counseling center clients reported that counseling helped them to stay enrolled at their institutions, and 64% indicated that counseling had helped with their academic performance, even when it was unlikely to be their reported reason for seeking treatment (Gallagher & Taylor, 2015).

Well-Being in College Students

It is clear that greater psychological resources would benefit and are needed on college campuses. It is important that the efforts to better address college student mental health concerns also include addressing well-being in addition to the traditional focus on treating mental illness, since well-being is predictive of positive outcomes that are valuable to both universities and their students. Psychological well-being is positively associated with student academic performance (Rodríguez-Muñoz et al., 2021). Research suggests that college students with very high life satisfaction demonstrated improved academic performance over those with average life satisfaction, in terms of greater student engagement, academic self-efficacy, and approach-oriented achievement goals and lower academic stress (Antaramian, 2017).

Counseling centers and other traditional modes of mental health care are important. However, evidence suggests that college counseling centers are not able to fully meet student demand for support relying on individual and group counseling modalities. Students are asking for and interested in more resources, including students who may not be recommended to traditional therapy due to their subclinical levels of symptoms. Stepped care models actually advocate a variety of interventions from low to high intensity interventions (Bailey et al., 2022; Cornish et al., 2017)

Interest in New Resources

Evidence suggests that students are interested in well-being and mental health resources from their universities in addition to traditional therapy. One example is Florida State University's Student Resilience Project designed to address student mental health needs and assist students in coping with stress (Oehme et al., 2019). The project is web-based and aims to destigmatize help-seeking behaviors, promote the use of services and resources available through the university, and help students develop resilience through skills such as mindfulness, distress tolerance, and emotional self-regulation (Oehme et al., 2019). Preliminary evidence found 80% of respondents specified they would likely return to the site for additional resources and 70% expressed that they would likely recommend the site to other students (Oehme et al., 2019).

Another example demonstrates students' interest in mental health resources specifically in the format of a college course. When Yale offered the course *Psychology and the Good Life*, which aimed to teach positive psychology principles and real-life applications of those principles, almost 25 percent of the university's undergraduate students enrolled, with 1,182 students taking the class, becoming the universities most popular class ever offered (Shimer, 2018). The responses of students to both FSU and Yale's mental health and well-being resources suggest that students are interested in resources when their universities make them available. Making resources available that have demonstrated usefulness is the present challenge.

Interventions for Students

Psychoeducation

Research suggests that one type of intervention that may help to protect mental health and prevent mental illness in college students is psychoeducation, particularly psychoeducational interventions geared to facilitate well-being. Lukens and McFarlane (2004) define

psychoeducation as “a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and education interventions” (p. 206).

An example of one of these well-being focused psychoeducational interventions at the college was implemented with medical students. A group-level intervention that focused on psychoeducation and stress management skills for these students resulted in a 46.7% decrease in stress prevalence, a significant decrease in anxiety levels, and improved psychological well-being (Bughi et al., 2006).

Another example is a 4-week mental health promotion program for college students that combined psychoeducation and applied mental health skills and exercises. Results found improvement in students’ scores on measures of depression, anxiety, well-being, and life satisfaction compared to students in a waitlist control (Viskovich & Pakenham, 2020). These improvements were enduring at a 12-week follow up (Viskovich & Pakenham, 2020).

In addition to aiding those with clinical level concerns, research suggests that psychoeducation can benefit those for whom traditional resources such as therapy are not designed primarily for. For instance, in one psychoeducational study, those with mild, subclinical panic attack symptoms experienced significant symptom reduction from psychoeducation alone and were less likely to require one-on-one treatment in the future (Baillie & Rapee, 2004). These findings support the idea that psychoeducation can benefit those without a clinical mental illness and may decrease the need for those individuals to seek therapy later on, thus decreasing the demand on counseling centers.

Course Format Resources

In terms of mental health resources, it seems that a credit-bearing, psychoeducational college course format may provide distinct benefits on college campuses. For example, a review

of research on mental health promotion and prevention programs for higher education students found interventions delivered in a class format to be more effective than those delivered in small groups (Conley et al., 2013).

Additionally, a class formatted approach to meeting mental health needs offers solutions to several of the problems with more traditional efforts and strategies (Howell & Passmore, 2019). For example, stigma poses another potential barrier when attempting to meet mental health needs. The stigma individuals hold significantly, negatively predicts whether students will seek mental health help (Eisenberg et al., 2009; Lally et al., 2013). A class that fulfills a university requirement and is delivered in a format similar to other courses may reduce the impediment created by stigma.

Another barrier to students receiving mental health services is lack of knowledge about resources. Being unaware of services was a significant predictor of not receiving those services in university students, and one study found that as many as half of students were unaware of campus mental health care resources (Dobmeier et al., 2013; Eisenberg et al., 2007). A class can inform students about resources, can be a resource in itself, and can be listed in the course catalog students already use.

Yet another difficulty with using traditional mental health resources alone is the significant rate of attrition in therapy. A meta-analyses of therapy attrition rates found rates ranged from 18% when measured by a predetermined number of sessions to close to 40% when measured by clinician report (Roseborough et al., 2016). Students may be less likely to discontinue a class they are receiving credit and have paid tuition for than they are to cease therapy. Demonstratively, in one state, withdrawals from college courses were found to be less

than 12% of total course enrollments (Florida Department of Education, 2011). This rate is significantly less than that reported for therapy.

Finally, lack of perceived need is a significant predictor of students not receiving mental health care (Eisenberg et al., 2007). Psychoeducation easily offered in a course format may serve to decrease this challenge. Young adults who received just 3 weeks of psychoeducation about mental health concerns demonstrated increased help-seeking attitudes and intentions, suggesting a psychoeducation course could help students in need of further therapy realize their need, as well as helping to meet that need in itself. (Taylor-Rodgers & Batterham, 2014).

In one pilot study, a college course aimed to address aspects of mental health, including depression, anxiety, and self-esteem, through teaching psychoeducational principles and skills and requiring practice of these skills (Schiraldi & Brown, 2001). Researchers found that at the end of the course students had significantly lower depression and anxiety scores and higher self-esteem (Schiraldi & Brown, 2001). An additional study on this course found that the improvements in anxiety and depression scores were greater in this class than the improvements gained in a more traditional stress-management course (Brown & Schiraldi, 2004). However, further studies on this course as well as any widespread implementation of a well-being focused psychoeducation resource has not occurred, despite the potential benefits it could have.

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APPENDIX B

Institutional Review Board Approval Letter

Memorandum

To: Lane Fischer
Department: BYU - EDUC - Counseling, Psychology, & Special Education
From: Sandee Aina, MPA, HRPP Associate Director
Wayne Larsen, MAcc, IRB Administrator
Bob Ridge, Ph.D., IRB Chair
Date: December 28, 2020
IRB#: IRB2020-486
Title: Effects of an Applied Mental Health Course

Brigham Young University's IRB has approved the research study referenced in the subject heading as expedited level, category 7.

The approval period is from 12/28/2020 to 12/27/2021. Please reference your assigned IRB identification number in any correspondence with the IRB. Continued approval is conditional upon your compliance with the following requirements:

1. A copy of the approved informed consent statement and associated recruiting documents (if applicable) can be accessed in iRIS. No other consent statement should be used. Each research subject must be provided with a copy or a way to access the consent statement.
2. Any modifications to the approved protocol must be submitted, reviewed, and approved by the IRB before modifications are incorporated in the study.
3. All recruiting tools must be submitted and approved by the IRB prior to use.
4. In addition, serious adverse events must be reported to the IRB immediately, with a written report by the PI within 24 hours of the PI's becoming aware of the event. Serious adverse events are (1) death of a research participant; or (2) serious injury to a research participant.
5. All other non-serious unanticipated problems should be reported to the IRB within 2 weeks of the first awareness of the problem by the PI. Prompt reporting is important, as unanticipated problems often require some modification of study procedures, protocols, and/or informed consent processes. Such modifications require the review and approval of the IRB.
6. A few months before the expiration date, you will receive a prompt from iRIS to renew this protocol. There will be two reminders. Please complete the form in a timely manner to ensure that there is no lapse in the study approval. Please refer to the IRB website for more information.

Instructions to access approved documents, submit modifications, report complaints, and adverse events can be found on the IRB website under iRIS guidance: https://irb.byu.edu/iris-training-resources.

APPENDIX C

Instruments

Thriving Quotient

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Somewhat agree (4)	Agree (5)	Strongly agree (6)
I feel as though I am learning things in my classes that are worthwhile to me as a person.						
I can usually find ways of applying what I'm learning in class to something else in my life.						
I am confident I will reach my educational goals.						
I find myself thinking about what I'm learning in class even when I'm not in class.						
Even if assignments are not interesting to me, I find a way to keep working at them until they are done well.						

I feel energized by the ideas I am learning in most of my classes.						
I know how to apply my strengths to achieve academic success.						
I am good at juggling all the demands of college life.						
Other people would say I'm a hard worker.						
Other people seem to make friends more easily than I do.						
I spend time making a difference in other people's lives.						
I don't have as many close friends as I wish I had.						
I value interacting with people whose viewpoints are different from my own.						

I feel like my friends really care about me.						
I know I can make a difference in my community.						
It is important to become aware of the perspectives of individuals from different backgrounds.						
I feel content with the kinds of friendships I currently have.						
When I'm faced with a problem in my life, I can usually think of several ways to solve it.						
My perspective on life is that I tend to see the glass as "half full" rather than "half empty."						

It's hard to make friends on this campus.						
It's important for me to make a contribution to my community.						
I look for the best in situations, even when things seem hopeless.						
My knowledge or opinions have been influenced or changed by becoming more aware of the perspectives of individuals from different backgrounds.						
I often feel lonely because I have few close friends with whom to share my concerns.						

Satisfaction with Life Scale

	1 - Strongly disagree	2 - Disagree	3 - Slightly disagree	4 - Neither agree nor disagree	5 - Slightly agree	6 - Agree	7 - Strongly agree
In most ways my life is close to my ideal.							
The conditions of my life are excellent.							
I am satisfied with my life.							
So far I have gotten the important things I want in life.							
If I could live my life over, I would change almost nothing.							

APPENDIX D

Course Syllabus

Mental Health and Well-Being, STDEV 141R

Understanding mental health as an important aspect of overall wellness, this course helps individuals to identify common mental health challenges in themselves or others. This course helps to explain stress, anxiety, and depression and gives students tools for managing mental health. Psychological flexibility, including openness, awareness, and engagement, is discussed and practiced by students in this course as tools for living one's values in the face of challenges.

Specific goals of the course include:

- **Experience and Self-Reflection**: By attending class and by completing course activities, you will be able to learn by experiencing firsthand. This class is interactive by design, with many different course activities for reflecting on your own experience.
- **Content and Process**: Learn the information and apply it. Pay attention to the *how* you interact with the course material, as it can help you recognize how you manage mental health.
- **Responsibility and Commitment**: Take responsibility for your own learning, especially when it comes to mental health. Benefiting from this class will require significant participation in discussions. Decide now to fully participate in order for yourself and your classmates to benefit from your perspective.

Texts: *The Happiness Trap: How to Stop Struggling and Start Living*, by Russ Harris. Other readings will be assigned.

Course Activities:

Required course activities—

- **Readings and Videos**, as assigned during the semester. These are called "Pre-Class Preps." Prior to each class, complete the reading, watch the video, and come to class prepared for discussion. Write about what you're learning in your journal.

- **Journal,** Keep a record of your thoughts, feelings, experiences, and insights over the course of the semester. Get a notebook to bring to class each time, to respond to writing prompts, and to help with comprehension and application of content. The journal is for yourself and will not be requested by the instructor. However, you will be requested to bring it to class each discussion day and you may see fit to share "excerpts" in discussions or reactions to self-directed activities. You will also be able to use content from your journal for your final reflection paper.

- **Discussions,** On days designated "discussion day" we will spend a significant portion of class time in small discussion groups. Here you will be able to reinforce what you have learned as a result of your experiential activity by sharing about the activity, by sharing some of your journal reflections about what you experienced, thought, or felt, and by having the opportunity to essentially "teach" the others in the group what you learned. On each discussion day, you will also be asked to fill in a short *investment points* sheet online that captures the level to which you engaged with the experiential assignment (30 possible pts.), the journal writing (10), and the discussion group (10).

- **Student evaluation,** Your feedback is highly valuable to improving the course for future students.

Experiential activity descriptions:

Letter to self: The first journal activity asks you to consider your reasons for taking the course and what you hope for by the end of the course. It asks you to consider how open and honest with yourself you would like to be, what you would like to be able to share, boundaries you would like to set for yourself in discussions, challenges you would like to set for yourself in discussions. You will complete an initial mental health management plan, to be updated

throughout the semester. If you decide that therapy is needed or desired during the course, write about how you will go about pursuing treatment.

Self-assessment: You will complete several mental health outcome surveys, for your own use only. You will complete this at the beginning and end of the semester (required) but will be permitted to complete it as many times as desired throughout the semester.

Mental health management plan: You will create an always-evolving plan for yourself to manage your mental health, including practices, coping strategies, social support, and resources you can utilize. The first version will be completed at the beginning of the semester, then will be updated throughout the semester including a culminating plan for the end of the semester.

Suicide prevention: You will practice noticing others who may be in distress and asking appropriate questions, connecting others with resources. You will explore available resources for managing mental health, including smartphone apps, websites, videos, books, etc. You will then share these resources with the class.

Genogram: You will complete a genogram for yourselves focused on mental health challenges, general health challenges, and personality factors. This will help you understand biological and psychological contributions to mental health.

Stress/Anxiety tracking/Breathing: You will complete a tracking sheet for several days, marking your experiences and daily ratings of stress or anxiety. You will practice relaxation strategies, as taught in class, on a daily basis for several days.

Exposure practice: You will engage in exposure-based practices, as taught in class, noting your responses when you aim to overcome avoidance.

Biopsychosocial model exploration: You will complete exploration sheets relating to biological, psychological, and social factors that relate to depression and overall mental health.

Behavioral activation practice: You will practice behavioral activation and track your progress over the period of several days.

Mindfulness practice: You will practice mindfulness, as taught and discussed in class, on a daily basis over the period of several days. Our first round will include mindfulness more generally, then our second round will focus specifically on mindful meditation practice.

Defusion practice: You will practice defusion on your own over the course of several days, recording your attempts and results.

Core values steps: You will complete a values sorting worksheet to determine your core values and steps you can take in the direction of these core values. Then you will take daily steps in the direction of your values, noticing results.

Self-compassion practice: You will explore and practice self-compassion through compassionate self or self-compassion breaks over the period of several days, noting your responses.

Final project: A multi-part project, but you will only submit the last step. Please read carefully!

- Complete a post-self-assessment at the end of the semester using the mental health measures (same as beginning of semester).
- Review and update your mental health management plan based on what you have learned this semester about yourself and what you need.
- Review your journal entries from throughout the semester, taking note of what you have learned about yourself and managing mental health.
- TO BE SUBMITTED: Complete a final reflection paper and submit via LS. I am going to give you significant latitude with this assignment, the emphasis being on:
    - How have you worked to address mental health?
    - What have you learned along the way that has been particularly impactful?
    - What are your plans to continue in one or more areas into the future?

I hope that this can be more for you than just an assignment to be graded; I believe that it can help crystallize the thoughts and feelings you've had during our semester together and help you purposefully reflect on strengths you've developed, habits you've begun, and plans to continue developing well-being.

Grading:

The challenge (and invitation) this course extends to you is that you can proactively address mental health. The most rewarding outcomes of the class will come as you engage with the course material and experiential assignments. My hope is that the personal growth will be its own reward.

Following each experiential assignment, the subsequent class period will utilize small discussion groups to teach each other what you learned from your experience. These experiential assignments will comprise the majority of the graded aspects of your course participation. Because assignments will be distributed and Investment Points reported in class, if you miss

class you will need to work out with the instructor what you might be able to do to make up missed material.

Activity	**Points Possible**	**% of Total Grade**
Activities—Investment points	12 x 50 = 600	60%
Pre-class preps (Readings, etc.)	15 x 10 = 150	15%
Final project	250	25%
TOTAL	**1000**	**100%**

Grades are then calculated according to the following system:

Grade	**% of Points Earned**	**Total Points**
A	94–100	940–1000
A-	90–93	900–939
B+	87–89	870–899
B	83–86	830–869
B-	80–82	800–829
C+	77–79	770–799
C	73–76	730–769
C-	70–72	700–729
D+	67–69	670–699
D	63–66	630–669
D-	60–62	600–629
E	< 59	0–599

For Your Information:

COVID-19

While COVID-19 conditions persist and until further notice, students and faculty are required to wear masks at all times during class; faculty are not at liberty to waive this expectation. Students who feel sick, including exhibiting symptoms commonly associated with COVID-19 (fever; cough; shortness of breath/difficulty breathing; chills; muscle pain; sore throat; new loss of taste or smell; etc.) should not attend class and should work with their instructor to develop a study plan for the duration of the illness.

Lecture Participation:

Participation through sharing is absolutely vital in this class and it is extremely likely that through your comments, questions, and discussions you will find the greatest benefit from the class. Participation via Zoom presents different challenges. Please take the necessary steps to be able to actively participate whether in person or via Zoom. These include:

- Minimize possible distractions to yourself during class. For example, be in a room by yourself. Turn off other screens.
- Decide now to speak up in class. Use the chat, raise your hand, or speak up. This is very welcome!
- Minimize possible distractions to others during class. For example, if you are in a location with background noise, keep your Zoom muted unless you are speaking.
- During discussions, you are encouraged (but not required) to unblank your Zoom video so that you can speak face-to-face.

Attendance will not be taken; however, in-class discussion groups will contain a self-rating component that will contribute to a portion of the final grade.

Student Disability:

Brigham Young University is committed to providing a working and learning atmosphere that reasonably accommodates qualified persons with disabilities. If you have any disability which

may impair your ability to complete this course successfully, please contact the University Accessibility Center (UAC), 2170 WSC or 422-2767. Reasonable academic accommodations are reviewed for all students who have qualified, documented disabilities. The UAC can also assess students for learning, attention, and emotional concerns. Services are coordinated with the student and instructor by the UAC. If you need assistance or if you feel you have been unlawfully discriminated against on the basis of disability, you may seek resolution through established grievance policy and procedures by contacting the Equal Employment Office at 422-5895, D-285 ASB.

Academic Standards and Integrity:

While all students sign the honor code, there are still specific skills most students need to master over time in order to correctly cite sources, especially in this new age of the internet, as well as deal with the stress and strain of college life without resorting to cheating. Academic honesty means, most fundamentally, that any work you present as your own must in fact be your own work and not that of another. Violations of this principle may result in a failing grade in the course and additional disciplinary action by the university. It is the university's expectation, and every instructor's expectation in class, that each student will abide by all Honor Code standards. Please call the Honor Code Office at 422-2847 if you have questions about those standards.

Preventing Sexual Discrimination or Harassment:

Brigham Young University prohibits unlawful sex discrimination against any participant in its education programs or activities. The university also prohibits sexual harassment-including sexual violence-committed by or against students, university employees, and visitors to campus. As outlined in university policy, sexual harassment, dating violence, domestic violence, sexual

assault, and stalking are considered forms of "Sexual Misconduct" prohibited by the university.

University policy requires all university employees in a teaching, managerial, or supervisory role to report all incidents of Sexual Misconduct that come to their attention in any way, including but not limited to face-to-face conversations, a written class assignment or paper, class discussion, email, text, or social media post. Incidents of Sexual Misconduct should be reported to the Title IX Coordinator at t9coordinator@byu.edu or (801) 422-8692. Reports may also be submitted through EthicsPoint at https://titleix.byu.edu/report or 1-888-238-1062 (24 hours a day).

BYU offers confidential resources for those affected by Sexual Misconduct, including the university's Victim Advocate, as well as a number of non-confidential resources and services that may be helpful. Additional information about Title IX, the university's Sexual Misconduct Policy, reporting requirements, and resources can be found at http://titleix.byu.edu or by contacting the university's Title IX Coordinator.

Course Schedule:

Date	**Topic**	**Due!**
Hour 1	I. Syllabus II. Introductions	Personal Info Sheet
Overview: Paying attention to mental health		
Hour 2	Everyone Has a Mental Health	Journal entry (Letter to Self)
Hour 3	Mental Health is Complex, Let's Not Oversimplify	Self-Assessment

Hour 4	*Discussion* (Self-assessment, Plan)	Mental Health Management Plan—1st draft
Hour 5	Suicide prevention: QPR	
Hour 6	*Discussion* (Suicide prevention activity)	Suicide prevention activity
Hour 7	Mental Health with More Context	
Hour 8	*Discussion* (Genogram)	Genogram
Anxiety		
Hour 9	Understanding stress & anxiety	
Hour 10	*Discussion* (Tracking and breathing)	Stress/Anxiety tracking/Breathing
Hour 11	Strategies for managing stress & anxiety	
Hour 12	*Discussion* (Exposure practice)	Exposure practice
Depression		
Hour 13	Understanding depression	
Hour 14	*Discussion* (Biopsychosocial model)	Biopsychosocial model exploration
Hour 15	Strategies for managing depression	
Hour 16	*Discussion* (Behavioral activation)	Behavioral activation practice
Psychological flexibility		

Hour 17	Mindfulness	
Hour 18	*Discussion* (Mindfulness practice 1)	Mindfulness practice 1
Hour 19	Openness	
Hour 20	*Discussion* (Defusion practice)	Defusion practice
Hour 21	Awareness	
Hour 22	*Discussion* (Mindfulness practice 2)	Mindfulness practice 2
Hour 23	Engagement	
Hour 24	*Discussion* (Core values steps)	Core values steps
Hour 25	Self-compassion	
Hour 26	*Discussion* (Self-compassion practice)	Self-compassion practice
Hour 27	Final project intro	
Hour 28	Last Day of Class What works for whom?	Final project -Mental Health Management Plan -Post Self-Assessment -Final reflection paper

APPENDIX E

Fidelity Checklist

Week 1, Day 1

Critical Items	Non-critical Items
☐ Syllabus Overview ☐ Creating Boundaries; Brave space ☐ A personal layer ☐ Describe homework (personal info sheet, self assessment and MH management plan)	☐ Introductions

Week 1, Day 2

Critical Items	Non-critical Items
☐ What is Mental Health? ☐ Imagine Dragons Video ☐ Introduce homework (letter to self)	☐ Questions about anything

Week 2, Day 1

(one day in week 2 because of holiday)

Critical Items	Non-critical Items
☐ Journal Review ☐ Context of Mental Health ☐ Biopsychosocial Model ☐ Biological ☐ Psychological ☐ Social ☐ Introduce homework (Talking about Mental Health)	☐ Questions about anything ☐ Imagine Dragons Video recap

Week 3, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion ☐ Class Discussion ☐ Introduce HW	☐ Questions about anything

Week 3, Day 2

Critical Items	Non-critical Items
☐ QPR Discussion, taught by RD ☐ Role play; how to talk to someone about suicide ☐ Introduce HW (talking to someone about suicide)	☐ Questions about anything

Week 4, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion ☐ Class Discussion ☐ Introduce HW (Mental Health in Family Context)	☐ Questions about anything

Week 4, Day 2

Critical Items	Non-critical Items
☐ Journal Review ☐ Nature vs. Nurture ☐ Stress-Diathesis Model ☐ Define stress ☐ Define diathesis	☐ Questions about anything

☐ Family Support vs Family Stress ☐ Discuss benefits and risks of seeing others' mental health ☐ Social Support as a buffer; If I'm having a bad day, who do I talk to about it? ☐ Introduce HW (Genogram)	

Week 5, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (Genogram) ☐ Class Discussion (Genogram) ☐ Introduce HW (Stress and Anxiety overview)	☐ Questions about anything

Week 5, Day 2

Critical Items	Non-critical Items
☐ Journal Review ☐ Anxiety's presentations ☐ What does my anxiety look like? ☐ Experience last week ☐ Rate from 1-10; what did I pay attention to for the rating? ☐ Psychological and physical experiences act on each other in a cycle ☐ Physiology; autonomous nervous system ☐ Relation between stress and performance (Yerkes-Dodson Curve) ☐ Practice breathing exercise; ☐ introduce other relaxation strategies ☐ and get ideas from students ☐ Introduce HW (tracking on anxiety, practice deep breathing, journal)	☐ Questions about anything

Week 6, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (tracking) ☐ Class Discussion (tracking) ☐ Introduce HW (managing stress and anxiety)	☐ Questions about anything

Week 6, Day 2

Critical Items	Non-critical Items
☐ Journal Review ☐ What am I avoiding? Does it work? ☐ Exposure Therapy ☐ Procrastination as an example ☐ Try sitting with the feeling noticing, and experiment with starting ☐ Swallow the frog ☐ Pomodoro technique ☐ What am I avoiding? ☐ How mindfulness can help ☐ Introduce HW (Exposure Practice)	☐ Questions about anything

Week 7, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (exposure) ☐ Class Discussion (exposure) ☐ Introduce HW (Understanding Depression)	☐ Questions about anything

Week 7, Day 2

Critical Items	Non-critical Items
☐ Journal Review (Depression) ☐ What does depression feel like (get class input) ☐ Metaphors for depression ☐ Ask Class: ☐ What makes depression hard to talk about? ☐ What helps with the talking? noticing, and experiment with starting ☐ Brené Brown Video on Empathy ☐ discuss validation and acceptance ☐ How therapists define depression ☐ Review Biopsychosocial Model-highlight biological factors in depression ☐ Introduce HW (Biopsychosocial model for self and one other)	☐ Questions about anything

Week 8, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (biopsychosocial model) ☐ Class Discussion ☐ Introduce HW (Depression Strategy)	☐ Questions about anything

Week 8, Day 2

Critical Items	Non-critical Items
☐ Journal Review ☐ Review Empathy/Validation and Biopsychosocial model ☐ Experiential: think of an experience that elicits a strong emotion to demonstrate how feelings can follow thoughts ☐ Experiential Avoidance ☐ Pain isn't pathological	☐ Questions about anything

☐ we focus on avoiding pain rather than pursuing values ☐ The nature of struggle (control as the problem) ☐ using a shovel in a hole metaphor ☐ Chinese finger trap metaphor ☐ Living Vitally with flexibility ☐ Psychological Flexibility ☐ Describe 3 pillars (open, aware, engaged) ☐ Behavioral Activation as Engagement ☐ Introduce HW (Behavioral Activation)	

Week 9, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (behavioral activation) ☐ Class Discussion ☐ Introduce HW (Intro to Mindfulness)	☐ Questions about anything

Week 9, Day 2

Critical Items	Non-critical Items
☐ Journal Review ☐ Review Psychological Flexibility ☐ Experiential: how did you get here? Do you remember? ☐ Mindfulness ☐ NOT easy, not a natural state, not relaxation, not for control, not to avoid distress ☐ YES: observing self, intention, here-and-now, no judgement (Kabat-Zinn quote) ☐ Mindful eating exercise ☐ what did you notice ☐ how did you experience mind's activity ☐ Cubbyholing (sensation, thoughts, feelings)	☐ Questions about anything

☐ Review what mindfulness has to do with mental health (ask students) ☐ Practice Mindful breathing ☐ Introduce HW (Mindfulness)	

Week 10, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (mindfulness) ☐ Class Discussion ☐ Introduce HW (openness)	☐ Questions about anything

Week 10, Day 2

Critical Items	Non-critical Items
☐ Journal Review (Defusion chapters from Happiness Trap) ☐ Fusion ☐ Hands to face metaphor ☐ Having vs buying the thought ☐ Experiential: Walking meditation ☐ Defusion Practices ☐ I'm having the thought that ☐ thanking your mind ☐ funny voice ☐ sing it ☐ repetition ☐ chessboard metaphor ☐ mind as the sky metaphor ☐ I am not my thoughts ☐ Let go of judgment ☐ A thought is not a fact ☐ realistic (not good/bad) ☐ gratitude, appreciation instead of comparison ☐ exceptions instead of always/never	☐ Questions about anything

☐ compassion/validation ☐ Review what mindfulness has to do with mental health (ask students) ☐ Introduce HW (Defusion)	

Week 11, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (defusion) ☐ Class Discussion ☐ Introduce HW (expansion)	☐ Questions about anything

Week 11, Day 2

Critical Items	Non-critical Items
☐ Journal Review (Expansion chapters from Happiness Trap) ☐ Expansion ☐ Connection as the opposite of avoidance ☐ Acceptance isn't ☐ liking distress ☐ fighting distress ☐ a one time event ☐ a guarantee that my feelings will change ☐ the final step ☐ watch "The Fly" on YouTube ☐ Acceptance IS ☐ acknowledge distress ☐ expand and make room for it ☐ make room for self, too ☐ connect to values ☐ move in the direction of values ☐ Monsters on the bus video ☐ Introduce HW (mindfulness)	☐ Questions about anything

Week 12, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (mindfulness) ☐ Class Discussion ☐ Introduce HW (core values worksheet)	☐ Questions about anything

Week 12, Day 2

Critical Items	Non-critical Items
☐ Journal Review (Core Values Worksheet) ☐ A goal-focused life ☐ The hedonic treadmill ☐ Living a life with purpose, meaning, fulfillment, and peace ☐ Values focused living: ☐ review Monsters on the Bus ☐ the compass ☐ chosen life directions ☐ Values are not: ☐ goals, feelings, outcomes, in the future, doesn't mean our paths are always straight ☐ Example: Pick a letter exercise ☐ Values-focused judgments ☐ Committed Action—a step in the direction of your value ☐ Introduce HW (committed action)	☐ Questions about anything

Week 13, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (Core Values Steps)	☐ Questions about anything

☐ Class Discussion ☐ Introduce HW (self-compassion)	

Week 13, Day 2

Critical Items	Non-critical Items
☐ Journal Review (self-compassion) ☐ Love one another…but not yourself? ☐ Three types of emotions ☐ threat-defend ☐ Go get-acquire-consume ☐ rest-digest ☐ Compassion can be practiced ☐ Be mindful of suffering ☐ create a compassionate voice ☐ not an expectation ☐ not the same thing as love ☐ Compassionate voice video ☐ Example: Pick a letter exercise ☐ Values-focused judgments ☐ Committed Action—a step in the direction of your value ☐ Introduce HW (self-compassion)	☐ Questions about anything

Week 14, Day 1

Critical Items	Non-critical Items
☐ Small Group Discussion (self-compassion) ☐ Class Discussion ☐ Introduce HW (start final project)	☐ Questions about anything

Week 14, Day 2

Critical Items	Non-critical Items
☐ Journal Review (self-compassion) ☐ Last day of class ☐ What works for who? ☐ Final Project information ☐ Final comments assignment	☐ Questions about anything