A COMPARISON OF MENTAL HEALTH EDUCATION: A LOOK INTO DALLAS SCHOOLS

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ABSTRACT

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As "mental health" has become a more common topic of conversation in society in recent decades, it is essential that high schools are doing the best possible job of educating their students on the heavily stigmatized topic. Research has demonstrated the benefits of having a strong health program for aims of intervention and prevention, so it is no surprise that schools continue to include information about mental health in order to fight societal stigmas and encourage students to seek self-help. The United States is far too large to examine on a whole, as is the state of Texas—or even just the city of Dallas. So, I have selected three Dallas schools in particular to use as subjects in my thesis, which differ in funding (government dollars versus private sources) and religious affiliation (secular versus non-secular).

I will first discuss other research studies that have been conducted throughout the United States, outlining the benefits of having a strong program to introduce topics of mental health to students. From there, I will then seek to gain a better understanding of the variation among curricula among a sample of Dallas schools: namely, does the institution's source of funding or religious affiliation affect how the information is taught? I will do this by drawing comparisons between the interview responses from three school faculty members. My aim is not to criticize any of the programs or to say how the curricula should be fixed/improved, but rather to use comparisons as a means of highlighting how the different methods may impact students. Finally, I will conclude by recapping all that I discovered, and discussing some further applications of my findings.

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INTRODUCTION: Who, What, and Why?

Before diving into what I have discovered through my research this year, I will first begin by explaining who I am, what I am writing my Plan II Honors thesis about, and why I have chosen to write specifically about mental health education. In short, however, I believe that in the same way that a student is not placed in a calculus class before learning the essentials of algebra, it is equally flawed to enroll students as citizens of society without first teaching them the basic information about mental health.

My name is Haley Ablon, and I am a 22-year-old student studying at the University of Texas at Austin. Before coming to UT, I attended a private school in Dallas, Texas for 15 years; looking back on my educational experience, I was taught a wide array of skills and constantly felt an overflow of curiosity from the academic curriculum. Nonetheless, I feel as though I was not adequately educated in certain areas of health; it is my belief that these essential, skimmed over areas proved to be extremely detrimental for my personal growth as a high school student. I often wonder how my high school and college experiences would have been different if I had been instead taught a perspective of mental health that was not marked by blame or guilt, and did not further my belief of misconceptions. I wonder if I would have spoken up sooner about my struggles, if I would have allowed others to help me, or even allowed myself to admit something was wrong in the first place.

When I was a sophomore in high school, I remember sitting in English class—which began every day with instructed silent meditation—feeling like there was not enough oxygen in the room, and as though I could not get a satisfying deep breath. I dreaded these daily meditations because the resulting stillness of being alone with my

thoughts was suffocating to me. I prayed to be released from the constant fear of chronic asthma, which was like trying to clench a strand of hope among a blanket of realistic perspective that this wish was not practical. I would pray to feel *nothing*, or to at least not feel the constant weight of a ten-pound brick. Though I knew that I was miserable, I did not want to admit that something might have been wrong with me (psychologically) because that felt like a direct reflection of my personal failures.

Though I did not know it at the time, I was battling an undiagnosed anxiety disorder, and had been since middle school. When I was finally diagnosed in college, I felt very confused as to how my disorder had gone undiagnosed by my friends, family, or teachers despite attending one of the top schools in Dallas. This confusion made me feel motivated to understand how my condition went unnoticed; it is my belief that my lack of awareness or willingness to admit that I had a mental health disorder was heavily due to the fact that I did not receive effective education about mental health at school. Sure, I had heard the word "anxiety" mentioned in health class, but I graduated with the incorrect assumption that anxiety—like many other psychological disorders—was a function of choice.

I have learned throughout my college years that mental health is a challenge for many individuals in both high school and college, regardless of creed or background. My interactions and experiences in college have showed me that it is not unusual for students to graduate from high school without having a robust understanding of mental health topics. This lack of knowledge produces a fundamental roadblock for a person entering existing in society, regardless of his/her personal mental health. For example, an uneducated student is rendered unable to help him/herself resolve mental health

challenges, and is also unable to be a resource for a friend in need. Thus, I wanted to dedicate my senior year to researching and understanding how mental health is taught in a selection of schools in Dallas, with an end goal of comparing some of the different approaches that are being utilized in high schools today. I predict that my research will yield the conclusion that elements of the curriculums in place today are better than the one I received, at least partially due to a rapidly changing social environment. That being said, however, I was still curious to see if I could identify any remaining areas of potential risk (or gaps) in this important area of education.

I quickly realized that it would not be reasonable to properly research and analyze each Dallas high school, as that feat is significantly beyond the scope of what I am capable of exploring in merely one year. For that reason, I have narrowed my scope to include three Dallas high schools that can be easily compared based on their similarities and differences. Schools in Dallas are of great interest to me not only because it is where I was born and raised, but also because Texas is one of the largest textbook producers in the country. From this statistic, it is not unreasonable to conclude that the books used in Texas are influential beyond Texas state borders.

In the first chapter, I will explore how "mental health" has been defined throughout history and in present teachings. Additionally, I will discuss what the current statues are in the state of Texas— as asserted by the legislation— and how these mandates alter the resulting product in schools. This exploration will lay the foundation of why we (as a society) should care about how mental health is presented to children, in addition to understanding how our society has gotten to this point. From there, I will dive into the second chapter, which outlines the research methods that I have utilized; this

chapter also includes a series of interviews that I conducted with educators of the mental health field. In the third chapter, I will then outline similarities and differences among the curricula that each professional described. In the fourth chapter, I will then present my own analysis about the three schools, stating my opinions about potential areas of risk. Additionally, I will highlight areas that I think are very successful for mental health education. Then finally, in the fifth chapter I will sum up my findings, and draw conclusions about how to tangibly take action with this learned information. It is my hope that throughout my thesis, I can make meaningful comparisons between some of the different ways that mental health is taught to students today. Though I would like to state whether or not the perceived gap in information has closed, I will not because it is beyond my education level to do so.

CHAPTER 1: Historical Background & Studies

Mental health is a relatively new topic of discussion compared to the ancient roots of medicine. Until recent decades, very little was known or discussed about the distinction between one's physical health and mental health. Nonetheless, newly discovered data and analyses have been disseminated throughout the world, and have continued to reveal that there is more than merely one type of health that each human possesses. Some cultures believed that 'mental health' was not a real entity, and perhaps was instead a construction of society and choice. As our society continues to evolve and as new information is discovered, the taboo topics of mental health are becoming more commonplace discussions among classrooms at school. Data registries are being established to provide schools with prevention programs that can be implemented, such as the National Registry of Evidence-Based Prevention Practices (NREPP) and the Best Practices Registry (BPR) (Substance Abuse and Mental Health Services Administration, page 54). These large-scale efforts are merely one demonstration of the rapid and continual expansion that is taking place in the mental health domain.

1.1: Importance of Mental Health Education

Various entities are working to develop strategic curriculum approaches, with the aim of ameliorating mental health for students both while they are in school, and for the future trajectories of their lives. In a 230-page instruction manual prepared for Substance Abuse and Mental Health Services Administration (SAMHSA) called "Preventing Suicide: A Toolkit for High Schools," the importance of suicide prevention programs is strongly expressed. The U.S. Department of Health and Human Services explains that

these suicide programs are essential in high schools, not only to uphold an unspoken commitment that schools make with parents to keep the students safe, but also for the academic trajectory of students (Substance Abuse and Mental Health Services Administration, page 12). The government document reports that research has shown that nearly 50% of students who are struggling academically feel either hopeless or sad, which is a stark contrast to what is seen among the students regularly receiving A's; only 20% of students scoring in this top grade range report feeling similar feelings of sadness of hopelessness that are reported by the 50% of students who are failing (Substance Abuse and Mental Health Services Administration, page 11). The numbers presented by this U.S. text are even more disheartening, as 1 out of every 53 high school students admit that they previously attempted suicide (but failed). Further, McIntosh's work from 2010 suggests that perhaps looking at suicide success rates alone are misleading; for every successful suicide, McIntosh estimates that there are between 100-200 unsuccessful suicide attempts by high school students (Substance Abuse and Mental Health Services Administration, page 10). Numbers of this size demonstrates that there is a substantial need for suicide prevention programs in high schools, as a high percentage of students are impacted. Each student is affected by school suicides—even the students who are not themselves suicidal—because a death in a school community starts a domino affect of suicide occurrences. When roughly 1.9% of students report that they attempted suicide in the past, this more than suggests that there is a need among youth that is currently unmet. If not for the focus on maintaining student well-being and a positive academic environment, another reason that schools must provide mental health prevention is to mitigate potential lawsuits that could arise if a student self-harms.

Many of these principles can be realized among the results of other studies conducted in recent years. While there have been extensive studies done in high income countries (HICs) like the United States, the knowledge regarding mental health intervention programs in countries that are marked by low or middle incomes (LMICs) remains lagging (19 TAC Chapter 115. Subchapter C). Thus, recent work by the WHO (World Health Organization) has begun to more critically investigate intervention attempts LMICs. This collective project was later described in a 2013 journal article, where many historical studies about LMICs are described and analyzed; however, only LMIC experiments completed after the year 2000 and with proper experimental design were included in the WHO's work. The reasoning behind this exclusive decision was to ensure that the included data was reliably obtained, and therefore capable of supporting valid conclusions.

1.2: State Regulations and Statutes

To gain a better understanding of the regulation landscape for health education in Texas, I read the guidelines in 19 TAC Chapter 115, Subchapter C. This ten-page document outlines objectives of the health information that students in high school receive, and includes a wide range of topics. Interestingly, not once is the term "mental health" used in the Texas guidelines. The words "emotional health" are used only one time, and they are said in a section that describes the importance of abstinence. Considering that this document is supposed to outline the important things that students need to learn about their health, it is quite disappointing (and concerning) that words

describing the broad entity of mental health are only mentioned one time, and not even as its own point.

That being said, there are a few buzzwords related to mental health that appear in the document of health education regulations. The words "anxiety," "depression," "eating disorders," and "suicide" each appear in the document, but unfortunately they each appear one time only. As a point of comparison, the word "abstinence" is mentioned three times, and "drug/drugs" appears 36 times; the term "bipolar" never appears at all. This discrepancy speaks to vagueness of the statutes regarding education of psychological health, as the guidelines do not explicitly identify particular pieces of information about mental health conditions.

Instead, general concepts are outlined without specific instructions. For example, the one mention of anxiety appears in the following context: "(H) examine causes and effects of stress and develop strategies for managing stress and coping with anxiety and depression" (19 TAC Chapter 115. Subchapter C). The lack of clarity presents room for grave misunderstandings or teachings, as educators can likely go about accomplishing letter H (above) in whichever way that they please. Though the curriculum at a given school is overseen by other faculty members at the school—and thus approved of by higher individuals in the chain at the school—this does not mean that two given schools will approach this challenge in the same way. Based on my understanding, this leniency can be both a good thing and a bad thing; on the positive side, this leaves room for educators to implement techniques that may be more unconventional or forward thinking. On the downside, the method selected by a given school or educator may be largely unsuccessful, yet continue to be used due to a vagueness of state requirements.

Though this is not the only existing document that outlines requirements for public schools in Texas, the examination of this document nonetheless serves as evidence that mental health education is not black and white, but can rather vary by school.

1.3: Collaboration Barriers

The Journal of School Health published an article in 2011 that emphasizes the disconnect between a school's intentions and its execution of mental health programming. There are many potential factors that can interplay to cause this disconnect; for example, the ratio of faculty may be wrong. If there are not enough faculty members trained in mental health support, then all of the students are not adequately catered to. This is a potential scenario when the disconnect is not due to a lack of care or prioritization of mental health education, but rather a shortage of resources such as funds, space, etc (Weist et al. 2011). This barrier is a result of position constraints that result from the school's structure. A similar situation may arise if trained faculty members are using a disproportionate chunk of their time aiding students with special needs; there is not enough man-power for the wellness faculty to meet the varying demanding needs of its students. This may also be the case when the teachers providing mental health education/support have too many roles on their plate—such as additionally managing registration, college applications, etc.

A second potential barrier for successful collaboration among mental health professionals (be that among school staff or outside providers) is reimbursement; dividing the funds can become difficult among two or more groups that are collaborating for a common goal, and parties may become less willing to help if they do not think they

will be reimbursed for their contributions. It is not unlikely that mental health providers in schools will become disenchanted with their work due to a frustration with payment and insurance, leading these valuably trained providers to become more distant from school needs. Many providers wrestle with proper funding, either from government grants or Medicaid— which is the "number 1 funder of child and adolescent mental health services" in the United States (Weist et al. 2011). Medicaid and other insurance entities are heavily bureaucratic, introducing further obstacles for providers to get the resources and compensation that they need in order to continue providing their services.

A lack of proper funding for mental health programs in schools leads to a lack of resources, such as proper facilities or materials to adequately provide for the students in need; if a school does not have funding to afford proper screening books and treatment plans, or if there are no private rooms in which discrete conversations can take place, then students will not be able to receive the full benefit of mental health support. Concerns for money or funding can also impact the way that certain faculty members are able to work together, as different individuals often have different opinions about how the limited funds should be allocated among the students. Many experts agree, however, that collaboration among several parties is the key to successful mental health programs for prevention and intervention (Substance Abuse and Mental Health Services Administration, page 9). Thus, it would be in the best interest of all stakeholders for the different team members to be better informed of their specific role in the student's unfolding greater process; if the stakeholders can better understand why the resources are being used in the way that they are planned, then perhaps this increased communication

among team members would lead to more successful collaboration since people will feel that they are on the same page.

A third reason that collaborative efforts are often stifled is due to uncoordinated efforts caused by a variance in desires among faculty members, parents, health providers, etc. Or, perhaps, a lack of communication between key players; one teacher may have an idea for action not knowing that another faculty member is involved with the student as well, meanwhile another uninformed faculty member may try to lead the student down an entirely different path for help. These paths may end up competing, being redundant, or neglecting to see the issue from a holistic perspective (Weist et al. 2011). One way to combat this problem is for the specific roles of key players to be more distinctly defined, and to reduce the overlap of positions. This role distinction will prevent members of a student's health team from working against each other, and will metaphorically streamline the group's efforts. Weist asserts that teams of providers will be most successful when they are comprised of a variety of individuals, some employed by the school and others who are community-employed. By having a wide array of individuals on the team who come from various backgrounds and experiences, the team will be more likely to effectively solve issues that arise throughout the patient's care. It is extremely valuable for schools to include community providers as well, as these outside connections make possible further referrals and support beyond a school's limited resources (Weist et al. 2011). Memorandums of Understanding are useful tools that can be applied in said collaborations, ensuring that all collaborating parties have a written agreement outlining how the parties will interplay to work together.

Oftentimes, proper staff training could help curb the unsuccessful or uncoordinated efforts; training of this sort, however, is not always a realistic option due to a shortage of time and/or resources. Nonetheless, when a team of people each pursues independent means to accomplish the group goal, it is not uncommon for one or more team members to become territorial. Attitudes of dominance and aggression threaten group progress, which could easily be a reason that a school is unable to provide adequate mental health services and preventions for students. One solution to combating this described lack of coordination is to have routine formal evaluations among all team members. These evaluations would provide opportunities for the group to discuss their progress and obstacles, and can yield better understanding and cooperation among team members. A second approach to combating a lack of coordination is to plan regular meetings that all providers can attend; this makes possible consistent dialogue, and allows an opportunity for team members to brainstorm concrete goals together.

I predict that legal barriers are also partially responsible for the rates observed in high schools. More specifically, FERPA laws (of the Family Educational Rights and Privacy Act) can complicate coordination efforts due to the medical confidentiality of students. Said laws have both positive and negative attributes; on the one hand, these laws enable a school to take actions to maintain the health and safety of a student whom they believe is in danger. But on the downside, school faculty members may be hesitant to collaborate with others due to a fear of confidentiality breach. A teacher may choose not to elicit help from another faculty member because they perceive doing so to be a violation, either morally or legally (of FERPA). Further, the differences in confidentiality that are ensured by FERPA (which is applicable to school faculty) versus HIPAA

(hospitals, outpatient centers, etc) introduce coordination hardships (Weist et al. 2011). HIPAA agreements prevent a health care provider from being able to openly discuss a plan of treatment with a school district without explicit permission from a student's parents. One way to minimize collaboration barriers that result from confidentiality concerns is to enact proper releases and permission upfront; then, a fear regarding confidentiality will not prevent a school employee from taking action. Either way, it is inevitable that communication will ensue between school providers, as dialogue is essential for the confirmation that actions are being taken to help a student in need (Weist et al. 2011). Mental health professionals need to communicate with a student's teachers, either to assess progress or to elicit the support of said teacher in propelling the student forward. Additionally, since the majority of high school students are minors, their parents are thus involved in this process as well (requiring further collaboration).

Students can also posses a fear of maintained confidentiality, thus decreasing a student's willingness to seek out help from school providers. Since the vast majority of high school students are minors, parents are inherently involved in the process in a way different than for college students. This involvement may deter students, as they do not want their parents involved in their personal matters. If the FERPA laws seem ambiguous to a student, then perhaps said student would fear that their words will be repeated, exaggerated, etc. Personally, I know that a fear of confidentiality breech stopped me from pursuing help, as I did not understand the guidelines surrounding confidentiality myself and was thus uncomfortable. Moving forward, it is possible to curb this particular fear among students by deliberately educating students about FERPA and HIPAA laws.

Regardless of a particular school's program or content, collaboration clearly "underpins the success of [School Mental Health] programs" (Weist et al. 2011). For this reason, it is essential that a given school focuses not only on the content of the information presented to students by prevention and intervention programs, but arguably more importantly that a school must focus on establishing collaborative teams to address student needs. Without this step of successful collaboration, attempts to educate or intervene could easily remain unsuccessful. One example of the importance of collaborative work can be seen in an Oregon study that was conducted in a middle school in 2000, and a second can be seen in a 1969 Texas study.

1.4: An Oregon Study

This study's main focus was to alter how children learn about scientific concepts of mental health, and to combat the taboo element attributed to topics of mental health. Thus, an Oregon middle school in Multnomah County enacted an experimental program with the school nurse in 2000 that featured collaboration among many faculty members (Desocio et al. 2006). A series of six modules were developed for fifth and sixth graders, which were taught in succession by the school nurse. The experimental program presented the children with accurate information while also allowing for students to ask questions; their ability to ask questions provided an important opportunity for the school nurse to correct any misconceptions that the students expressed, and prevent incorrect information from being further spread. The school felt that it was essential to begin discussions of mental health at a young age, as studies show that 20% of children

experience some sort of mental disorder that effects their development (Desocio et al. 2006).

The research from the Oregon middle school revealed that part of the reason the topic is so taboo stems from the fact that adults are fearful of discussing mental health topics with children (Desocio et al. 2006). Thus, roughly one out of every five children is affected by a condition that adults do not want to discuss—so in a class of 20 students, it is not unlikely that four students could directly relate to these lessons. This has proven to be very problematic, as "[without] comfortable adults as reliable sources of information, children form faulty conceptions and negative attitudes about mental illness from bits of overheard conversations, television commercials advertising medications, high profile news stories about homicides and suicides attributed to mental disorders, and dramatic representations of mental illness on television and in the movies" (Desocio et al. 2006). Television and movies are intentionally written to over-dramatize events for entertainment, and often are not factually correct; when children in our society use these fictional stories as a baseline for interpreting science, their perceptions become nearly indistinguishable from fact. A deeper look into an Oregon study can better describe where society stands today.

In an effort to alter how children learn about scientific concepts of mental health, the aforementioned middle school in Multnomah County enacted an experimental program with the school nurse in 2000 (Desocio et al. 2006). A series of six modules were developed for fifth and sixth graders, which were taught in succession by the school nurse. The experimental program presented the children with accurate information while also allowing for students to ask questions; their ability to ask questions provided an

important opportunity for the school nurse to correct any misconceptions that the students expressed, and prevent incorrect information from being further spread. The school felt that it was essential to begin discussions of mental health at a young age, as studies show that 20% of children experience some sort of mental disorder that effects their development (Desocio et al. 2006). If you consider this statistic in terms of people, that means that one out of every five children is affected by a condition that adults do not want to discuss—so in a class of 20 students, it is not unlikely that roughly four could directly benefit from these lessons.

The results of the experiment showed that the classes had an immediate and tangible impact on the students, as the middle school students became more likely to report mental health conditions for themselves or their friends. This difference is likely a partial result of the program's ability to decrease the social stigma associated with mental health. When the information is presented in a school environment similar to that of any other lesson, mental health becomes less of a taboo, and comes across as a more normal topic. The first experimental module taught students proper terminology, and normalized the frequency of people that struggle with mental health disorders. Students participated in an activity in which they picked out magazine pictures of people they believe did (or did not) struggle with their mental health; this activity proved an opportune way for misconceptions and stereotypes to be mentioned, and then corrected by the teacher (or nurse). The nurse then pointed out pictures of famous people with conditions, showing that the health condition is based on genetics and circumstances—not choice. This first module allowed for kids to walk away with the idea that they are not immune, and that their future is not ruined if they too struggle (Desocio et al. 2006).

Because of the development of a child's brain, around ten years old is the optimal age to inform children about mental health since their brains are just starting to understand that their inner thoughts are personal, and not known to others such as their parents. DeSocio explains "by reducing [the students'] fears and misconceptions about mental illness, they may be more likely to seek help early for themselves or to serve as sources of acceptance, support, and referral for peers who are struggling with emotional problems" (Desocio et al. 2006). The second module furthers this likelihood, teaching students a scientific foundation about brain function and structure. This knowledge further allows for mental health disorders to be an error in brain function, rather than an error of character. Most likely, children are able to begin viewing one's mental health as a physiological product of their genes and experiences, for which they are not entirely responsible. Perhaps by removing some of the responsibility associated with brain products, students can disassociate their condition from feelings of guilt or blame.

In the third module that the nurse teaches, students learned about coping with stress. One point that the nurse emphasized is that stress can be both good and bad, depending on the circumstances. Students were provided with acronyms that represented ways they could deal with stress in a healthy manner. The fourth module built upon the third, further explaining how each student can build their own "backpack" of resources to self-monitor their mental health. The nurse explained that each person has the ability to be resilient regardless of genetics, and described how one might go about seeking help from a friend or adult.

As part of this module, DeSocio makes a very interesting point regarding why the age of students can further complicate things; for example with 10-year-olds, children

love making secret groups with their friends. Kids are taught that it is essential to honor a secret, and vow to not repeat what they are told. While this promise is harmless when the secret is about a crush on a classmate, another promise can be very problematic if the kid vows not to repeat that their friend is struggling. Kids feel pressure to adhere to the morals and values of being a good friend to their peers, and as a result, oftentimes feelings of struggle become hidden and suppressed from adults. In this case, kids are unintentionally harming their friends by stifling adult recognition of a problem (Desocio et al. 2006). To further prove this point, role-playing activities were utilized within the modules.

Another example of role-play can be seen in the fifth module, which focuses on some of the most common disorders that children experience: anxiety and depression. This module also describes the connection between depression and suicide, which is explained through role-play. Imaginative activities like these are extremely useful in an educational environment, as students are able to practice how they will act if they find themselves in a similar situation in the future. Then finally, in the sixth module, the class discusses ADHD and completed various evaluations. These completed evaluations thus classifying the experimental modules as a success. Students requested further classes and discussions began approaching adults about issues more frequently, and helped students to normalize their experiences. Additionally, the experiment helped teachers to identify a suicidal student in the middle school, who they were then able to help (Desocio et al. 2006). All of the realized successes show that prevention programs like this make a positive difference, and have the power to affect widespread changes. If the evaluations did not reflect such high percentages of change (of perspective), then I would not assert

the essential presence of such programs in high schools as well. The conclusions drawn from the Oregon middle school prove compatible with the results of other experiments.

1.5: A Texas Study

In 1969, public schools in Dallas, Texas tested the implementation of mental health services throughout the district, providing for both students and their families. Jennings' journal article outlines the coordinated establishment of Youth and Family Centers (YFCs) by schools and local health providers, aiming to provide a variety of health services for both the students and their families; the clinics had physicians, therapists, behavioral therapists, and a 24-hour crisis service (Jennings et al. 2000). Like the Oregon school, the Dallas centers mirror the desire to normalize mental health; "the services are close to home, accessible, user friendly, and relatively devoid of stigma" (Jennings et al. 2000). The presence of these health clinics also increased the number of students who sought out help for both physical and mental health concerns. Ron Anderson—CEO of Parkland Hospital in Dallas—asserted that children need to graduate from high school for their own health, and suggests that the implemented medical system contributes to the graduation rate (Jennings et al. 2000). Though these clinics greatly differ from the experimental modules introduced in Oregon, these public schools in the Dallas district are nonetheless another example supporting that a school has the ability to positively impact the level of mental health awareness among its students.

1.6: How Past Research Defines A Successful Program

There has been countless further studies performed in order to help define what makes a program successful, in addition to the standards that should be met by mental health teachings. Though I would love to further discuss these studies and all that I read, it is unfortunately beyond the scope of my project to do so; for that reason, I have included an appendix at the end of my thesis that provides some sources for further information. The articles featured in the appendix further discuss what some previous studies have determined properly constitutes 'success' for a school's mental health program. These texts are fantastic, and helped to provide me with a solid orientation of the deeper corners of peripheral studies.

Chapter 2: Interview Methods and Results

My research proposal was classified as exempt by the University of Texas IRB, yet was still overseen. Accordingly, I was able to email the written interviews directly to correspondents methodically planned out which professionals to interview for my thesis, as I quickly realized that it was unrealistic to embark upon speaking with unlimited individuals. While I originally hoped to collect a wide range of responses from a variety of schools across Dallas, my ideal correspondents were not all plausible due to politics, timing, access, IRB limitations, or other reasons. I chose to contact a selection of three professionals that work at a variety of educational institutions in Texas, including schools with various levels and funding. Before diving into my interviews with each person, I will first provide a roadmap of who I interviewed, and why.

****Note**: in my thesis, I have used pseudonyms for both the names of the schools, and the educators that I interviewed.

2.1: Interviewees

The first professional that I interviewed works at Rushmore High School, a high school in a neighboring school district (of the Dallas Independent School District). The reason that I have included a school from a neighboring district is because I encountered too many political barriers with DISD, which complicated my ability to conduct research. Nonetheless, I was interested to see how Paul Parker's perspective would differ from those of private high schools, despite Rushmore's higher rankings and funds. While I would have liked to include other DISD schools for a further analysis of how state

regulations and statues impact the health curriculum, this proved incredibly difficult due to issues of timing and politics. That being said, this limitation may prove beneficial among my data, ensuring that all students being considered are within a relatively similar socioeconomic class. This similarity prevents for me from having to factor for variables such as relative wealth among target students, and to instead evaluate how students within a given social class are educated—regardless of whether their schooling is private, public, secular, or non-secular. By eliminating the finance variable, I believe that my data will have more accuracy, and will not have confounding variables preventing later conclusions.

Rushmore High has significantly larger classes than do the private schools, which is important to note. Nonetheless, the Dallas community (and many universities and individuals throughout the USA) unquestionably associates Rushmore High with strong academics, and of possessing significant talent. Rushmore students are known to out-perform students from other public schools. One caveat with the Rushmore curriculum, however, is that the health course is not merely taught to high school students—but rather can be taken earlier as an 8th grader, in middle school. While this may introduce questions of how well the information is absorbed if taught at a younger age, this is still a valid comparison to the other schools because I can equally evaluate the total information included in the curriculum by the time students graduate from high school.

The second person I interviewed was Joan Jenson from the St. Johnson School. This private school in Dallas emphasizes Christianity in its curriculum and culture, as the students learn about both secular and non-secular topics. Though religion is not reflected in every course, weekly chapel, in addition to the modesty of their uniforms, reinforces

the religious mindset and grounding of the institution. St. Johnson is co-ed, enrolls students from Pre-Kindergarten through 12th grade, and is known for its strong athletics program. The school is known to do a good job of preparing students for college, and its high financial advantage is clear based on the buildings of the school alone. The St. Johnson School differs from the other private school (Smithson Academy) in that it is a non-secular institution, specifically emphasizing Christian teachings.

The third professional that I interviewed is Sally Smith, the counselor at Smithson Academy—which is a co-ed, secular private school with students ages Pre-Kinderarten through 12th grade. Each grade at Smithson Academy has roughly 110-120 students, similar to that of St. Johnson School. It is very clear upon visiting their campus that Smithson Academy is extremely well funded, and has facilities and resources that would place the school in the upper echelon economically. Ms. Smith is a very valuable resource for many reasons, especially because she personally restructured the Smithson curriculum in recent years. Additionally, I wanted to include Sally because I believe that she brings unique insight due to her various avenues of professional involvement—as not only a school counselor for the past five years, but also as a licensed therapist outside of Smithson Academy.

I specifically chose to contrast non-secular private schools with differing religions, aiming to see if the leniency in curriculum determination has an effect on the information that is taught to students. I thought that this comparison would allow for me to shed some light upon whether or not a religious institution teaches health topics in a different way than a secular educational institution. My prediction before conducting the research was that I would find some differences, but that for the most part, the

information would remain relatively constant across the board; after all, it was my understanding that religion have no bearing on concepts of science such as anxiety, bipolar, etc. If any differences did become apparent, however, I predicted that they would be about how topics of anxiety are explained with relation to God. For example, it is reasonable that perhaps anxiety is invalidated by teachings that prayers to God will combat feelings of fear (that are elsewhere described as a chemical imbalance, for example). Though beyond the scope of my research, I also predicted that larger differences would be prominent in categories such as sexuality or sex education. However since those topics are not included in my interviews, differences such as these would not be surfaced by my research.

Another reason that the distinction between private and public schools is important is because it dictates how much latitude a given school has in designing their own curriculum. The faculty members at the two private schools (St. Johnson and Smithson Academy) have complete control over what is taught and in what way, and are not bound by the government statutes of education requirements; public school educators (like at Rushmore High) do not have this same ability. Public schools are mandated to adhere to a set of course objectives, unlike privately funded institutions. Thus, it seems that it is logical to conclude that public school curriculums are more likely to include a broad range of information in order to comply with state regulations.

2.2: Research Methods

It is my belief that it is *crucial* that mental health education is effectively taught to high school students, for many reasons. First of all, not all students have the means or

desire to attend college; thus, for many students in the USA, their formal education ends at the age of roughly 18 when they graduate high school. Assuming that these students do not go back to school, this means that schools (and educators) have until the age of 18 to impart upon students the essential information that is needed to be a healthy individual. For that reason, it is very possible that a high school health class is the last opportunity for formal instruction about such important topics. As a society, we should not allow for individuals to graduate high school without being introduced and equipped to the skills necessary to upkeep their mental health. This requirement affects not only relationships for the students, but also their career prospects, happiness, and so much more. Society cannot afford for students to graduate from high school without being thoroughly exposed to and informed about a universal experience: that of human mental health.

Thus, I created an open-ended survey with questions that will yield meaningful responses to propel my research. The results will be a tangible representation produced by each school being examined, and provides opportunities for both objective and subjective analysis. The survey is made up of 28 questions that together develop a holistic view of each school's curricula and attitude.

The first four questions target the teacher's identity and background. The following five questions (questions 5-9) ask objective questions about the structure of the course in which mental health topics are taught. Questions 10 through 14 present inquiries regarding the amount of latitude that the teacher has in developing their respective curriculum. Together, the responses to these initial 14 questions will create a descriptive picture of each course's structure and flexibility. The next portion of the interview was designed to reveal information about the content of each course.

Thus, questions 15 through 18 ask detailed questions about course content, specifically focusing in on four topics: anxiety, depression, eating disorders, and bipolar disorder. By asking specific sub-questions under each of these four topics, I will be able to collect a dependable view of each school's attitude in relation to course topics. For example, if an interview reveals that inaccurate information is taught to students, this will warrant further considerations as to whether the incorrect information is an accident or a planned deceit. I consider these four questions to be the meat of my survey, as their responses will provide a strong base of data; it is important that these sub-questions are both detailed and specific, as they will give strong direction for understanding a given school's curriculum. The sub-questions will provide concrete information that can be compared and contrasted among the schools.

2.3: The Interview Itself: 28 Questions

Below is a copy of the interview that was emailed to each of the interviewees.

Interview Questions for High School Educators:

Thank you for agreeing to fill out this survey on behalf of your high school. Each of the questions are open-ended, so you can answer however you feel is most accurate. There are no right or wrong answers. The more information that you provide, the more substantial conclusions I will be able to draw!

1. **What is your name and age**?
2. **What school do you work at, and how long have you been there?**
3. **What other roles do you have at the school?** *For example, do you teach another class, serve as a coach or nurse, help with scheduling, etc?*
4. **Has the curriculum changed since you've been teaching health—either at another school, or in the same school**?

5. **At your particular school, what class presents this information?**

6. **At what age is this class taken, and is it possible for students to opt out /substitute the course?**

7. **What other topics are covered in this specific class?** *(Ex: Sexual health, communication skills, science, etc?)*

8. **How many times is this information formally taught in class?**

9. **Is the information taught informally too** (such as posters or pamphlets on the walls)?

10. **How much leniency do you personally have in terms of altering the topics covered about mental health?** *For example, could you restructure the entire program next year if you wanted (assuming that you had the principal's permission)?*

11. **Do you teach the topics based on state regulations, or based on what you think is most important for students?**

12. **Is there a certain way that you have to present the info** (such as powerpoints or assigned readings), **or is that up to your discretion?→ If so, can you pick the specific texts, or are they already picked for you?**

13. **Do you think that the presented information changes students' perspective and experience in high school? If so, what makes you say that?**

14. **Do you think that the class has an impact on how likely a student is to seek help for mental health in the future?**

15. **Regarding anxiety… please answer these questions based on what students are taught**.
    a. Do you use an analogy to explain anxiety?
    b. Do you explain anxiety by using any scientific information?
    c. Do you use a particular teaching activity?
    d. Is there a particular reading(s) that you assign?
    e. Do students express any misconceptions about anxiety? Which ones?
    f. What are students taught is the cause of anxiety?

g. Do you think there is a distinction between an anxiety disorder, and experiencing stress? If so, are the students taught how to know the difference?

h. Is it possible to make anxiety go away?

i. Is anxiety a choice?

j. How do you know if you have anxiety?

k. At what age can you start showing signs?

l. Can you fix anxiety on your own?

m. Is it bad if you have anxiety?

n. What resources are students given to learn more?

o. How common is anxiety?

p. What is the best thing to say to a friend who has anxiety?

16. Regarding depression… please answer these questions based on what students are taught.

a. What scientific connections are made about depression?

b. What are students taught is the cause of depression?

c. What resources are students given to learn more?

d. How do you know if you have depression?

e. At what age can people become to show signs?

f. Any particular readings assigned?

g. What are they taught about how depression connects to suicide?

h. Can depression ever go away?

i. Can you fix depression on your own?

j. Is depression a choice?

k. Is it bad if you have depression?

l. How common is depression?

m. What is the best thing to say to a friend who struggles with depression?

17. Regarding bipolar disorder… please answer these questions based on what students are taught.

a. What scientific connections are drawn? (ex: Genetic? Based on hormones?)

b. How do you treat bipolar disorder? Can you make it go away?

c. Can you fix bipolar disorder on your own?

d. Do you assign any particular readings?

e. What causes one to have bipolar disorder?

f. How do you know if you have bipolar disorder?

g. At what age can you start showing signs?

h. How common is it?

i. What is the best thing to say to a friend who has it?

j. How do you know if someone is short-tempered versus bipolar?

18. Regarding eating disorders… please answer these questions based on what students are taught.

a. Who has them?

b. What causes them?

c. At what age can people start showing signs?

d. Can boys and girls have them?

e. Do they ever go away?

f. What are the different kinds?

g. What is the best way to help a friend that may be struggling with one?

h. In a culture like ours that focuses on image and beauty, what is the line between caring about your appearance in a "normal" way versus having a problem?

i. What do people eat who have eating disorders? What do they not eat?

j. How big/small do you have to be in order to have an eating disorder?

k. Will people always deny that they have one if you ask them?

l. How long does treatment take?

m. Can you fix eating disorders on your own?

19. Is there anything that you wish was part of the curriculum, that isn't currently?

20. Is there anything that students are taught in the class that you personally think is wrong or misleading?

21. **What are students taught about drugs to treat mental health?** *(For example, are they addicting or dangerous? How common are they?)*

22. **Are students ever tested on the information that they learn in this class about mental health? → If so, how is the class graded?**

23. **Prior to this class, where do you think that students get most of their information about mental health topics?**

24. **Do you provide an opportunity for students to discuss their own health with others in the class?**

25. Do you discuss famous individuals who struggle with mental health?

26. Do you think your students feel uncomfortable discussing topics of mental health with peers and adults?

27. **What sort of stigma do you think students associate with these topics of mental health? Further, does the curriculum do anything to address that?**

28. What do you think is one change that (in an ideal world) will help move society towards breaking the stigma associated with psychological disorders?

CHAPTER 3: Data

3.1: Interview Results for Rushmore High School

At Rushmore High School, I interviewed Paul Parker. Paul Parker is a varsity football coach at Rushmore High School, but he has also held a variety of other roles throughout his 12 years as an educator in the district; some of the other roles he has filled consist of Men's Track and Field coach, and a classroom teacher of biology and health education. He reported that the health curriculum has remained the same in his opinion throughout the years that he has been teaching health topics, which students are exposed to in a course called Health Education. Interestingly, this course is available for students in grades 8-12, spanning across both middle school and high school ages. Mr. Parker said that at Rushmore, students can take this course during any semester that they choose (either fall or spring), but that it is a state requirement that this course is taken by each student in order to graduate from high school (Parker). To this point, it is thus not possible for students to opt out of this course, for that would prevent students from being able to graduate. As a result, all students graduating from both Rushmore and other public Texas high schools receive some sort of education about health prior to their graduation—as mandated by state legislature.

At Rushmore, the Health Education covers a wide range of topics—consisting of mental and emotional health, drugs, tobaccos usage, alcohol consumption, teen relationships, family relationships, citizenship, nutrition, depression, anxiety, teen suicide, CPR, and first aid. Each topic is discussed for about a week before the course moves on to the next topic, however Mr. Parker explained how "the curriculum flows in a manner that each topic builds upon itself as the semester progresses [but] all topics can be

revisited throughout the course" (Parker). That being said, however, each topic is typically formally taught only one time; this means that students do not learn about anxiety several times throughout their education, but rather only one time (during its week of coverage and introduction) unless the course later calls for an additional visitation. Thus, there is not guarantee or structured plan for topics to be discussed repetitively throughout a student's 8-12th grade experience, or from another source outside of the Health Education class.

Unlike many course curricula in which information is directly assigned to be read from a textbook or film, the Rushmore Health Education Course is "formally instructed as well as student led" (Parker). Mr. Parker stated that he is able to restructure the class as he pleases, so long as he meets all of the state requirements for the mandated topics to be included. Thus, if he wanted to completely redesign the curriculum's structure or assignments next year in 2019, he has the latitude to do so as long as the content remains the same. Additionally, he informed me that he has the freedom to add information to the course curriculum based on the needs he perceives among his students. Nonetheless, the state requirements go a long way in explaining why Mr. Parker may feel that the curriculum has remained relatively the same throughout his 12 years of teaching—especially if the state's requirements have not radically changed in recent years.

So long as the course content is in accordance with state requirements, there is no one specified way that the information must be exposed to students. For example, Mr. Parker shared that there are very few textbook readings that are assigned (like what would be the standard format in a history or sociology course). Instead, he said that the normal method of teaching in his class includes lectures (from him, the teacher) via

PowerPoint presentations, but that he also uses films and library research. He also picks specific texts that he wants to assign for reading, allowing for Mr. Parker to have some element of control over which sources his students are exposed to.

Mr. Parker reported that he believes that the Health Education course does, in fact, positively impact students' perspectives "in a number of areas, especially in the areas of mental and emotional health and nutrition" (Parker). More specifically, he discussed how students tend to be very engaged by the topic of teen suicide, given the high rate of reported teen suicide incidents in the nation. Thus, it is reasonable to conclude that perhaps students take a greater interest in topics that they feel are directly relevant to their world (and greater society). Perhaps due to the sparked interest in students or perhaps due to the enlightened perspective, either way, Mr. Parker believes that students are more likely to seek help following participation in this course.

The Health Education course also provides students with a variety of potential avenues that they can pursue in order to obtain the help they may need or want, furthered by the guest speakers that are asked to join the classes. Perhaps by engaging society members (who are beyond the course community) in conversations, students may feel that their resources are not limited to the classroom or school at large. As shown by the research on the importance of mental health education and prevention in schools, it makes great sense that this cooperative engagement with wider community members subconsciously provides a connection the fact that potential resources are far stretching, and available from many different places and individuals.

Additionally, Mr. Parker provided many details about what Rushmore students are taught about anxiety. For example, the Rushmore program draws upon analogies to

explain anxiety to their students, in addition to explanations using scientific information. Not only are facts about anxiety merely given to students, but teaching activities are also used to help students to understand what anxiety looks like. Since Mr. Parker stated that there are not many textbook readings assigned in this course, it was not surprising for me to find out that there are not any specific readings that are assigned to students regarding anxiety (Parker).

When asked if his students seem to express common misconceptions about anxiety, he reported that students often "have difficulties sorting out what their personal causes of anxiety are" (Parker), and how their anxieties can be resolved. To combat this misconception, students are taught that there are many causes of anxiety such as family life, money, school workload, dating, social life, drugs and alcohol, and personal relationships. Mr. Parker explained that students are taught that an individual can have an anxiety disorder that coexists with experiencing stress, but that they can manifest themselves in a variety of ways in each student's life. He also teaches that anxiety disorders and stress can have a symbiotic relationship, but that there are distinct differences as well. Students at Rushmore are taught that it is possible to make anxiety go away, but it was unclear from Mr. Parker's responses if he is referring to all types of anxieties, or just some. On that note, he also stated that students are taught that whether or not anxiety is a choice "depends if the anxiety is recognized and manageable" (Parker).

To that point, students are taught that there are many symptoms that an individual can express when anxious, which can be used to realize when anxiety is present. Some of the symptoms include "mild depression, mild panic attacks, loss of sleep, social

withdrawal, loss of appetite, agitation, anger, short temper, loss of patience, [and] grades suffer" (Parker), and can start to appear in one's early teens. Students are taught that the best way they can help a friend with anxiety is to "ask what may be the sources [of their anxiety and to] just listen… and then when given the opportunity offer advice" (Parker). Students are taught that they can fix their anxiety on their own as well, perhaps without relying on the support of peers. However, in order for a student to fix their anxiety on their own, they must be provided with certain tools—both for realization, and coping mechanisms. It is important to note that anxiety is not presented as a merely bad thing, but as something that can be good as well. In order to cope, however, students are also informed that there are countless resources that are available on campus, through which students can learn more. The condition of anxiety is not at all uncommon, as it is one of the leading three reasons for concern among students and parents in the school district where Rushmore High School is located.

Next, Mr. Parker provided information about depression, as taught to students in Health Education. Some scientific connections are drawn upon, such as heredity and genetics, or chemical imbalances. Social connections are also emphasized as a cause of depression— such as family history, social expectations or failures, academic hardships, relationship issues such as dating violence, or issues at home (with family). There are several ways that an individual can know that they have depression (mood swings, repetition of negative thoughts, behavioral issues, loss or gain of weight, changes in sleep or appetite, etc), however a medical diagnosis is required for severe depression. Mr. Parker reports that students are taught that depression can be experienced at any age if it is driven by genetics. Further, students are provided with a range of potential resources

that can be used to cope with feelings of depression, such as "school counselors, professional guest speakers, teacher/coaches and anonymous Q&A" (Parker). Students at Rushmore are taught about "all aspects of drug treatment… and the commonality of over prescription and/or the multiplier effect" (Parker). In order to ensure that the students are paying attention to the course and absorbing the information that is presented, students are assessed using multiple choice questions, critical thinking responses, and true/false.

The information regarding depression is introduced to students mainly through guest speakers (who are local professionals), and/or lectures given in class by Mr. Parker. Rushmore students are taught that depression is connected to suicide, as "when we feel that we no longer can get help or that there is no way out of the situation… this can manifest into suicide" (Parker). Unlike anxiety, depression is presented as something that cannot be purged without medical help, and that an individual cannot fix that depression alone. For that reason, students are taught that the best way to support a friend struggling with depression is to suggest that they seek out professional help. Severe depression is not a healthy condition, and is "more than likely not a choice" says Mr. Parker since the condition is driven by chemical imbalance. Nonetheless, students are informed of how common it is to struggle from depression, especially after the age of 19.

The next topic specifically asked about (in the interview) is bipolar disorder. In the Health Education course at Rushmore, Mr. Parker says that students are taught about the biological causes of bipolar disorder (such as genetics and changes in brain chemistry) in addition to non-biological causes (death of a loved one, stress, and drug or alcohol abuse). Students are taught that there is "no absolute cure for this condition and [it] must be monitored professionally" (Parker); in other words, bipolar disorder is not

something that an individual can fix on their own. Though specific readings are not assigned to students about bipolar disorder, other sources are used—for example, medical professionals are brought into the classroom to speak to students. It is important to note that students are taught that this condition is very common, and can be marked by consistent mood swings from anger/ agitation to euphoria; these symptoms can happen at any age, but are most common after an individual turns 19. Finally, students are additionally equipped with suggestions for how to help a friend that may be struggling with bipolar disorder, such as encouraging the friend to promptly seek professional help.

The last topic covered by the interview explores the teachings about eating disorders; students at Rushmore are taught that eating disorders can happen among both men and women, and at any age. Mr. Parker teaches that there are many different types of eating disorders that an individual can have—such as anorexia, bulimia, binge eating, and night eating— that manifest in a variety of eating habits. For example, one individual may consume thousands of calories and then purge, whereas another individual may limit their calorie intake all together (Parker). Nonetheless, for all forms of eating disorders, professional help is needed in order to overcome the symptoms. Because of the need for professional help in order for an eating disorder to go away due to the cognitive piece, students are taught that if they think a friend may be struggling, the best thing to say is to encourage them to seek the care that they need. There is no set amount of recovery time; rather, it depends on the individual and their condition. In response to question 18h (which asks about the line between a normal level of caring about ones image versus having a disorder), Mr. Parker shared that he thinks "the important teaching piece here is not necessarily body image but the actual health of the individual" (Parker).

On the note of body image and size, he teaches his students that the physical body shape of an individual suffering from an eating disorder can vary; Mr. Parker says one's shape/size depends on the length of time that an individual has engaged in those eating behaviors, "and the long/short term effects of the disorder" (Parker). Further, people who experience eating disorders may or may not deny that they are struggling, based on the relationship of the people in the conversation.

When asked if there are any topics that Mr. Parker wished were part of the Health Education curriculum (but that is not currently included), he mentioned dating violence, date rape, and child abuse. Nonetheless, he said that he agrees with the correctness of everything that *is* taught in the curriculum, and does not feel that anything that he is required to teach students in his course is wrong or misleading. Mr. Parker said that other than a potential psychology class, his course is the main avenue through which students gain information about mental health topics. Students are also provided the opportunity to discuss their own mental health during the course, as his class features "a transparent open respectful Q&A environment. We also have anonymous Q&A opportunities as well" (Parker). In addition, towards the end of the course, the class discusses famous individuals that struggle with their own mental health. This concluding lesson nicely complements that Mr. Parker says that most students want someone to talk to, although some still do feel uncomfortable discussing topics of mental health with adults.

It is important that students are informed of mental health topics in a way that does not further the stigma, but rather fights to break it down by demonstrating that "all of us [in] some ways struggle with our mental health and it is the topic we as humans ignore the most or spend the least amount of time with" (Parker). The Rushmore High

School teacher suggested that perhaps if more work could be done at the elementary level in an ideal world, this might help society as a whole to realize mental health issues at an earlier age before they develop into more serious issues.

3.2: Interview Results for The St. Johnson School

At The St. Johnson School, I interviewed Joan Jenson, even though she does not personally teach topics of mental health to St. Johnson students. She has worked at The St. Johnson School for five years, and is instead an advisor. The reason that she completed the survey on behalf of The St. Johnson School is because the school does not have a specific 'curriculum,' but rather the students receive information from a variety of sources throughout the years. For example, "mental wellness information is given to students in health, special programming days, through clubs, emails, schoology posts and special events throughout the year" (Jenson). Joan Jenson also said that posters and pamphlets are available around the school, which serve as an additional way that information is informally given to students. Nonetheless, due to the wide range of sources through which students are taught, there is not one faculty member that can answer the interview questions in the same way that Mr. Parker could for Rushmore (as the Health Education teacher).

Unlike Rushmore, The St. Johnson School is a private school; thus, St. Johnson faculty members have the leniency to alter which topics are taught to students on campus. More specifically, Ms. Jenson and the dean work together to "make the programming priorities" (Jenson). This greatly differs from how things are streamlined at Rushmore, which is dictated by the Texas statutes—not faculty members at the school. At The St.

Johnson School, there also is not a specific way that the information must be presented to students; venues such as PowerPoints or readings can be used, and selectively picked by the school without restrictions. When asked if she thought that the information presented to students about mental health will change their perspective and experience in high school, Ms. Jenson said that she believes students become more likely to ask for help (for themselves) or to seek help for a friend about whom they are concerned. She also believes that the programming conducted at The St. Johnson School contributes to making students more likely to pursue help for their mental health in the future.

At The St. Johnson School, anxiety is taught slightly differently than at Rushmore. For example, The St. Johnson School does not use an analogy to explain anxiety, nor do they use a particular teaching activity. The scientific information that is provided to explain anxiety concerns the symptoms (Jenson), but additional causes of anxiety are also mentioned—such as outside and internal pressures. Like at Rushmore, there are not any specific assigned readings. Ms. Jenson mentioned an additional misconception that was not mentioned in Mr. Parker's response, such that "at times people without anxiety will say that it is something that can be controlled [or will say] 'just don't worry'" (Jenson). The very fact that misconceptions such as this one are vocalized is a good thing in an educational environment, as that presents an opportunity for the information to be corrected for the benefit of all other students in the class as well.

When asked about the distinction between having an anxiety disorder and just being stressed, Ms. Jenson stated that she believes students can tell the difference based on what they are taught through programming at The St. Johnson School; while stress will come and go based on the surrounding situations, an anxiety disorder is marked by

ongoing anxiety. Ms. Jenson reported that anxiety is not a choice, which slightly differs from the response of Mr. Parker—such that it depends. Whereas Mr. Parker said that the way one can know if they have anxiety is by certain symptoms, Ms. Jenson instead said that "worrying constantly even when you know that there isn't anything to worry about" (Jenson) is one way that St. Johnson students are taught to identify anxiety. Ms. Jenson also said that signs of anxiety can begin in toddlerhood, which suggests that anxiety is something that individuals can struggle with before their social life or work pressures become complicated; at Rushmore, students are taught that anxiety begins to appear in early teens. This discrepancy in starting ages inherently suggests something about the phase of life that an individual is experiencing, and thus has implications for what may cause anxiety. Though Mr. Parker wrote in the interview that it starts in early teens, that restriction may not be what is actually taught to students at Rushmore—it is possible that his response reflected one line of teaching, but is not inclusive of the entirety of information taught by the Health Education course. Nonetheless, since he is the teacher of the course, I think that it is interesting to consider what his gut response was to my question about age.

Moving on with The St. Johnson School, Ms. Jenson said that anxiety likely cannot be fixed by an individual on their own, and that profession help is needed by most people; this is very similar to what Mr. Parker said, such that in order for anxiety to be fixed, an individual must be provided with the necessary tools. According to both answers that the educators provided, anxiety is not something that one can wish away or eliminate with a light switch. Ms. Jenson and Mr. Parker differed, however, in their response to whether anxiety is good or bad; which Mr. Parker said that anxiety can be

both good and bad, Ms. Jenson's response did not mention anxiety being potentially good, and instead focused on the discomfort that are caused for an individual experiencing anxiety. She further added that an individual suffering from anxiety "would want to treat it to get relief from the symptoms" (Jenson), which implies that anxiety is not something that people want to linger, but rather something that is desired to go away. One way that The St. Johnson School helps students to learn more or to seek out said treatment is by providing referrals to professionals in the area who could help. St. Johnson students are also taught that prescription drugs can be an important aspect of mental health treatment for many people, but that they are not always necessary (Jenson).

The students at St. Johnson are taught that it is fairly common for students to experience anxiety, and that the best thing a student can say in response to a peer who has anxiety is to merely listen without judgment or providing advice. This is similar to Mr. Parker's response to the same question, in which he also stressed the importance of listening to a friend while they talk. He did not mention in his response, however, that it is best to not give advice. There are many ways that the suggestion regarding advice can be interpreted, but my personal guess is that St. Johnson students are dissuaded from giving peers advice about anxiety because kids often do not understand the complexities of the cognitive disorder, and thus are not able to provide sympathetic insight to struggling friends (even though they may want to do so).

Regarding depression, The St. Johnson School teaches its students about some of the scientific connections— such as brain transmitters, the biochemical makeup of the brain, and heredity. Additionally, students are taught about how non-biological external factors can also cause depression beginning in childhood. Specific readings about

depression are not assigned at St. Johnson, and instead presentations are utilized to provide students with the information. Ms. Jenson mentioned that students are taught to identify if they have depression by visiting DSM 5, or if he/she experiences "2 weeks of sadness affecting concentration, sleep, appetite, irritability, [and] sluggishness" (Jenson). This response differs from that of Mr. Parker, who said that severe depression must be professionally diagnosed. Both answers are completely compatible, as their differences can be easily explained by the fact that the educators differently interpreted what my question (in the interview) was asking of them.

Depression is taught as a common condition among students, and one that is not a choice or easy to live with. As a matter of fact, depression can impact a student's social life, academic performance, sleep, and even concentration. Because St. Johnson students are taught through conclusive programming that depression cannot be fixed on one's own—and that professional help is needed to resolve the issues—the school is good about providing professional references for depression as well as anxiety. Depression is presented as a condition that can go away with the support of proper talk therapy and medications; but that even if the symptoms pacify, one must be prepared for future depressive episodes. Nonetheless, The St. Johnson School encourages students that there are many ways to help a friend that is struggling with depression. For example, students are told to listen without judging or offering advice (like with anxiety), and to even offer to accompany their peers to see a professional.

In response to my questions about bipolar disorder, Ms. Jenson informed me that genes can be 'weakened' or altered due to stress and external elements, thus leading to bipolar expression. When genes are changed as a result of external elements, a gene is

'awakened.' This process that she describes is consistent with Mr. Parker's answer, which emphasized the fact that bipolar disorder is not merely caused by internal biological functions. It is unclear from the interview responses whether St. Johnson students are given the impression that bipolar disorder can ever go away, but they are informed of the ways that medication and therapy are used to treat the disorder. Ms. Jenson's answer was also very compatible with Mr. Parker's about the symptoms to look for when evaluating levels of bipolar expression, however her answer on behalf of The St. Johnson School provided further specifics on the matter.

She added that "mania, extreme irritability, unusually happy, risk taking, starting big things and not finishing them, [or] bouts of depression" (Jenson) are major indicators of having bipolar disorder that can begin to show in childhood or teens. The age at which onset occurs is described a bit differently by Mr. Parker, who said that symptoms can start at any age but most are above 19 years old. As the teenage years are infamous for being very dramatic and stressful, looking at risking behavior can provide great incite: such as if an individual is engaging with sex, money, and partying. Though Ms. St. Johnson said that it is unknown how common bipolar disorder truly is, St. Johnson students are still told to listen to their peers and to offer accompanying them to pursue help.

On the topic of eating disorders, the first question about who has them resulted in different answers from The St. Johnson School and Rushmore; while Mr. Parker (of Rushmore) said that boys and girls have them alike, Ms. Jenson said that the "majority [are] girls but boys have [them] too" (Jenson). Her answer for the 18b—about what causes eating disorders—was stellar. She mentioned a variety of things that can cause

eating disorders, such as media images, having a perfectionist personality, genetics, and a lack of control in other areas of life (Jenson). This answer is much more expansive of that than Mr. Parker's, and identifies the fact that there are an infinite number of driving factors; a response such as hers moves towards removing the stigma associated with eating disorders, by removing an element of culpability from the person who is struggling, and making it so that it is not 'their fault' or 'a choice.' She also gave a very insightful answer to the question of when people start showing signs of eating disorders; she pointed out that the childhood and teenage years are when they typically start, but that the starting age has been decreasing.

Ms. Jenson used a mathematical reference to help explain whether or not eating disorders ever go away; she explained that "much like an addition it will be something that you always need to be vigilant of, even when you are in recovery" (Jenson). This was a great way of answering this question with both accuracy and precision, by using the word 'addition' to explain the way that an eating disorder impacts a person moving forward even once treatment has ceased. She also wisely mentioned that as the friend of someone struggling from an eating disorder, trying to reason with them is not a good idea; though she did not explicitly say, I believe that with her response, she was referencing the fact that eating disorders are incredibly complex, and are not something that can be fixed by the comments or challenges of a peer. The St. Johnson School also suggests that people offer to accompany their friends to seek help, which is a great way of directing a peer towards the resources that they need while also remaining present and supportive. When asked about the types of eating disorders, she gave a very similar list as

Mr. Parker; she named bulimia, binge eating, and anorexia—whereas Mr. Parker also included night eating.

Slightly differing from Mr. Parker's response, Ms. Jenson stated that St. Johnson students are taught that if thoughts of image and food consume their lives and if they cut out groups of foods, then perhaps this is a way to know that a person has gone beyond the line of caring about their image in a 'normal' way. For example, people with eating disorders may "restrict food groups—carbs, meat, sugar, [or] gluten" (Jenson). In addition to restrictive habits, Students are also taught to watch for intrusive thoughts, as that may be another indicator of an issue. Also different than what Rushmore students are taught, Ms. Jenson shared that St. Johnson students are taught that you cannot tell if a person has an eating disorder merely by looking at them. Like at Rushmore, however, students at The St. Johnson School are taught that people with eating disorders will often deny their situation, but that that is not always the case. Both The St. Johnson School and Rushmore High School teaches students that treatment for eating disorders varies based on the person, and that there is no one set plan for everyone. Ms. Jenson designated in her responses the importance of early intervention for eating disorders (especially anorexia) due to their potential to be deadly.

Ms. Jenson stated that she does not feel that there is anything that is not included in the St. Johnson curriculum (but that should be), nor does she feel that there is anything incorrect or misleading that students are taught about mental health through the cumulative school programming. Students are not assessed or graded on their understanding of the presented material, which greatly differs from Rushmore High School. Also unlike Rushmore, students at The St. Johnson School are not given the

chance to discuss their own mental health during the school programming; the same element of group discussion is not had.

Prior to the mental health programming that St. Johnson students receive at school, Ms. Jenson predicts that students get the majority of mental health information from their friends. "NAMI does a health class presentation that discusses [famous individuals that struggle with mental health]" (Jenson), which may further work to break down the stigma of the formerly taboo topic. To further combat some of the stigmas, The St. Johnson School teaches students that mental health is analogous to emotional health; Ms. Jenson says that although she still believes that stigmas exist among her students, she nonetheless thinks that students are becoming more comfortable discussing these topics. After all, Ms. Jenson believes that open and honest conversations about mental health struggles between students and their parents are the key to normalizing the human struggle (with mental health).

3.3: Interview Results for Smithson Academy

At Smithson, I interviewed Sally Smith; she teaches the Health and Wellness course at Smithson Academy, where she has worked for the past five years. She additionally sponsors two clubs (One Love Foundation and the South Asian Students Association), and teaches two online courses through the Global Online Academy—Introduction to Psychology, and Abnormal Psychology. Upon arriving to Smithson, she completely re-wrote the entire curriculum for the Health and Wellness course, which is a required 30-hour course that all students must complete before their junior year. There is no substitution option for this class, nor can students opt out of the course; thus, all

students at Smithson Academy graduate having learned about "sexual health, identity, advocacy, communication, [and] prevention of risky behaviors (substance abuse, suicide, intimate partner violence)" (Smith), in addition to many other topics.

Like at Ms. Jenson, Ms. Smith has complete autonomy over the curriculum of Health and Wellness, as the Head of Upper School and the Director of Academics has given her the unlimited ability to alter which topics are covered in her course. This dynamic is drastically different than at Rushmore, due to the fact that Smithson Academy is a private school while Rushmore High School is public—and thus subjected to Texas regulations. Since Smithson Academy is not bound by the same state regulations and Ms. Smith can therefore have more control over the curriculum, this allows her to teach "based on neuroscience, best practices, [and] what helps adolescent brains solidify information" (Smith). She uses her own discretion in terms of which sources to present to Smithson students, and can independently select the mediums through which she disseminates information.

Ms. Smith says that the point of her course is to change students' perspectives and their overall experience in high school, and she believes that this aim is effective based on the fact that towards the end of the course, students self-report that they learned a lot. She also believes that the Health and Wellness course has a positive impact on the likelihood that students will seek help for their mental health in the future. Similar to Mr. Parker from Rushmore High School, Ms. Smith also utilizes an analogy to explain anxiety to her students. She further explains anxiety by using scientific information, such as "the neuroanatomy and what is happening biologically (fight or flight) and neurologically when experiencing anxiety" (Smith). Ms. Smith reported that she thinks

that her students are unaware of all of the possible physical manifestations of anxiety, and that they had misconceptions about what panic attacks are; to fight this misconception, she assigns optional readings such as quizzes, research, etc.

As for the causes of anxiety, Smithson Academy students are taught that there are a variety of possible drivers: psychological, biological, sociocultural influences, and environmental factors. Students are also taught how to know the difference between an anxiety disorder and merely experiencing stress, namely that a student may meet the anxiety criteria if their normal daily functions are disrupted due to stress. Ms. Smith tells students that if they are concerned that they may have anxiety, they can meet with her to discuss things; her students are taught about treatment options that are available to help treat anxiety, and that some of the symptoms can potentially be mitigated by a change in mindset. Nonetheless, in most cases, treating anxiety "usually requires the help of a trusted adult" (Smith). As for how students can support their peers, she advises students to respond with encouraging messages such as "I am here for you," "you are not alone in this," "I'm not sure what to say, but I'm so glad you told me," or "can you tell me about it? What helps?" (Smith).

Ms. Smith stated that she teaches her students that anxiety is neither good nor bad, which differs from the message that is taught at The St. Johnson School or Rushmore. Her perspective more closely aligns with that of Rushmore High School, which informs students that anxiety can both be good and bad—not just bad. Her teachings are supplemented by the YAM program at UT Southwestern, which comes to Smithson Academy to teach students for five days during the Health and Wellness course. In addition, students are provided with additional resources on class websites (through

Smithson Academy), and given references to external websites with accurate information. Ms. Smith says "about 15% of students will experience symptoms of a mental health disorder," and that symptoms of anxiety can begin to show as early as elementary school. She believes, however, that the percentage of struggling students fluctuates based on the intensity of the school that kids attend.

Like with anxiety, Ms. Smith also teaches students about neuroanatomy and the neurological events that occur when someone has depression. She teaches her students that the same four broad categories of psychology, sociocultural influences, biological, and environmental factors are also the causes of depression. Smithson students are taught that if they feel that they have sadness that "interferes with… daily functioning and [they] are experiencing certain symptoms, [they] might meet the criteria for depression" (Smith). Ms. Smith feels that this is the easiest way to describe to students what they should look for, as the signs can begin to show in elementary school. To further help students, Smithson has guest speakers come speak—like at Rushmore. For example, UT Southwestern YAM provides insightful information about depression, and provides several readings (such as brochures) for Smithson students. These brochures explain the connection between depression and suicide, whereby "when depression become[s] severe, it is common for adolescents to have suicidal thoughts" (Smith).

Smithson Academy students are taught about the variety of resources they can lean on to combat feelings of depression, in addition to the differing types of treatment that are available. Like anxiety, Ms. Smith teaches that depression also usually mandates that a trusted adult be involved in order for a kid to overcome depression. As depression is presented as a condition that is not a choice, Ms. Smith emphasizes that students can

still work to change their mindsets, and therefore alter how they may be feeling. Also like anxiety, Ms. Smith teaches her students that depression is neither good nor bad—which slightly differs from the messages provided at Rushmore and St. Johnson. Finally, Ms. Smith advises her students to respond with encouragement to a friend who may be suffering, like how both Rushmore and St. Johnson students are also advised.

Smithson Academy takes a very different approach to teaching bipolar disorder than do Rushmore or St. Johnson; it is not included at Smithson, except when talking briefly about suicide. Ms. Smith said that the only exception to this generalization, however, is if a student specifically asks about bipolar disorder. Thus, this omission of information leaves students with a gap of information that students at both St. Johnson and Rushmore *are* provided in school. Ms. Smith explained that there are two leading reasons that bipolar disorder is not included in the Health and Wellness class; first, the course has limited time, and thus only so much information can be covered in class. The second reason that the class does not cover bipolar disorder is because the "average age of onset is 25" (Smith), meaning that bipolar disorder is something that the majority of students do not face while in high school. An additional topic that is not discussed in the Health and Wellness course at Smithson Academy is the range of drugs that are used to treat mental health; students are, however, taught about SSRIs, and how they affect the brain. Nonetheless, Ms. Smith's reasoning for omitting this information is because if a student were to take any of these medications, they would first have to have a formal appointment with a doctor—at which point students would be given all of the information about mental health drugs that they would need to know. This may include whether the drugs are addicting, dangerous, commonly prescribed, etc.

At Smithson Academy, the topic of eating disorders is introduced to students in a way that is even more inclusive than at Rushmore or St. Johnson; at Smithson Academy, Ms. Smith teaches her students how "EDs can affect anyone… [even] students who are gender fluid or not on the binary." Both faculty members from Rushmore and St. Johnson acknowledged that eating disorders are not limited to merely one gender, however neither Ms. Jenson nor Mr. Parker mentioned gender fluid or gender nonconforming individuals in any of their responses (about eating disorders, or any other topics). However, like both Mr. Parker and Ms. Jenson, Ms. Smith also teaches her students that professional medical treatment is required for individuals battling eating disorders. She explains to her students that eating disorders can begin for a student as early as elementary school, and that they are "the most lethal mental health disorders." Smithson Academy students are taught that contrary to what most people think, eating disorders actually are not about the food; rather, they are a response to environmental, sociocultural, biological, and psychological factors. Rather than specifically labeling or limiting the types of eating disorders like St. Johnson or Rushmore does (ex: anorexia, bulimia), Smithson Academy uses more broad terms: "feeding and eating disorders" (Smith). To better explain the variety and complexities of eating disorders, Ms. Smith shows students a video. This particular video also outlines what types of things people with eating disorders will consume.

Like Ms. Jenson (from St. Johnson), Ms. Smith also teaches her students that there is not a physical shape or trait that is indicative of having an eating disorder; an individual can be "any shape, any size, any race, [and] any gender" (Smith). Further, the treatment that is required for each individual suffering from an eating disorder looks different, as it "depends on the frequency and intensity of symptoms" (Smith). Smithson

Academy students are taught that the best thing they can do for a friend that they are concerned about is to encourage them to speak with an adult, and that their peers may often deny accusations of disordered eating (and even become angered). Facts such as these may or may not have been familiar to Smithson students prior to taking the Health and Wellness Course, where the majority of prior knowledge is estimated to have come from the Internet.

Ms. Smith suggested that this course should be taught again when students are in 11th or 12th grade, in order to refresh and expand upon the health information "with [a] curriculum that is developmentally appropriate for that group" (Smith). She also said that she wishes that she had more time with students. There is nothing that she teaches her students that she thinks is wrong or misleading—which is not surprising, seeing as she designed the curriculum for the Health and Wellness course herself. When asked for the context, Ms. Smith also provides students with information about which celebrities struggle with their own mental health. Though the class is currently assessed on a pass/fail basis, Ms. Smith has thought about changing this form of evaluation in the future.

Like at Rushmore High School, Students are given the opportunity to discuss their own mental health in class. She said that in her class, many students openly self-disclose to their classmates when they are struggling with a mental health disorder if relevant; the curriculum encourages students that "'it is okay to share' their experiences and struggles." Conversations regarding mental health at Smithson Academy have come a long way in the five years since Ms. Smith re-designed the curriculum, as she informed me that "students openly talk about suicide, depression, OCD, anxiety, [and] EDs during

senior speeches" (Smith), which are given weekly in front of all high school students and faculty members.

CHAPTER 4: My Analysis

4.1: My Analysis of Rushmore High School

Because Rushmore is a public school and must teach in accordance with state statues, this means that Mr. Parker (in addition to all other public schools in the state of Texas) are relatively bound to a set curriculum. This limitation may be problematic, however, if the state cannot keep up with new scientific discoveries, thus meaning that the most current or advanced information may not be included in the health curriculum state-wide.

Nonetheless, Mr. Parker still has the latitude to add to the curriculum in whichever way he chooses. This opportunity is extremely powerful for public schools, especially given the context of state requirements; this window of choice allows for schools to perhaps introduce information or concepts that they feel are not adequately covered by the state requirements, and thus ensure that their students are properly informed about important topics. The danger with this open window of opportunity for any public school, however, is that perhaps not all teachers at public schools across the state will choose to take advantage of their ability to enhance the curriculum. Or, perhaps the window of choice could be filled (by teachers) with incorrect or insignificant information, thus wasting the opportunity of further impact.

Mr. Parker noted that he asks (professional) community members to come speak with his class; by bringing in community members and fostering conversation between adults and students about a formerly taboo topic, I believe that this exercise normalizes topics of mental health, and likely works to break down the stigma associated with conversations of mental health. The broad engagement also may demonstrate to students

how common some of the disorders are among humans, in addition to demonstrating to students the wide net of resources available to them beyond the classroom.

Rushmore students are taught that whether or not anxiety is a choice "depends if the anxiety is recognized and manageable" (Parker). When I learned this, I thought it was very interesting. I can understand why each perspective might be taught to students about whether or not an individual chooses to have anxiety, however, I wonder if this approach also undermines the severity of reality that many people with anxiety face—in which resolution is not as simple as merely recognizing that they suffer from anxiety. For example, it can take years of therapy and hard work in order to regain some element of control over one's life that felt previously dominated by anxiety, and the mere realization of anxious symptoms is not itself a cure to struggling. This may be a potential risk of presenting anxiety in terms of a partial choice.

While reading about how anxiety is taught to students—more specifically, about whether or not anxiety is a choice—I noticed that I personally became slightly upset. My response was a reaction based on my own personal experiences of feeling that my peers did not understand what it felt like for me to have anxiety, and being constantly told that I could choose for my anxiety to go away. When I sat with the feelings of discomfort and tried to understand why it bothered me so much for students to be taught that they have some potential control over anxiety, I realized that a great deal of my frustration stemmed from my opposing experience of feeling that I did not have control over my anxiety at the time (even though I wished I had). I think that by presenting anxiety in this way, students run the risk of incorrectly understanding the complexities of anxiety. One potential risk of

students concluding that anxiety is a choice is that this conclusion may have negative impacts on many others, like it did for me.

These expectations—for example, that people should be able to control their anxiety and make it go away if it is recognized—may feel unfair and even impossible for some based on their vantage point. I can understand (and appreciate) the positive outlook that students are taught to have on anxiety… however I feel that this approach is also potentially harmful and destructive for students who may have anxiety disorders they are unaware of (like me), and who then develop inner frustration with themselves because their experiences do not align with those discussed in class. This made me wonder about the proper balance when teaching whether anxiety is a choice, so as to empower people to feel that they are capable of overcoming obstacles yet while not marginalizing people who feel that they cannot.

With respect to the questions of who has an eating disorder and what their physical size may be, I was hoping to find responses that emphasized the fact that one's size is not a predictor of whether or not that person has an eating disorder. It is very possible that this message *is* conveyed (or even emphasized) in the Health Education course, but I am not unquestionably convinced—from the interview responses alone—that this message is passed on to students. Personally, I think that it is very important for students to understand that merely because someone is larger does not mean that they do not suffer from an eating disorder, and likewise, that people can be extremely skinny and have no cognitive issues with food. This is a misconception that I feel many of my peers and I had that was never clarified by school, so I specifically included question 18j to try

and discover whether or not this misconception is specifically targeted by schools' curricula in 2018.

4.2: My Analysis of The St. Johnson School

Ms. Jenson stated that she believes that students are able to make the distinction between when they are merely stressed, versus if they have an anxiety disorder. Personally, when reading this response I felt a bit discouraged—though she is not wrong about the distinction, it is my opinion that not all students have the perspective to properly make this distinction. I know that I, for example, was not able to make the distinction, and neither were many of my peers. Thus, I think that one risk of assuming that students can make the distinction on their own, is that students may slip through the cracks who are in need of help, but lack the perspective to recognize that themselves. For that reason, perhaps students would benefit from having distinguishing factors explicitly outlined so that students are better able to realize if they are struggling.

Ms. Jenson mentioned that students are advised not to give their peers advice who are severely struggling; I though that this was a very interesting perspective, yet also a very insightful approach. It is my belief that Ms. Jenson is referring to the complexities of psychological disorders that cannot be understood (or empathized with) by peers who do not share their struggles. For that reason, perhaps St. Johnson is onto something by discouraging students from inserting their opinions in complicated matters that they cannot understand (no matter how much they may want to). Topics of mental health can

be very personal, so perhaps St. Johnson is wise to dissuade students from butting into their peers' personal matters.

Though I may be reading too deeply into Ms. Jenson's comment about who gets eating disorders, I thought it was interesting that she gave a different answer than Mr. Parker—yet each was only a sentence long. I wonder if this has anything to do with the fact that Mr. Parker is a man and therefore is more aware of the issues that young males (in high school) face, or if rather this is a function of the fact that he regularly teaches this information and therefore has refined an equal answer irrespective of his own gender. That being said, however, Ms. Jenson also acknowledged that both boys and girls can have them, so she is not in any way wrong. Thus, in no way am I criticizing Ms. Jenson's answer, as I would have had the same response that she did; I just think it is interesting to briefly consider how her answer differed from that of Mr. Parker. One risk of assuming that the educators gender impacts how the information is taught, however, is that comparing Ms. Smith's answer to the two aforementioned responses would challenge this conclusion.

I really liked Ms. Jenson's mathematical analogy to support St. Johnson's teachings of whether an eating disorder can ever go away; she said "much like an addition it will be something that you always need to be vigilant of, even when you are in recovery" (Jenson). By using a mathematical reference to an extremely accessible concept (of addition), this inherently creates a mental image to help students more concretely comprehend her point. She is the only one that made such a reference, but I thought that it was very powerful, and I predict that it goes a long way in terms of resonance for students. The tactic of creating visual images for students to mentally view

is very creative, and is one that I think Smithson Academy and Rushmore High School should strive to implement as well.

Ms. Jenson shared that students at The St. Johnson School are taught that you cannot tell if a person has an eating disorder merely by looking at them; I was very happy to read that students are given this perspective, as I certainly was not taught that when I was in high school. I think that this is an extremely important message, and one that I think might have changed my own trajectory had I known that I did not have to be a twig in order to classify as having a disorder. The way that St. Johnson students are informed about the relationship between size and classification successfully works to combat the misconception (that many people share) that one must be incredibly skinny in order to have a legitimate problem worthy of seeking help.

In my opinion, the information that is taught in this course does not seem to be impacted by the fact that St. Johnson is a Christian school—which is different than what I predicted I could find. That being said, however, it is important to note that the information about The St. Johnson School must be carefully compared to that of Rushmore and Smithson Academy due to the fact that Ms. Jenson (who completed the interview) is not the predominant teacher of a high school health course.

4.3: My Analysis of Smithson Academy

Ms. Smith mentions gender fluidity and non-binary in her responses; her word choice and discourse speaks volumes to the environment that Smithson Academy provides for its students, such that these topics are bluntly mentioned to students. Topics of gender and sexuality can be very controversial, yet Ms. Smith's words normalize the

differences among people that students may not have previously been exposed to. Thus, though my interview did not ask about gender fluid students or sexuality, the fact that Ms. Smith speaks with these liberal and inclusive terms suggests that Smithson Academy has an element of unmatched acceptance and inclusion that is not had at St. Johnson or Rushmore.

I believe that the decision to omit information about bipolar disorder can have very drastic (and negative) impacts on students in the future; although students may not face the disorder while in high school, omitting the information leaves students unknowledgeable about a common condition that will indirectly affect their life in some way—whether they develop bipolar disorder later in life themselves, or whether they have a friend or spouse dealing who struggles with the condition. Thus, I personally believe that it is important for all students to learn about bipolar disorder, even if they may not be dealing with it during high school.

Similarly, I think that there is also risk of omitting the majority of information about drugs that can be used to treat mental health conditions. No, students do not need to know the name of every drug and what each one does; however, by discussing their usage in class, perhaps students would not be as fearful or skeptical of using them in the future. For example, if students were informed of how commonly they are used, and the positive monumental impacts that the drugs can have, perhaps students would not feel shame about trying them. Thus, this could potentially snowball into students having an accelerated recovery period once they are already in treatment for a mental health disorder.

Overall, I think it is interesting to consider how Ms. Smith's responses differ from those of Rushmore or St. Johnson, and how much of the discrepancy may be due to the fact that Ms. Smith is trained as a professional psychologist. It is not unreasonable to assume that this additional education helped to shape her approach to topics of mental health, in a way that neither Mr. Parker nor St. Johnson faculty members experienced. This theory is obviously not bulletproof, as other schools also bring in guest speakers that are professional providers in the city; nonetheless, these guest speakers are not the predominant educators for the majority of the course.

Additionally, on the note of being a licensed psychologist, her training likely impacted the way that Ms. Smith chose to structure the Health and Wellness curriculum at Smithson Academy. Her additional framework and knowledge certainly enriched the Smithson curriculum, and provides an interesting frame for comparisons between Smithson Academy and The St. Johnson School—both of which are not bound by state regulations, like Rushmore is. It is possible that her enhanced perspective would have also manifested itself in the curriculum even if Smithson Academy was public (and therefore bound by regulations), but this cannot be known for sure because those research conditions did not exist.

Finally, it is interesting to consider how students are graded in this course: on a basis of pass/fail. This form of grading offers potential benefits and disadvantages. One benefit is that time is not wasted conducting formal assessments, and can instead be used as additional hours for instructional activities and lessons. A second benefit is that perhaps students will be more engaged with the information if it does not feel like a chore, and will actively take part in their own education because it feels like a choice; this

same potential upside, however, is also a potential disadvantage. If students know that they will not be given formal assessments on what is covered in class, then perhaps they may feel that they don't need to actually pay attention to the material being presented. This would be very detrimental to the development of a society that is well-educated about topics of mental health, and who are ideally able to care for themselves and others.

4.4: Limitations

My research has its limitations, and it would be improper for them not to be explicitly stated. First, the sample size; my interview research only includes three schools, which (by many standards) is a very small number of subjects. The limited number of schools does not for any reason indicate that the information I collected is inaccurate, nor does the limited sample size mean that the three schools are not reflective of the type of curricula a Dallas student might experience. However, the limited sample size does mean that I could only make a controlled number of comparisons among what I gathered, and that each element of a curricula only has three supporting examples. For that reason, the data cannot be broadly applied . Additionally, the small sample size means that I am very unlikely to have an accurate representation of all Dallas Schools. The limited sample size is partially a result of resources, and of needing to have a narrowed scope for my thesis. The TA of the thesis course reminded me of the necessity of a narrowed scope, as my initial thesis idea would have likely been over 400 pages long.

The second limitation was time—the time for the thesis schedule, and the time of my subjects. For example, I had less than one year to create, submit, disseminate, collect,

analyze, and write the interviews/research for my thesis; as a result, I was forced to maintain a more focused approach to my project, and was not able to include as many peripheral variables and aspects. I had to limit how much time could be spent for each phase of my thesis, in order to ensure that I would complete the project on time—and in a solid manner that reflects the pride I hold for my worth ethic and products. But not only was it my time that was limited due to the school year, but I was also limited by the amount of time I acquired from subjects. This limitation of their time forced me to shorten the interview, omitting interesting points and preventing me from gaining all of the information I had originally hoped for. It is also possible that the quality of the interview results suffered due to their time limitation, as I have no way to know whether the interviewees rushed to complete the questions, or rather sat down with an unlimited time crunch. Had the interviews been conducted over the summer or during a different time of the school year, it is possible that I would have gotten more or less specific answers to the very same set of questions.

The third limitation to be considered is the unusually high level of economic resources that each of the three included schools enjoy. For that reason, these schools most likely have access to more learning aids than a low-funded school in the same area. This resource difference is important to note because the economic standing of the three schools means that their data is quite possibly not representative of all Dallas schools at large. The same limits of generalizing would have been true, however, had I instead looked at three public schools in Dallas that were in impoverished areas, or that notoriously performed at lower levels than its counterparts in the district.

Because each of the included schools notoriously perform above average and have high funding, this may also affect what information is taught; because the students who attend the three schools are not high-risk, perhaps this leads teachers to conclude that certain concepts or topics do not need to be drilled into the students as hard.

The fourth limitation can be understood by considering how the interviews were conducted— digitally through a computer screen. The digital aspect of the interview results in potential ambiguity of responses, or misunderstandings that result from being unable to speak face-to-face with the teachers. Had I been in person and was able to ask follow-up questions or restate what I heard, then perhaps some of my misunderstandings regarding the curricula or their responses could have been cleared up. Thus, like an interview, there remains the possibility that I incorrectly understood or interpreted what one of the teachers was trying to communicate. Additionally, because I was unable to break the ice by interviewing the subjects in person, the interviewees may have been more guarded and brief when answering the questions because they may not have felt comfortable sharing certain pieces of information with me. Whereas if I would have been face-to-face, perhaps I could have calmed some of their concerns, and therefore decreased the limitation of anonymity.

Additionally, interviewees may have been negatively affected by the amount of labor I asked of them, by hand-typing their responses rather than merely being able to speak aloud. This aspect of digital interviews may have limited the responses I received, making them more brief. There is also an element of permanence that is associated with technology and typing, as many worry that their answers will be "out in the world

forever." This fear may have led interviewees to leave out details that they would have shared verbally, yet felt discomfort about putting into writing.

The fifth limitation that I encountered quite often was confidentiality. In order to meet IRB regulations and remain fully ethical, I was unable to ask some of the questions that I wanted to include, and had to modify the methods through which I collected information. I also wanted to ensure that I was not publically criticizing any individual or their performance at their job, so I went to extra lengths to protect the identities of participants—even if that meant omitting other important data that would have been extremely insightful or transformative. Had I not had to worry about adhering to such strict guidelines and my own moral objectives, perhaps I would have gone about doing my research differently, and sought out different types of evidence.

The final limitation that I encountered was transparency; educational institutions are barred by such strict guidelines, which I suspect contributed to the level of information I was given. I also have to assume that each teacher is telling me the truth, and is not reporting to include an entire topic or activity that is not actually taught to students. Also, just because a certain message is said aloud in class, I cannot assume that all students of the school adopt the same mindset; for example, though a teacher may mention "gender non-conformity" without judgment, there is no guarantee that students fully buy into that perspective. Students could instead remain extremely judgmental and oppressive to certain groups, meaning that the school's teachings may not accurately reflect the environment achieved by the particular school. Or, another possibility is that a teacher reports that students are taught to think in terms of ABC, but in reality, are actually taught CDE. There is no way to know for sure whether the teachers' responses

are completely truthful, and if they accurately represent the academic institution for which they work.

CHAPTER 5: Summary and Wrap-Up

It is crucial that mental health education is effectively taught to high school students, for many reasons. First of all, not all students have the means or desire to attend college; thus, for many students in the USA, their formal education ends at the age of roughly 18 when they graduate high school. Assuming that these students do not go back to school, this means that schools (and educators) have until the age of 18 to impart upon students the essential information that is needed to be a healthy individual. For that reason, it is very possible that a high school health class is the last opportunity for formal instruction about such important topics. As a society, we should not allow for individuals to graduate high school without being introduced and equipped to the skills necessary to upkeep their mental health. This requirement affects not only relationships for the students, but also their career prospects, happiness, and so much more. Society cannot afford for students to graduate from high school without being thoroughly exposed to and informed about a universal experience: that of human mental health.

In summary, in the previous chapters, I designed and conducted a research project in order to gain a better understanding of what the mental health curriculums look like in three different Dallas high schools. These schools have many similarities; all three schools are co-ed, their students come from stable economic backgrounds, and each offers a variety of sports and activities. Nonetheless, there are also two main distinctions that differentiate the three schools from each other: whether the school is a private or public institution, and whether the school is secular or non-secular.

First, lets consider a school's classification of being either private or public. The initial reason that this distinction is important is because it dictates how much latitude a

given school has in designing their own curriculum. Faculty members at the two private schools (St. St. Johnson and Smithson Academy) have complete control over what is taught and in what way, and are not bound by the government statutes of education requirements; public school educators (like at Rushmore High) do not have this same ability. For example, if Ms. Smith decided to play bingo in her class every single day rather than to teach topics of mental health, there would not be governmental consequences; the same is not true for Mr. Parker, however, who would face consequences from the state/government.

Thus, it seems (from my research) that it is logical to conclude that public school curriculums are more likely to include a broad range of information in order to comply with state regulations. This conclusion is supported by Rushmore's wide range of topics, whereas the Smithson Academy curriculum does not cover certain topics—such as bipolar disorder or prescribed drugs for mental health disorders. However, this mandate of widely covering topics is not bullet proof in terms of securing high quality education, as there is no guarantee that each topic is covered in depth due to how the regulations are written. The state regulations are quite broad, and leave open many avenues for how to approach the topics. While this broad quality is great in that it allows for educators to be creative and present the information in the avenue they believe will have the most resonance with students, this broadness can also be a slippery slope for ensuring that things are thoroughly taught to students.

A second place where the public versus private classification seems to make a difference is in the assessment format. While Rushmore is required to assess students with a grade, Smithson Academy does not have this same requirement; instead, Smithson

Academy decided to make Health and Wellness a pass/fail course. This difference (in grading) may have an impact on how well the information is absorbed or learned, based on whether students felt that they had the pressure to understand and internalize the material that the class is presenting. If students do not take the course/programming seriously, the result is that students are exiting high school without essential knowledge that will be directly applicable to their daily lives for the remainder of their life. This possibility is a major risk, and is one that threatens the success of teaching students the essential information that they need.

A third difference between public and private schools is whether or not a health course is even offered; while topics of mental health are taught to students at all three schools regardless of the school's classification of being public or private, institutions that are privately funded (and not bound by government regulations) are not required to even have a formal course. To illustrate this point, consider how The St. Johnson School does not have a formal "curriculum," and instead exposes students to health information through programming activities. This does not mean that no private schools use a formal class setting, as demonstrated by Smithson Academy.

There is a fourth difference between public and private institutions that I did not specifically encounter in my research, but that would have been present had the subset of researched schools been slightly different: funding. Private schools are funded by private money in the form of tuition bills and donations, whereas public schools are funded the government and citizen tax dollars. Thus, this discrepancy makes possible that some public schools are left with significantly less resources than are private schools. This discrepancy can manifest itself not only in terms of the quality of instruction given to

students, but also in terms of the resources that students have access to both at school and at home. Nonetheless, I did not encounter the ramifications of this distinction based on the three schools that I studied, since all three schools are extremely well-funded.

Changing directions, lets now consider whether a school's curriculum appears to be affected by its status of being secular or non-secular. Based on my research, it does not seem that this classification has a direct impact on what students are taught. Students at all three schools (no matter if the school is secular or non-secular) are taught about the scientific and environmental causes of disorders, and never was a religious term or concept mentioned. This is the conclusion that I was expecting that I would reach, and that I would not find that students are taught (at a non-secular institution) that prayer is the remedy for psychological conditions/disorders. Thus, my prediction about secular and non-secular schools was correct among the three schools that I studied, but it is absolutely possible that I would have reached a different conclusion had I included a different subset of Dallas schools.

Though I wish it were within my wheelhouse to make recommendations for how topics of mental health could be more meaningful taught to students, I am not educated about developing educational curriculums. Additionally, I also lack enough knowledge about the psychological experiences of high school students to make insightful suggestions about which methods of teaching would be most effective; thus, the intent of this thesis was not to "fix" or change any of the curriculums. Rather, the goal was to discuss and compare how three different schools approach these topics in order to highlight elements that are great, in addition to elements that pose potential risks.

Overall, I do believe that the curriculum has greatly improved since I was in high school. Perhaps this is because I am differently analyzing the information now that I have a more refined perspective (as a 22 year old, who is passionate about mental health) than when I was 14 and felt invincible; or, perhaps this is because the information is being presented in more effective ways today. I cannot assert with confidence which of the two is the predominant explanation for why I prefer the curriculums today than the one I received myself, but I predict that it is a combination of the two. Nonetheless, although there will always be some parts of the curriculum (and the way that it is taught) that can improved upon, I can say with confidence that I think that schools are moving in a positive direction with respect to mental health education. A prime example of this progress can be seen in Ms. Smith's comments, where she discusses gender as being fluid or non-binary. If all other schools do not already present students with this perspective, I believe that this thinking will soon be—which is a great achievement for society.

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APPENDIX

Adelman, Howard, and Linda Taylor. "School Mental Health Project ." *SMHP Psych UCLA*, smhp.psych.ucla.edu/powerpoint/mentalhealth/Handouts1.pdf.

This Powerpoint (uploaded to the web) outlines the thoughts and studies of the UCLA Psychology Department, specifically under the provision of Taylor and Adelman. The School Mental Health Project collected a lot of information that generally describes the landscape of my thesis topic, and this Powerpoint provides references to their specific books that provide further detail.

"Counseling and Mental Health Services of the Coordinated School Health Model." *Counseling and Mental Health Services of the Coordinated School Health Model*. Texas Education Agency, 2017. Web.

This webpage lays out rough requirements for teachers and schools in the state of Texas relating to personal and mental health. The specifics are laid out for each age level, and this helps provide a 30,000-foot view of the curriculum layout mandated by state education. Also heavily discusses suicide prevention, and offers many resources targeted at this aim.

Durlak, Joseph A., and Anne M. Wells. "Primary Prevention Mental Health Programs for Children and Adolescents: A Meta-Analytic Review." *American Journal of Community Psychology*, vol. 25, no. 2, 1997, pp. 115–152., doi:10.1023/a:1024654026646.

This journal article discusses the process of conducting experiments surrounding mental health, in addition to their accuracy and documentation. More specifically, this article discusses a Loyola University experiment surrounding the effects of primary prevention (for mental health).

"Home MHATexas." *Mental Health America of Texas*, Mental Health America of Texas, 2017, www.mhatexas.org/.

This URL goes to the home page of a not-for-profit organization whose headquarters are in Austin, Texas. There are many tabs, articles, and further information that can be reached through hyperlinks on this page. This organization is a gateway to accessing pertinent information about important mental health topics, and current legislatures in place in Texas. More specifically, the 85th legislature.

"Home—Texas Coalition for Healthy Minds." ***Texas Coalition for Healthy Minds*****, Texas Coalition for Healthy Minds, 2017, www.coalitionhealthyminds.org/.**

This URL leads to the home page of a large advocacy group in Texas that aims to prevent and combat mental illnesses, in addition to substance abuses and disorders. There are many further links and resources listed on this page, and features persuasion for constituents to contact state representatives.

Specht, Jacqueline A. "Mental Health in Schools." ***Canadian Journal of School Psychology*****, vol. 28, no. 1, Apr. 2012, pp. 43–55.** ***SAGE*****, doi:10.1177/0829573512468857.**

This journal article discusses research about how inclusion primes and worsens mental illnesses experienced by children who feel excluded in a school environment. She carefully explores and describes the connection between mental health, and a child's experience in school. Specht proposes in her article that as a result of her research, perhaps the solution is that perhaps school counselors should alter their roles/duties in order to benefit students.

BIOGRAPHY

Haley Ablon was born in Dallas, Texas, and has lived the majority of her life in Texas—with sporadic periods of time spent in Europe. She enrolled in Plan II Honors in August of 2014 after graduating from her high school, and has since enjoyed various disciplines of study. She was very involved with Alpha Epsilon Phi throughout college, and held many leadership positions within the organization during her four years of involvement. Haley is staying at The University of Texas for Law School.