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I, Skyler VanMeter, hereby submit this original work as part of the requirements for the degree of Doctor of Philosophy in School Psychology.

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Group Acceptance and Commitment Therapy for Challenging Classroom Behaviors in an Alternative School Setting

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Group Acceptance and Commitment Therapy for Challenging Classroom Behaviors in an Alternative School Setting

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by

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Abstract

With youth currently experiencing elevated rates of mental and behavioral health concerns, the need for flexible and cost-effective interventions in schools is at an all-time high. This need is even more pronounced in alternative education settings, where students may be at higher risk for adverse outcomes if not adequately supported. Acceptance and commitment therapy (ACT) is one increasingly popular intervention in these settings, yet relatively little is known about its capacity to impact directly observable classroom behaviors, especially when administered in a group format. At present, existing studies on ACT in educational settings have focused primarily on internalizing problems, relied on indirect measures of behavior, or utilized individual therapy, which may be time- or cost-prohibitive. Considering these gaps in the literature and the growing need for school-based providers to understand the uses and limitations of the tools available to them, the present study aimed to investigate the effects of weekly ACT groups on directly observed classroom behaviors in an alternative education setting. Results of the study indicated that although the intervention was viewed favorably by group participants, a functional relation between the intervention and the level of classroom behavior was not observed. Limitations, implications for practice, and recommendations for future research are discussed.

Acknowledgement

In the book *A Liberated Mind: How to Pivot Toward What Matters*, ACT pioneer Dr. Steven Hayes describes the relationship between values and vulnerability with the simple phrase, "we hurt where we care, and we care where we hurt." Although we rarely think of it this way, the act of caring demands that we open ourselves up to the potential for negative emotion. Similarly, negative emotions are often a good indicator that something we care about is on the line.

During my training, I, like many graduate students, experienced my fair share of negative emotion. I worried that I wasn't smart enough, that I wouldn't overcome the challenges that came my way, and on the worst days, that our systems were just too broken to fix. As each of these thoughts bubbled to the surface, I found myself wanting to lean away, sometimes even to quit. With the help of family, colleagues, faculty, and supervisors, however, I have come to realize that in this field, it's okay—maybe even important—to be a little vulnerable. After all, this work matters, and none of us would pick someone who didn't care about it to do it.

With that said, this acknowledgement is more than a thank-you for the support that got me to this point in my training, this is a thank-you for helping me to find the courage to pursue a career that puts me in contact with my values, with all the vulnerability that it may bring. To my advisors, Dr. Renee Hawkins, and Dr. Lori Vincent, and to my third committee member, Dr. Rachel Saunders, thank you for your unrelenting commitment, guidance, and patience. To my field supervisors, Heidi Raney, Elizabeth Wagner, and Dr. Nathan Fite, thank you for challenging me and providing me with such strong role models for effective practice. Mom, Dad, Emily, and Sarah, thank you for the sacrifices, long phone calls, laughs, and love. To all who have been part of the journey, named and unnamed, I owe you more than an acknowledgement—I owe you a career.

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Group Acceptance and Commitment Therapy for Challenging Classroom Behaviors in an Alternative School Setting

Over the last several years, the state of youth mental and behavioral health has drawn increased public attention. As noted in the U.S. Surgeon General's 2021 mental health advisory on this issue, today's children and adolescents have been exposed to a wide range of potential stressors including the COVID-19 pandemic, highly publicized instances of sociopolitical unrest and mass violence, and a variety of novel interpersonal challenges unique to the modern era (e.g., increased dependence on social media; Office of the Surgeon General, 2021). While the full longitudinal impact of these factors is unclear, youth have already begun to demonstrate elevated rates of anxiety, depression, and behavioral problems (Cameron et al., 2020; Patrick et al., 2020). Given this trend of rising need and the fact that many families lack consistent access to mental and behavioral healthcare, it is becoming increasingly important for schools to support students in these areas. At present, nearly a quarter of youth who receive mental health services do so through their school (Duong et al., 2021), a number which only seems likely to increase in the coming years.

When schools fail to provide adequate support and outside services are not easily accessible, youth mental and behavioral health problems can become functionally impairing and may give rise to negative long-term consequences. Unaddressed internalizing problems (e.g., anxiety and depression), may render students less likely to graduate high school or attend college and more likely to engage in self-harm or attempt suicide (Duschene et al., 2008; Ferguson & Woodward, 2002). Similarly, unmitigated externalizing problems (e.g., disruptive behaviors, defiance, and physical aggression) have been associated with diminished student engagement, poorer teacher-assigned grades, and increased likelihood to have encounters with the criminal justice system (Broidy et al., 2003; Oliver et al., 2020; Zimmerman et al., 2013).

Further compounding student risk, research indicates that students affected by internalizing and externalizing problems often exhibit comorbid symptom profiles, exposing them to both a broad range of adverse outcomes and potentially more static developmental trajectories (Wilner et al., 2016). Comorbid presentation of internalizing and externalizing problems may also complicate school-based support, prompting staff to implement multiple distinct interventions (e.g., contingency management and cognitive behavioral therapy) to effectively meet students' needs. Although this approach can be effective, it may also become cumbersome and prohibitively resource-intensive in settings like schools, especially as more students begin to require this level of support (Moore et al., 2022; Shernoff et al., 2017).

While many at-risk students attend traditional schools, those at the highest risk of adverse outcomes are often placed in alternative education settings, typically already qualified for special education services under an eligibility category such as emotional disturbance (Foley & Pang, 2006). Although these settings may be better equipped to accommodate students with more complex needs in some ways, they also face unique challenges. Some studies have indicated, for example, that students in alternative schools demonstrate lower rates of school attendance and earn less credits per semester than their peers in traditional settings (Wilkerson et al, 2016). As one might expect, these barriers can undermine intervention efforts in these placements, as students must typically be in regular attendance to receive therapeutic services and earn sufficient credit to graduate.

When these unique challenges are considered in conjunction with other factors affecting educational settings more broadly (e.g., staff turnover; limited time, space, and funding), there appears to be a growing need for research into the effectiveness, indications, and contraindications of commonly used therapeutic interventions so that settings like alternative

schools can maximize outcomes for students with the highest risk behaviors in spite of common institutional barriers.

Acceptance and Commitment Therapy

One increasingly popular intervention that may be suited to address a wide range of mental and behavioral health concerns in schools is acceptance and commitment therapy (ACT; pronounced as the word "act"). ACT is a "third-wave" behavioral therapy which seeks to help individuals increase their psychological flexibility—the ability to live in the moment, direct attention flexibly, and engage in positive behaviors without being preoccupied by thoughts or feelings (Hayes et al., 2004).

Compared to traditional cognitive behavioral therapy (CBT), the most widely used evidence-based strategy for many internalizing problems (e.g., depression and anxiety), ACT differs in that it does not teach individuals to try to regulate or reappraise thoughts or feelings, but rather to "accept" that negative thoughts and feelings occur and that trying to control them is often ineffective or counterproductive (Ciarrochi & Bailey, 2008). As one learns to accept that struggling to moderate their experience rarely reduces symptoms, ACT proposes that rather than continuing to struggle, individuals should instead "commit" to values-based action (i.e., engaging in behaviors which function in service of their ideals; Hayes et al., 2004). ACT also differs from traditional behavioral interventions in that it more explicitly emphasizes the role of private events (e.g., thoughts and feelings) in the maintenance of maladaptive behavior and seeks to teach more flexible ways of relating to these experiences accordingly (Collard, 2019; Hayes & Hofmann, 2017).

Although the goals and assumptions of ACT may differ from traditional CBT, sessions of these two modalities are often similar in structure. A typical ACT program, for example, may

contain lessons dedicated to psychoeducation (i.e., learning about how people learn, think, and behave), exercises (e.g., clarifying values), and opportunities to practice specific skills (e.g., mindfulness and "defusion"). Given that ACT encourages new and potentially challenging ways of thinking about thoughts and feelings, one unique feature of ACT is that metaphors are frequently used to illustrate key points (Stoddard & Afari, 2014). Overall, the components of ACT are designed to teach individuals that, a) it is normal to have negative thoughts and feelings, b) humans can learn to face negative thoughts and feelings with openness rather than avoidance, and c), engaging in valued actions, even when negative thoughts and feelings are present, will likely be more fulfilling than avoidance in the long term.

Outside of school settings, ACT has been used successfully to address a variety of mental and behavioral health problems in individuals across the lifespan. One meta-analysis by Bai and colleagues (2020), for example, included studies with participants ranging from ages 7-91 and found that ACT interventions produced significant reductions in depressive symptoms when compared to control groups. Although primarily with college-aged adults and older, another empirical review and meta-analysis by Bluett and colleagues (2014) indicated that ACT performed as effectively as CBT in the treatment of anxiety disorders and obsessive-compulsive spectrum disorders. Additionally, with respect to externalizing concerns and potential antecedents to these types of behaviors, research has indicated that ACT may be effective for reducing both anger among military veterans and physical aggression among incarcerated individuals (Donahue et al., 2017; Eisenbeck et al., 2016).

ACT in Schools

Despite its versatility and increased use over the past decade in other contexts, research on the effectiveness of ACT in school settings is still in its relative infancy. One recent meta-

analysis assessed both the methodological quality and findings of studies on the use of ACT in schools and found that nearly all nine eligible studies were published within the last several years, suffered from methodological weaknesses, and pointed toward inconclusive evidence for the effectiveness of ACT as a school-based intervention (Knight & Samuel, 2022).

The authors of the same meta-analysis, however, proposed that the state of the literature may be in a similar position to what was observed in the early days of CBT, concluding that additional research should be conducted to strengthen future analyses. In the remainder of this section, a brief summary of the literature is provided to demonstrate what is currently known about ACT in schools and to highlight areas of study which may be useful to explore as the field continues to assess the suitability of ACT for school-based contexts.

Internalizing Problems

The majority of published large-sample studies on ACT in schools have targeted internalizing problems. Livheim and colleagues (2015), for example, evaluated the results of two pilot studies using a brief ACT intervention for depressive symptoms and school stress. The first pilot study, conducted in Australia, included 66 adolescent students (ages 12-17) with mild to moderate depressive symptoms. The second pilot study, conducted in Sweden, included 32 adolescent students (ages 14-15) with psychosocial problems such as depression but focused primarily on measuring feelings of school-related stress. Both groups received ACT intervention based on the ACT Experiential Adolescent Group manual (Hayes & Rowse, 2008). Results of the two pilots indicated that the brief ACT interventions were effective. In the Australian study, the ACT group demonstrated greater reductions in depressive symptoms when compared to a treatment as usual control, and in the Swedish study, the ACT group exhibited greater reductions in school stress than the group assigned to the treatment as usual condition.

Another study on the impact of school-based ACT interventions on internalizing problems was conducted by Burkhardt and colleagues (2016). In this study, researchers examined the effectiveness of a hybrid ACT and positive psychology program in a randomized controlled trial. The study utilized a large sample of Australian high school students (ages 15-18; $n = 76$) which received either the combined ACT/positive psychology intervention or a "pastoral care" class designed to help students address life challenges. Results from this study indicated that students in the ACT/positive psychology group demonstrated greater reductions in depression, stress, and composite depression/anxiety symptoms when compared to students in the control group.

More recently, Peterson and colleagues (2022) investigated the utility of a school-based ACT group for students struggling with anxiety (73.1% female; $M_{age} = 15.6$, $SD = 1.6$) using a randomized wait list-controlled design. Similar to what had been demonstrated in a limited number of other trials of ACT groups in schools (e.g., Smith et al., 2020, Brookshier, 2016), results indicated a significant decrease in anxiety for the immediate treatment group when compared to a waitlist control. A novel finding in this study, however, was that small increases in school attendance were also observed for the ACT group post-intervention, which may provide some preliminary support for using ACT to promote observable and socially significant behavior changes in schools.

Externalizing Problems

At present, studies on the impact of school-based ACT interventions on externalizing problems are limited. In one early study, Gómez and colleagues (2014) examined the effectiveness of ACT in reducing aggressive, oppositional, and impulsive behaviors in five adolescents across several settings. Participants in the study attended four 90-minute sessions of

individual school-based ACT for a period of two weeks. Throughout the study, classroom behaviors were assessed by teachers and an independent observer using frequency counts of "disruptive" and "desirable" behaviors for each student. Results from this study indicated significant decreases in disruptive behaviors and increases in desirable behaviors. In addition to the behavioral outcomes, the authors also reported that participants showed decreases in impulsivity. Although this study offers a useful starting point, the length of sessions and use of individual therapy may be restrictive in school environments. Additionally, the lack of reported interobserver agreement data to validate teacher observations may raise questions about the accuracy of the reported behavioral changes in the study.

Fang & Ding (2020) conducted a pilot study of school-based ACT groups with 35 Chinese youth and examined the effects of intervention on several variables, including school engagement, as measured by the Utrecht Work Engagement Scale - student (UWES-s). ACT interventions consisted of 10 one-hour workshops across five weeks. Results from this study indicated a small to moderate effect size (d=.49) for change in school engagement—which may indirectly indicate reductions in incompatible externalizing behaviors such as disruption, however, such behaviors were not measured directly.

Wilson and colleagues (2022) utilized a non-concurrent multiple-baseline across participants design to evaluate the effectiveness of an individualized school-based ACT protocol for three White students (ages 10-14) with frequent off-task behavior, class disruption, and aggression in the classroom. Participants reportedly had various mental and behavioral health diagnoses including oppositional defiant disorder, attention-deficit/hyperactivity disorder, and bipolar disorder. Behavior was assessed during each phase using direct observation with 30-second whole-interval recording. Intervention sessions were approximately 30-minutes in length

and varied in duration from two to 11 sessions based on the participant. Results indicated that during the intervention phase, student classroom behaviors improved significantly compared to baseline and treatment-control conditions. The study conducted by Wilson and colleagues (2022), is currently the most robustly designed trial of school-based ACT for externalizing problems using direct observation.

Finally, a new systematic review and meta-analysis on the use of third-wave behavioral therapies such as ACT for children and adolescents found, in part, that reductions in participant externalizing symptoms were insignificant when the quality of study was controlled for (Perkins et al., 2023). Although this finding should be considered and may bear relevance to the present study, this analysis included any type of third-wave behavioral therapy (i.e., not ACT exclusively) and included some studies of ACT in non-school contexts, which may limit the specificity of its conclusions and further reflect a need for research in this area.

Current Study

Although a small amount of affirmative evidence for school-based ACT is accumulating, there seems to be little understanding of its utility for addressing externalizing concerns and other overt challenging behaviors that many students exhibit daily in their classrooms. Furthermore, of the available studies, very few are methodologically rigorous single-case designs using systematic direct observation. Considering that direct observation is the gold standard for assessing behaviors in schools, more data of this nature could help school-based practitioners decide if ACT is a suitable intervention for their students when compared to more robustly studied interventions.

Additionally, given that the two existing direct observation studies, Gómez and colleagues (2014) and Wilson and colleagues (2022), used individualized sessions and/or

conducted sessions individually, information is also needed on the efficacy of more resource-efficient standardized group formats of ACT targeting directly observable behaviors. In light of the rising levels of need among school-aged youth, the added importance of understanding effective interventions in alternative school settings, and the current state of the literature, this study posed the following research questions and hypotheses:

RQ1: Is there a functional relation between school-based ACT groups and directly observed challenging classroom behaviors?

Hypothesis 1: There is a functional relation between school-based ACT groups and directly observed classroom behaviors such that participation in ACT groups results in decreased directly observed challenging behaviors.

RQ2: Do students report internalizing benefits in addition to the reductions in directly observed classroom behaviors, if any?

Hypothesis 2: Students will report reductions in internalizing symptoms.

RQ3: Do students view the intervention as an acceptable way to address these problems (i.e., was the group enjoyable, did they feel like they learned new concepts)?

Hypothesis 3: Students will find the intervention acceptable.

RQ4: Do teachers view the intervention as effective and acceptable?

Hypothesis 4: Teachers will find the intervention effective and acceptable.

Method

Participants and Setting

Participants in the present study included seven middle school students (henceforth referred to as "Students 1-7") enrolled at an alternative education setting in a mid-sized midwestern city (ages 13-14, $M = 13.40$, $SD = .45$). Of the seven participating students, four students were African American or Black (three male, one female), and three students were

White (one male, one female, and one identifying as non-binary). All students were in either seventh or eighth grade. Specific demographic information for each participant is featured in Table 1.

No specific information was collected with respect to participants' DSM diagnoses or special education eligibility category; however, all participating students had Individualized Education Programs (IEPs) and consequently received services beyond the intervention provided in the study. Examples of these services included a school-wide token economy for reinforcing positive behaviors and individual therapy sessions with a licensed provider. These additional supports remained in place throughout the study.

In lieu of specific diagnostic labels, narrative descriptions were collected through consultation with teachers and were, in many cases, corroborated through direct observation during the screening process. According to teachers, Students 1, 2, 6, and 7 (all male students) were cited as having the most typical and frequent presentations of externalizing concerns (e.g., cursing at staff and fighting). Based on direct observation, these concerns seemed most apparent for Students 2, 6 and 7. Student 2 had several outbursts resulting in his classmates having to leave the room per school policy during the screening process, and Student 6 reportedly engaged in fighting and elopement, however, this was not directly observed. Student 7, although present less often, engaged in loud arguments with teachers, used inappropriate language, and sang disruptively in class. Student 1's outbursts tended to be perceived by teachers as less imposing (e.g., inappropriate off-hand comments when a task demand was placed or when expressing disapproval) and his primary observed off-task behaviors involved engaging in unassigned activities such as talking to friends or refusing to work on assigned projects.

Teachers reported that Students 3, 4, and 5 exhibited instances of high intensity but low-frequency off-task behaviors, but no high intensity behaviors were directly observed from these students during screening. Direct observation did suggest, however, that these students were frequently non-compliant (i.e., not engaging with assigned activities or materials), out of seat (i.e., away from their designated area), and sleeping during academic instruction. At various points during the study, more disruptive behaviors were demonstrated by each of these students (e.g., eloping, cursing at staff, attempting to harm themselves or others).

During the baseline phase of the study, Students 1-7 were placed into groups (Groups 1-3) based on level, trend, and intensity of their behavior (i.e., how disruptive the behaviors were to the class). Students 1 and 2 were assigned to Group 1, Students 3 and 4 were assigned to Group 2, and Students 5, 6, and 7 were assigned to Group 3. For clarity, it should be noted that student numbers were assigned after the start of intervention so that numbers were in order following the start of each intervention group (e.g., Students 1 and 2 belonged to Group 1, the group which received intervention first).

Screening

Participants were screened from two age-eligible homeroom classes (Classroom 1 and Classroom 2) located in the school's building designated for elementary through middle school students. Classroom 1 had a total of eight students (three of whom participated in the study), and Classroom 2 had a total of seven students (four of whom participated in the study).

Of the nine students deemed eligible after screening, seven provided assent and returned completed consent forms, and intervention data were ultimately obtained for five. Student 6 had an escalation of aggressive behavior which led to an in-school suspension and hindered his ability to participate, and Student 7 returned his study consent after the specified deadline.

Although the research team aimed to still include Student 7 to ensure he was provided with the intervention he was offered, he was frequently tardy or absent due to transportation issues and thus was unable to participate.

Student Risk Screening Scale – Internalizing and Externalizing

Lead teachers of the two age-eligible classrooms completed the Student Risk Screening Scale - Internalizing and Externalizing (SRSS-IE; Lane et al., 2016) for each student in their respective homerooms. The SRSS-IE is a popular free-access screening tool for internalizing and externalizing problems in schools and consists of twelve brief questions answered on a 4-point Likert-type scale. Studies of the SRSS-IE indicate that it is both a valid and reliable screener for internalizing and externalizing problems in secondary school settings (Lane et al., 2010; Lane et al., 2013). Students with moderate-to-high risk scores in externalizing behaviors on the SRSS-IE (i.e., scores ranging from 4-21) were additionally screened using an abbreviated 15-minute version of the Behavioral Observation of Students in Schools protocol (BOSS; Shapiro; 2004).

Behavioral Observation of Students in Schools

The BOSS is a popular and well-validated observation protocol commonly used in both research and practice (Volpe et al., 2005). When administering the BOSS, target students are observed for a set duration broken into equal intervals (e.g., 20 minutes with 15 second intervals) and randomly selected peers are observed during every fifth interval for comparison. On-task behaviors (i.e., active and passive engagement) are assessed using momentary time sampling at the beginning of each interval while off-task behaviors (i.e., off-task motor, off-task verbal, and off-task passive) are assessed using partial-interval recording throughout the entirety of each interval. Operational definitions for each subcategory of behavior are provided in Appendix A.

Students with elevated SRSS-IE scores (i.e., four or greater) and elevated off-task behavior as measured by the BOSS (i.e., off-task behavior observed in 15% or more of the observation intervals) were deemed eligible to participate.

Dependent Variables

Percentage of Intervals with Off-Task Behavior

The primary dependent variable, percentage of intervals with off-task behavior, was generated using data from the BOSS. During primary data collection, observations using the BOSS protocol were conducted 2-3 times per week during the students' morning academic block. Each observation was approximately 20 minutes in length and used 15-second intervals. After each observation was completed, the percentage of intervals with off-task behavior was calculated by totaling the number of intervals with at least one occurrence of passive, verbal, or motor off-task behavior, dividing by the total number of observed intervals for the student, and multiplying by 100.

Although research typically uses the BOSS as a measure of student engagement (i.e., on-task behavior), off-task behaviors were selected in this study due to their social significance (i.e., association with negative outcomes) and frequent relevance to students' referrals to an alternative setting. Some research indicates that on-task behavior of students with behavioral problems is often below that of a typically engaged student (i.e., below 80% of observed intervals; Rhode et al., 2010), but focusing on on-task behavior measured by momentary-time sampling may have also resulted in an underestimation of the severity of the off-task behaviors. While partial-interval recording of the off-task behaviors introduces the risk of over-estimating the degree to which students are off-task, this method was deemed more likely to reflect the types of concerns that teachers and administrators most regularly provide disciplinary action for.

Subjective Units of Distress

In addition to overt behavioral concerns measured by the BOSS, participants' internalizing symptoms were tracked across all phases of this study using a self-report measure known as a Subjective Units of Distress (SUD) scale (Appendix B). SUD scales are a simple way to track an individual's experience in clinical practice and have additionally been used in previous studies of mental and behavioral health interventions in schools (Cook et al., 2015; McCabe et al., 2015). Students were planned to complete the brief SUDs at the beginning of each school day with their teacher's help, but limited SUDs data were returned.

SRSS-IE

The SRSS-IE first used in the screening process was readministered at the study's conclusion to gauge broad changes in teacher perceptions of student internalizing and externalizing symptoms.

Independent Variable

A six-session ACT curriculum adapted from A*CT for Adolescent*s (Turrell & Bell, 2016) was used for this study. *ACT for Adolescent*s is a therapy manual that contains scaffolded modules on key ACT principles such as, "Identifying Values," "Setting Goals," and "Defusing from Thoughts." Material from the manual was selected by the PI to a) provide a logically structured overview of core ACT themes, and b) fit within six 30-minute group sessions. Each session contained a brief instructional component and often included metaphors to explain difficult topics, activities to highlight and allow opportunities to practice key skills, and applied examples to help facilitate generalization and understanding. Sample scripts for each ACT session were created to maximize intervention adherence and may be found in Appendix C.

Research Assistants

Study activities (i.e., behavioral observations and ACT sessions) were conducted by trained school psychology doctoral students. Specifically, behavioral observations were conducted by four volunteer doctoral students, and—due to scheduling challenges—the principal investigator (PI). In acknowledgment of the methodological concerns introduced by this, primary data collection conducted by the PI was kept to a minimum throughout the study (13.04% of sessions across baseline and intervention). Prior to independent data collection, each volunteer observer was provided with operational definitions and required to reach a minimum of 85% interobserver agreement with the PI or another previously trained observer.

ACT groups were facilitated by one volunteer doctoral student (a Black cisgender male) and again due to scheduling challenges, the PI (a White cisgender male). The PI was responsible for fully facilitating one of the three ACT groups (Group 2) and co-facilitating the other two groups assigned to the volunteer at times during the study (Groups 1 and 3). The volunteer facilitator was required to have completed prior coursework in behavioral mental health counseling and to attend a 1-hour training on the core principles of ACT held by the PI prior to beginning intervention. The PI previously completed coursework in both advanced behavioral theory (including modules on relational frame theory and ACT) and behavioral mental health counseling and had approximately two years of supervised clinical experience using ACT and other therapeutic interventions at the time of the study.

Design and Procedures

Due to the potentially harmful or otherwise undesirable behaviors selected for this study, a multiple baseline across groups design was used (Baer et al., 1968; Gast et al., 2014). Multiple baseline designs allow for participants to continue in the intervention condition rather than having treatment withdrawn. Additionally, information learned during intervention could not be

removed, which further supported this choice. While this design was deemed appropriate for the situation and presented research questions, the staggering of intervention start points did require withholding potentially effective treatment longer for some groups (Kennedy, 2005).

During the baseline phase of the study, direct observation data for the dependent variables were collected three days per typical week. Groups were moved to the intervention phase based on the presence of high frequencies of off-task behaviors with consideration given to the severity or intrusiveness of the behavior (e.g., although behaviors like sleeping were problematic, they were less of a disruption to the class than an outburst of threats or otherwise inappropriate language). Due to time constraints, some students were moved to intervention before establishing a stable baseline. Once students were moved to the intervention phase, they attended a 6-session ACT group based on *ACT for Adolescents* (Turell & Bell, 2016). Sessions were generally held for thirty minutes once per week, however, due to time shortages, Group 2 received the last two sessions in one week, and Group 3 only received five of the six planned sessions.

Baseline

During the baseline phase, no changes were made to the services or programming that students received. Graduate students collected direct observation data on on-task behavior (momentary time sampling) and off-task behaviors (partial interval recording) as described previously. Students were also asked to fill out the SUD scale daily with the help of their teacher to track potential internalizing symptom changes. Baseline was concluded for participants after the collection of at least 5 direct observation data points, a stable trend was established, or behavior was trending upward. As mentioned previously, some students were moved to intervention more quickly due to time constraints.

Intervention

During the intervention phase of the study, data collection procedures remained the same, however, graduate students also facilitated ACT groups based on *ACT for Adolescent*s (Turrell & Bell, 2016). Groups 1 and 3 were co-led by the PI and a trained graduate student, and Group 2 was led by the PI. Sessions took place approximately once per week for 6 weeks.

Interobserver Agreement

Exact-count interobserver agreement (IOA) was assessed for BOSS data for 33.00% of baseline sessions and 25.00% of intervention sessions during the study and was calculated by dividing the number of intervals with exact agreement across all observed behaviors by the total number of intervals and multiplying by 100. Across conditions, IOA was 88.65% (range, 67.50% - 97.50%) indicating acceptable average levels of agreement between observers. Following sessions with IOA below 80% (two total occasions), observers were required to reach 85% agreement with another observer or the PI prior to resuming independent data collection.

Intervention Adherence

Intervention adherence was measured for each ACT group session using the checklist provided in Appendix B. Maximum adherence (100%) required that all applicable lesson material (e.g., review of previous session, new material, applied exercise) was covered. Failure to achieve 80% adherence was planned to result in pre-teaching sessions for facilitators until a minimum of 90% adherence was achieved, but this was not necessary during the study. Adherence was 100% across sessions for Groups 1 and 2, and 98% across sessions for Group 3 (homework during Week 2 was not assigned due to being rushed at the end of session).

Social Validity

Social validity was assessed at the end of the study using the Children's Usage Rating Profile (CURP; Briesch & Chafouleas, 2009) and a brief teacher survey based on questions from the Intervention Rating Profile (IRP-15; Martens et al., 1990) and modified to better fit the context of the intervention. The CURP is comprised of 21 questions which assess participants' perceptions of the intervention using a 1-4 scale, with 1 being "I totally disagree" and 4 being "I totally agree." The questions on the CURP yield three sub-scales, *Personal desirability* (i.e., how much does the individual like the intervention), *Feasibility* (i.e., how much effort does the intervention take and how does it fit with the students' schedules), and *Understanding* (i.e., to what degree does the student understand the intervention and feel confident in their ability to participate in it successfully).

The brief teacher survey included eight statements, "This was an acceptable intervention to address my students' needs," "This intervention seemed to be effective or useful," "Students seemed to enjoy participating in the intervention," "This intervention was a good way to help students," "This intervention did not result in negative side effects for students," "I would want my students to try this kind of intervention again," "This intervention took too long to do," and "Most teachers in my position would find this intervention acceptable." For each statement, the responding teacher was asked to indicate their agreement from one, "Strongly Disagree" to four, "Strongly Agree."

Data Analysis

Visual analysis was conducted by the PI to assess the level, trend, and variability of the collected data and to detect any changes between phases and groups. The PI's interpretation of the data was additionally verified by a supervisor/licensed psychologist. Non-overlap of all pairs (NAP; Parker & Vannest, 2009) was used for each participant to gauge effect size, which is often

difficult to discern from visual analysis alone (Olive & Smith, 2005; Parker et al., 2007). NAP is calculated by a) determining the total number of pairs by multiplying the number of points in the baseline phase by the number of points in the intervention phase, b) determining the number of pairs for which the intervention point is an improvement or tie over the baseline point, c) adding the number of improved pairs with half the number of tied pairs, and d) dividing the sum in c by the total number of pairs (Rakap et al., 2020). NAP yields effect sizes from 0 to 1.0 with effect sizes from .51 to .59 indicating small effects, .60 to .89 indicating moderate effects, and .90 and above indicating large effects (Maggin et al., 2019).

Results

Overall, the degree of change in directly observed off-task behavior following the introduction of weekly ACT groups varied between participants, and no consistently replicated positive or negative effects were observed. Data were highly variable and student absences introduced additional difficulties with establishing stable trends. With respect to internalizing symptoms, limited SUDs ratings were returned, making it difficult to speak to the impacts of the weekly groups on students' daily perceived levels of distress during the study. Although aspects of social validity were high for teachers and students rating the intervention, teachers ultimately did not feel that it was noticeably effective. In support of this assertion, changes in teacher-completed SRSS-IE scores following intervention showed no clear trend, with some students increasing in internalizing and externalizing symptoms, others decreasing, and others showing minimal change.

Off-task Behavior

With respect to Research Question 1, (Is there a functional relation between school-based ACT groups and directly observed challenging classroom behaviors?) decreases in off-task

behavior were observed for some students (primarily those assigned to Group 1), but this effect was not replicated consistently across groups. All participants demonstrated decreases in off-task behavior immediately following the introduction of intervention, but data remained highly variable for many participants, making it difficult to interpret the results with visual analysis alone (Figure 1). Effect sizes and mean changes from baseline to intervention provided additional clarity and pointed toward an overall inconclusive result across groups.

Group 1: Students 1 and 2

Based on visual analysis, students in Group 1 showed a slight general reduction in the percentage of intervals with off-task behavior from baseline to intervention (Figure 1). Student 1's baseline data began around 30% off-task and trended upward in subsequent observations. Student 2's baseline data were more variable and slightly higher than Student 1's, alternating between observations with moderate and high percentages of off-task behavior.

After intervention was introduced, both students in Group 1 saw immediate reductions, with elevated observations occurring soon thereafter. After Student 1's original reduction, a single observation spiked significantly past baseline levels. During subsequent observations, Student 1's off-task levels dropped significantly and established a relatively low and stable trend to conclude the study. Similarly, following Student 2's initial decrease to start intervention, observers recorded several sessions with increased rates of off-task behavior, a session with the lowest levels of off-task behavior observed for the study, and a relatively low and stable trend afterwards.

Using means and effect size to supplement visual analysis, during baseline, Student 1 had a mean percentage of off-task behaviors of 36.34% which decreased to 27.68% during intervention while Student 2 had a mean baseline percentage of 42.81% which decreased to

28.13% (Table 2). Effect size estimates for Student 1 and Student 2 calculated using NAP were 0.77 and 0.74, respectively, indicating a moderate positive effect (Table 2).

Group 2: Students 3 and 4

Compared to Group 1, Group 2's data were more variable, and the trend was significantly less clear (Figure 1; Table 2). Each of the two included students (Students 3 and 4) frequently slept in class, and thus produced very high rates of off-task behavior (off-task passive) on some occasions. Student 3 began baseline with off-task behavior observed in 100% of intervals and dropped into a stable period of moderate off-task behavior before returning to 100%. Student 4 began with a comparatively low rate of off-task behavior which rose and fell during baseline, rising again just before intervention was introduced.

As with Group 1, reductions were seen in the first observations following the introduction of intervention for both students in Group 2. After Student 3's initial decrease in off-task behavior, their data alternated between high and study-low percentages of off-task behavior, hitting very high rates on several occasions. No clear trend for Student 3 was present based on variability, however, an increase may have occurred based on frequency. As intervention continued, Student 3's data went on to settle into a short period of stable low rates, and then ended the study with an observation at 100%. After the initial reduction for Student 4, their data remained relatively stable around the lowest baseline points, however, toward the end of intervention, off-task behaviors increased and concluded with a final observation at 100%.

Mean calculations for Group 2 showed that Student 3 had a mean of 68.62% during baseline which rose to 69.14% during intervention, while Student 4 had a mean of 47.91% during baseline which rose to 52.00%. Effect size estimates for Student 3 and Student 4

calculated using NAP were 0.60 and 0.51, however, due the persistent variability in Group 2 both within and across phases, caution should be used in interpretation.

Group 3: Students 5, 6, and 7

For the final group, Group 3, only 1 student (Student 5) was able to consistently attend the intervention. Furthermore, due to a series of student absences and school events, establishing a baseline trend was difficult for Student 5, limiting the ability to interpret their data reliably. According to visual analysis of the data as-presented, Student 5 began baseline with low rates of off-task behavior, which eventually escalated to a very high rate just prior to intervention. After the introduction of intervention, off-task behavior dropped off slightly during the first two observations, and sharply increased for the final point obtained.

Student 5's average percentage of intervals with off-task behavior during baseline was 34.77% which rose sharply to 76.04% during intervention (Table 2). NAP calculations for Student 5 yielded an effect size of 0.25, a moderate negative effect, but this should be interpreted with caution due to the lack of a stable trend, the gap in data collection, and the significant variability of the data within and across phases.

SUDs

With respect to Research Question 2, (Do students report internalizing benefits in addition to the reductions in directly observed classroom behaviors, if any?), returned SUDs data were extremely limited, which presented challenges for analysis and interpretation. For the data that were obtained, no overarching trend was apparent using visual analysis. Based on changes in mean from baseline to intervention, all students except for Student 5 saw small decreases in SUDs ratings (Table 3). Given that this measure is typically used as a clinical indicator rather

than a robust tool for research, however, the quantity of returned data is insufficient to make generalized statements about the students' internalizing symptoms.

Group 1: Students 1 and 2

Student 1 began baseline with a low level of perceived distress (primarily ratings of 1 and 2) which dropped to zero just before intervention. Student 2 began baseline with a moderate amount of perceived distress (a rating of 5 on the first measured day) which dropped to lower levels during the remainder of baseline (ratings of 0s and 1s). In the intervention phase, Student 1 continued to report relatively low levels of perceived distress comparable to those observed during baseline. Student 2 began intervention with several ratings at zero, briefly increased, and decreased back to zero for the final collected point.

Group 2: Students 3 and 4

Due to Student 3's frequent sleeping, SUDs data (typically obtained at the start of school when the student was presumably most tired) was limited. Baseline data included two ratings (zero and two) and intervention consisted of a single returned point at zero. Student 4, on the other hand, began baseline data collection reporting high levels of perceived distress (ratings of nine and 10) throughout baseline, except for a single point which was rated as a zero. During intervention, Student 4's ratings showed greater variability, alternating between points of moderate perceived distress (ratings between 5 and 7) and high distress (ratings of 10).

Group 3: Students 5, 6, and 7

Limited SUDs data were available for Students 5 and 6 across phases, and no data were available for Student 7. Students 5 and 6 both demonstrated low levels of perceived distress during baseline. Only one intervention point was obtained for Student 5 which was a single rating of 1, indicating low levels of perceived distress.

SRSS-IE

Scores from the SRSS-IE readministered at the conclusion of the study varied a considerable amount from the original screening in several cases, but this variation did not indicate a clear trend and was not replicated across students (Table 3). Student 1 demonstrated a dramatic increase in teacher-reported indicators of internalizing problems and a small increase in teacher-reported externalizing problems. Student 2 showed a change in the opposite direction with a moderate decrease in teacher-reported indicators of internalizing problems and a small decrease in teacher-reported externalizing problems. Students 3, 4, and 5 demonstrated changes of a lesser magnitude across the internalizing and externalizing scales with both ratings for Student 3 and 5 increasing a small amount, and ratings for Student 4 decreasing a small amount.

Social Validity

With respect to Research Questions 3 and 4 (Do students view the intervention as an acceptable way to address these problems [e.g., was the group enjoyable, did they feel like they learned]? and Do teachers view the intervention as effective and acceptable?), data from the CURP suggested that students largely felt the intervention was desirable and feasible and that they understood the intervention and how it applied to them. Out of a maximum of 4.0, the average student rating for Desirability was 3.47, Feasibility was 3.36, and Understanding was 3.37. This produced an Overall Rating of 3.40 out of 4.0, indicating acceptable social validity.

Data from the teacher social validity questionnaire indicated that although the teacher viewed the intervention favorably and believed students did as well, little direct behavioral benefit was observed. Specifically, given the options “Strongly Disagree,” “Disagree,” “Agree,” and “Strongly Agree,” the teacher replied “Agree” to the items, “This was an acceptable intervention to address my students’ needs,” “Students seemed to enjoy participating in the

intervention," "This intervention was a good way to help students," "This intervention did not result in negative side effects for students," "I would want my students to try this kind of intervention again," and "Most teachers in my position would find this intervention acceptable." The teacher replied "Disagree" to the items "This intervention seemed to be effective or useful," and "This intervention took too long to do."

Discussion

When considered in full, the findings of this study were largely inconclusive regarding the use of group-based ACT as an intervention for directly observed classroom behaviors in an alternative school setting (Research Question 1) and whether internalizing benefits may occur alongside reductions in observed classroom behavior (Research Question 2). Importantly, however, the intervention resulted in no clearly replicated negative effects, and social validity was high across student participants (Research Question 3). The primary modes of analysis, visual analysis and NAP, suggested moderate positive effects for both participants in Group 1, low-moderate effects for participants in Group 2, and a moderate negative effect for Student 5 in Group 3, however, as stated previously, this must be interpreted with caution due to the limited number of observations and lack of stable trend at baseline. With respect to internalizing concerns, SUDs data were not returned regularly enough to draw meaningful conclusions, and no visual trend was apparent.

In contrast to what primary analyses suggested, mean increases in off-task behavior occurred across phases for several participants (Students 3, 4, and 5; Figure 2), a situation which sometimes arises when relying on visual analysis and measures of non-overlap. With this said, however, these increases were minimal for Students 3 and 4, and gaps in Student 5's data (accompanied by a sharp increase in off-task behavior prior to intervention) may render measures

of central tendency misleading without further context. Conversely, mean decreases in off-task behavior were observed for Students 1 and 2 (Table 2).

Relative to existing literature, these findings conflict with the results of some prior research (e.g., Gomez et al., 2014; Wilson et al., 2022) and align more closely with the recent systematic review of third-wave behavioral therapies for externalizing concerns (Perkins et al., 2023) and meta-analysis of ACT in schools (Knight & Samuels, 2022), both of which suggest that the current evidence for ACT as a behavioral intervention for children and adolescents is inconclusive. This may be evidence that more careful thought and research is required to determine the type of population this intervention is best suited for and to establish whether it is an appropriate choice for behavioral concerns in schools.

Limitations

This study has several limitations which should be noted. First, student attendance and early data collection choices made collecting data more difficult than anticipated and ultimately hindered the study team's ability to fully answer the research questions. While this outcome was virtually unavoidable for the direct observation data, utilizing data from pre-existing systems to monitor internalizing concerns (e.g., check-in/check-out data) would have likely resulted in a more robust analysis. As mentioned previously, some research has suggested that students in alternative settings may miss school more frequently than peers in traditional settings. To maximize the likelihood of obtaining interpretable results in future research, attendance considerations should be more actively incorporated into recruitment and design choices (e.g., evaluating attendance trends over time prior to enrollment or setting looser inclusionary criteria).

Another significant limitation in this study was the dosage of the intervention. Due to logistical challenges in the recruitment and baseline phases, the duration of the intervention had

to be shortened from eight weeks to six. Paired with end-of-year scheduling conflicts, this resulted in six sessions being held for Groups 1 and 2, and only five sessions being held for the single participant left in Group 3. Given that each session was designed to be 30-minutes to easily fit within the school schedule, by the end of the study, participants had only received between 2.5 and 3.0 total hours of intervention. It is entirely possible that to see significant effects for this population, a greater dose would be required. Other studies of ACT for directly observed classroom behaviors, for example, extended as long as 11 sessions or lasted up to 90 minutes each (5.5 to 6.0 total intervention hours; Gomez et al, 2014; Wilson et al., 2022). Importantly, however, this increased dose may also reduce feasibility for some schools and alternative settings, especially if being added on to an established therapeutic regimen as was the case in the present study.

Beyond these limitations, there were also several potential confounds which may affect the interpretability of the study. First, participant medications and additional psychotherapy sessions were not actively monitored. Although results were inconclusive across groups and not controlling for these factors is common in school-based research, failure to monitor them could have affected the interpretation of results in theory. While the staggered introduction of intervention in a multiple-baseline design does have some benefit with respect to replication and verification of an effect independent of other factors (i.e., it is unlikely that all participants would experience unrelated changes precisely when intervention was introduced), future research should more carefully control for the potential for other interventions to interfere with the data.

Second, the group with the greatest improvement during the study (Group 1) was also the group in which the identity and interests of the lead and co-facilitator most closely reflected the identities and interests of the participants (i.e., both facilitators were cisgender males, both

facilitators shared common interests with the participants, and one facilitator, identifying as Black, shared a racial identity with the participants which may have been a novelty for the students given the demographics of the school staff). Given this fact, it is possible that stronger rapport (and subsequent therapeutic alliance) may have impacted the results in a manner not attributable to the curriculum alone. While it is difficult to know conclusively, this may be an important consideration when interpreting results or conducting similar small-sample research in the future.

A final limitation of the present study is that the direct observation variables as assessed do not necessarily paint a full picture of the behaviors as they occurred in the classroom. When using the BOSS, important changes in behavioral intensity, latency or, to some degree, topography, may be obscured by the nature of the instrument. This is particularly true given that the individual categories of off-task behavior were aggregated. While the data here seem to align with teacher ratings of student internalizing and externalizing symptoms using the SRSS-IE, it is possible that important changes were in fact missed because of the choice in measurement of the dependent variables.

Future Directions

Given the various challenges encountered during this study and the questions remaining following a review of its results, there are many opportunities for future research in this area. Perhaps most obviously, future research should investigate the impacts of full-length group ACT curricula (i.e., 8-12 sessions) for observable classroom behaviors in order to eliminate the potential impact of insufficient dosage for participants in this study. If research of this nature is successful, it will also be crucial to more carefully investigate the referral concerns that ACT is best suited for by disaggregating off-task behaviors and to compare the effects of ACT for

students with behavioral concerns against other alternatives indicated for addressing the same types of behaviors (e.g., class-wide contingencies).

To further illustrate this point, during this study, topography of student off-task behavior varied widely and may have impacted the effectiveness of the intervention (e.g., students in Group 2 would often try to sleep rather than participate and had to be prompted frequently to encourage participation). Although Students in Group 1 had more frequent outbursts and presented with more typical externalizing concerns, they also seemed to fair better in this study which may warrant further investigation.

Another suggestion for research is to consider training existing mental health staff to administer ACT rather than coordinating additional services. This may be important for a variety of reasons. First, practitioners already present in the building may have rapport established with students which could allow for less labored implementation. Second, therapists and social workers already functioning in alternative schools will likely have greater familiarity and authority in scheduling time and space in the building they serve, allowing them to bypass some of the administrative challenges encountered during this study. Finally, having students' primary school-based mental healthcare provider administer the intervention exclusively could help eliminate potential interaction effects. It may be the case, for example, that the effectiveness of ACT is lessened for students concurrently receiving traditional CBT-based interventions due to conflicting messages between these modalities (i.e., learning to employ strategies to challenge thoughts and change their content as opposed to "defusing" and not trying to change their content).

Practical Implications

Due to the mixed results of the present study, it is difficult to make definitive clinical prescriptions based on its findings. Some lessons learned from the study, however, may prove useful for others looking to conduct similar research or to facilitate groups in their own setting. First, it is advisable that school-based practitioners aiming to implement group ACT interventions consider how such an intervention would fit into their setting (i.e., evaluating whether the setting has adequate time and space) and work with administrators to decide if groups of this nature would be more beneficial than traditional classroom behavioral interventions (e.g., the Good Behavior Game). This is especially true if many students in the class could benefit from support for externalizing behaviors.

Second, practitioners should be aware that if ACT groups are deemed the most appropriate intervention, as with any intervention, both student and interventionist characteristics may be worth considering (i.e., shared backgrounds, identities, or interests between students and facilitators; student histories of attendance and active engagement in group interventions).

Finally, it may be helpful to consider the developmental course of participating students when selecting intervention materials. Although students seemed to enjoy the intervention, in the opinion of the group facilitators, more time dedicated to identifying values may have been useful. Other ACT manuals (e.g., The Thriving Adolescent; Hayes & Ciarrochi, 2015) may take a more favorable approach to ACT-based intervention with this age group due to the explicit acknowledgement within the curriculum that most adolescents are still in the process of exploring what they value.

Conclusion

Nested within communities and serving youth from a wide range of backgrounds, schools have historically played an important role in addressing our society's most pressing issues.

Today, the ability for youth to access effective and affordable mental and behavioral health interventions is among these issues, and, prepared or not, educational settings have been called to meet the rising need.

In acknowledgment of this call, the present study investigated and offered inconclusive evidence for one potential tool for school-based practitioners—group-based ACT for students with challenging classroom behaviors. Barriers and limitations encountered during this study provide new insights and directions for further research, including investigating the effects of full-length ACT groups facilitated by professionals already embedded in the system, more carefully assessing the behavioral presentations for which the intervention might be most effective, and conducting further direct comparisons between school-based ACT groups and more traditional behavioral interventions**.**

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Table 1. Participant Demographics

Participant ID	Group Assignment	Age	Grade	Gender	Race
Student 1	Group 1	13 years, 4 months	7th	Male	Black or African American
Student 2	Group 1	14 years, 4 months	7th	Male	Black or African American
Student 3	Group 2	13 years, 3 months	7th	Female	Black or African American
Student 4	Group 2	14 years, 7 months	8th	Female	White
Student 5	Group 3	13 years, 1 month	7th	Non-Binary	White
Student 6	Group 3	13 years, 0 months	7th	Male	White
Student 7	Group 3	13 years, 5 months	7th	Male	Black or African American

Table 2. BOSS Descriptive Statistics

Participant	Baseline Mean Off-Task	Baseline SD	Intervention Mean Off-Task	Intervention SD	Mean Change	Effect Size (NAP)
Student 1	36.34%	16.78%	27.68%	22.58%	-8.66%	0.77
Student 2	42.81%	12.95%	28.13%	16.23%	-14.68%	0.74
Student 3	68.62%	25.68%	69.14%	28.80%	+0.52%	0.60
Student 4	47.91%	22.74%	52.00%	28.79%	+4.09%	0.51
Student 5	34.77%	38.69%	76.04%	19.20%	+41.27%	0.25

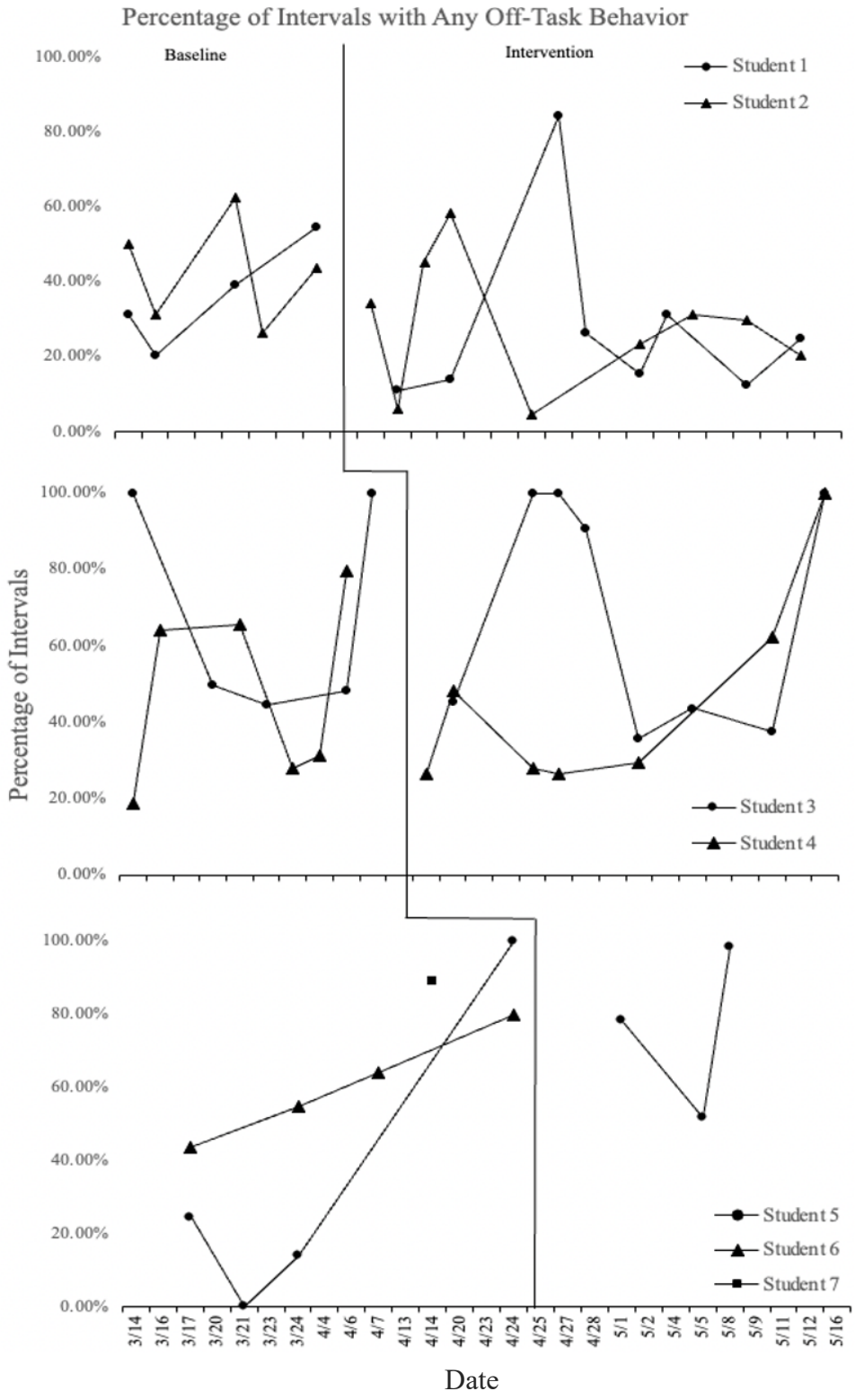
Table 3. SUDs Descriptive Statistics

Participant	Baseline Mean SUDs	Baseline SD	Intervention Mean SUDs	Intervention SD	Mean Change
Student 1	1.0	0.71	0.80	0.75	-0.20
Student 2	1.5	2.06	1.0	1.60	-0.50
Student 3	1.0	1.0	0.0	N/A	-1.0
Student 4	7.8	3.92	7.4	2.24	-0.40
Student 5	0.67	0.47	1.0	N/A	+0.33

Table 4. SRSS-IE Pre to Post Changes

Participant	SRSS-IE Total	SRSS-I (Internalizing)	SRSS-E (Externalizing)
Student 1	+20	+15	5
Student 2	-13	-9	-4
Student 3	+3	+3	0
Student 4	-1	-1	0
Student 5	+1	+4	-3

Figure 1.


Percentage of Intervals with Any Off-Task Behavior
Baseline
Intervention
Student 1
Student 2
Student 3
Student 4
Student 5
Student 6
Student 7
Percentage of Intervals
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
3/14
3/16
3/17
3/20
3/21
3/23
3/24
4/4
4/6
4/7
4/13
4/14
4/20
4/23
4/24
4/25
4/27
4/28
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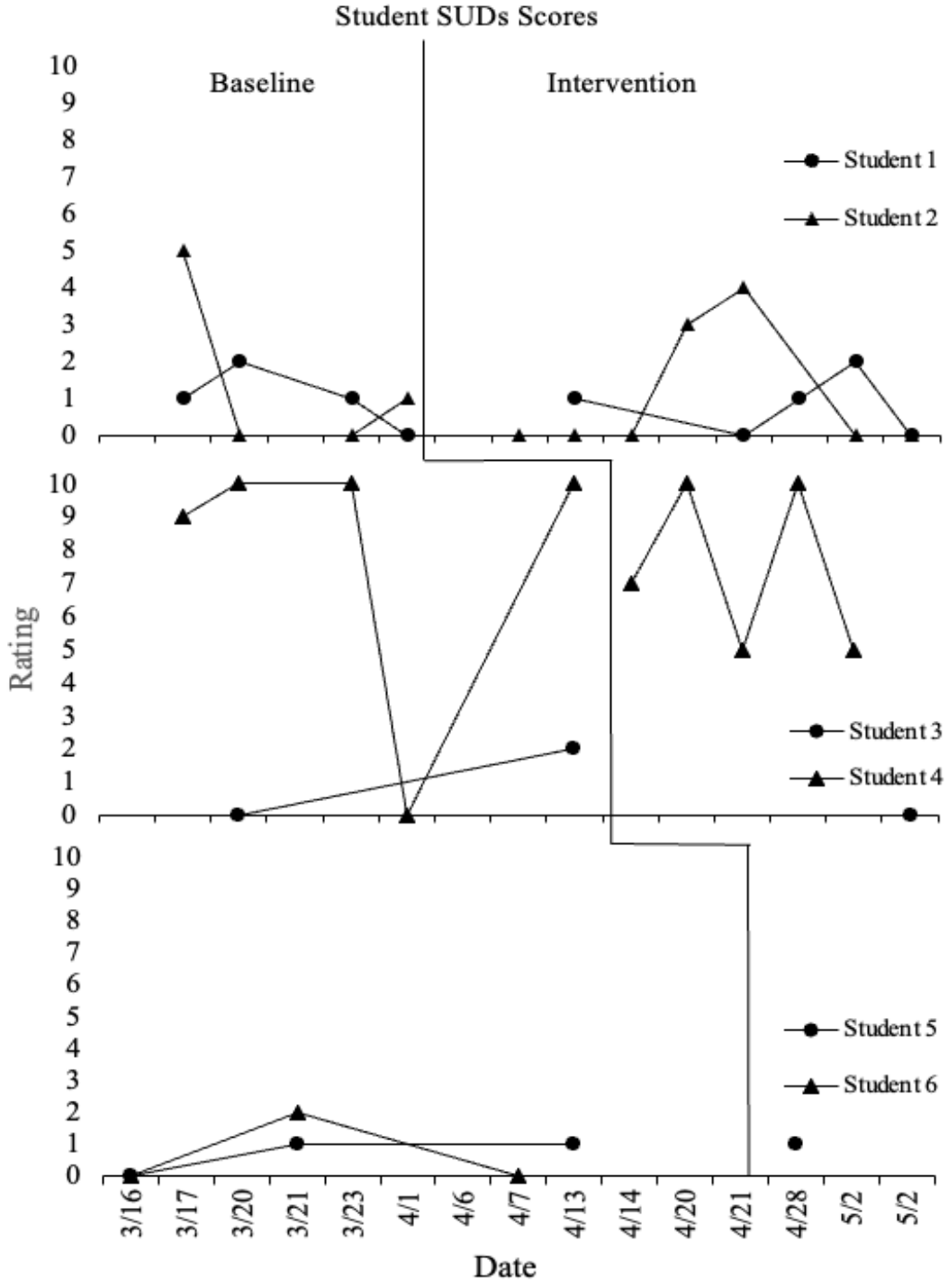
5/2
5/4
5/5
5/8
5/9
5/11
5/12
5/16
Date

Figure 2.


Student SUDs Scores
Baseline
Intervention
Student 1
Student 2
Student 3
Student 4
Student 5
Student 6
Rating
Date
3/16
3/17
3/20
3/21
3/23
4/1
4/6
4/7
4/13
4/14
4/20
4/21
4/28
5/2
5/2

Appendix A
BOSS Operational Definitions

Operational definitions (Shapiro, 2004):

Active Engaged Time (AET) is defined as times when the student is actively attending to the assigned work (e.g., writing, reading aloud, raising a hand, talking to the teacher about the assigned material). Non-Examples of AET include talking about non-academic work, calling out without permission, walking around the classroom without permission, and other off-task behaviors.

Passive Engage Time (PET) is defined as times in which the student is passively attending to assigned work (e.g., listening to the lecture, looking at a worksheet, silently reading assigned materials). Non-examples of PET include walking around the classroom aimlessly, reading unassigned materials, and other forms of off-task behavior.

Off-Task Motor (OFT-M) is defined as any instance of motor activity that is not directly associated with an assigned academic task (e.g., aimlessly flipping through a book, playing with objects not related to the academic task, turning around in their seat). Non-examples of OFT-M include passing papers to other students as instructed, laughing at a joke told by another student, or swinging feet while working on assigned material.

Off-Task Verbal (OFT-V) is defined as audible verbalizations that are not permitted and/or are not related to an assigned academic task (e.g., making an audible sound such as whistling, humming, or forced burping, talking with another student about topics unrelated to the assigned academic task, calling out academic answers when the teacher has not permitted such behavior). Non-examples of OFT-V include laughing at a joke told by the teacher, talking to

another student about the assigned academic task, or calling out an answer when prompted by the teacher.

Off-Task Passive **(OFT-P)** is defined as times when the student is passively not attending to an assigned activity for a period of at least 3 consecutive seconds within a single interval (e.g., quietly waiting after completing an assignment but not engaged in a behavior authorized by the teacher, staring out the window, passively listening to other students talk about issues unrelated to the academic task). Non-examples of OFT-P include quietly reading an assigned book, passively listening to other students talk about assigned work in an assigned learning group.

Appendix B

ACT Scripts and Worksheets

Week 1: Introduction

Sample Script

Check-in/Introduce group:

- Hi, everyone, it's good to meet you all! My name is _____, and I'll be leading your weekly groups from now through the end of school. We've got a few things to do today, but first, I just want to do some introductions.

- Let's go around and share our names, favorite hobbies, and what we like most about those hobbies.

- Very nice! I appreciate you all sharing. Those sound like some interesting hobbies!

- So, out of curiosity, who here has ever felt annoyed, upset, angry, sad? All of us, right? As we've all experienced, thoughts, feelings, and hard situations are a part of life. Sometimes, these things can really get in the way of our goals. Put a different way, if we're not careful, our thoughts and feelings can make us act in ways that aren't helpful for us.

- Everyone tries to deal with thoughts and feelings in different ways (e.g., distraction, avoidance of difficult things). No matter what we do though, they always seem to come back. We really don't have that much control over them. Have you ever had someone tell you, "Stop being mad"? Good luck, right? The good news is that it's totally normal. Negative thoughts and feelings come back for most people, and they don't just go away when we ask. If we're going to be successful though, we still need to find a way to meet our goals when these things come up.

- With that said, the point of this group is 1), to help us get a better idea of our goals and values, the things we care about and 2), to talk about strategies that help us live up to these goals and values, *especially* when we're being challenged by thoughts and feelings.

Group rules/Reinforcer Assessment:

- Now, if we're going to be working on these things together, I think that it's important that we have some rules in place that keep these groups respectful. What are some rules that you all think are important? (3-4 rules; **add one for confidentiality if they do not suggest**).

- And, because I want you all to have your work in groups rewarded, what kinds of things would you like to earn during each session (within reason; chips, candy, stickers)?

Goals Activity: Worksheet

- Great! For the rest of our time today, I want us to do an activity to get to know everyone better and start thinking about exactly what it is that matters to us. (Hand out ***Goals and Values Worksheet***).
- First, we're going to be thinking about each of our values. These are "big ideas" that matter to us. On this worksheet, we're going to circle 2-3 words in the word bank that represent ideas or qualities that you care about in your life. If these don't fit, feel free to write in your own!
- Finally, we're going to talk about our goals for short term, medium term, and long term (*Help them frame these as SMART goals, if possible).*

Conclusion: Great, these are some awesome goals and values. Thank you all for your participation, today I'm really looking forward to working with you all over the coming weeks.

Goals and Values Worksheet

Name _____

1. **Values –** Pick 2-3 things that you care about most or that you would like to show others. If you have other ideas, write them below!

Acceptance	Friendliness	Love	Self-awareness
Adventure	Forgiveness	Mindfulness	Self-care
Authenticity	Fun	Orderliness	Self-control
Care for others	Generosity	Open-Mindedness	Spirituality
Contribution	Honesty	Patience	Skillfulness
Cooperativeness	Humor	Persistence	Supportiveness
Courage	Independence	Power	Teamwork
Curiosity	Justice	Respect	Toughness
Encouragement	Kindness	Responsibility	Trustworthiness

Others**:** _____

2. **Goals –** Putting values into action!

Short-Term (1 week – 1 month)	**Medium-Term (1 month- 1 year)**	**Long-Term (1 year – 5+ years)**
Goal:	**Goal:**	**Goal:**

Think about…

a. What kinds of things can make it harder for you to reach these goals?
b. What kinds of things can help you reach these goals (e.g., qualities you have, resources you have)?
c. How do your "values" relate to your goals?

Week 2: Creative Hopelessness

Sample Script

Review Group Rules/Check-in:

- (*Review Group Rules, ask how everyone's week went*).
- So, in our introduction last week, I mentioned briefly that all of us have negative thoughts and feelings, and we all have different ways of trying to avoid them. If we're going to start embracing our thoughts and feelings, we need to recognize behaviors we do to avoid them.

Psychoeducation:

- We can remember these different ways we avoid thoughts and feelings with the acronym **DOTS**: **D**istraction, **O**pting out, **T**ime travel, and **S**elf-harm.
- When we **D**istract ourselves, we might daydream, play with our phones, click a pen repeatedly, or make random noises.
- **O**pting out could be skipping something we were supposed to go to, not doing our work or paying attention in class or avoiding your teacher a question you need to ask.
- **T**ime traveling is when we start "wishing" and think about how we could've done things differently in the past or could go differently in the future.
- **S**elf-harming might be things like sleeping too much, not exercising enough or too much, poking ourselves with staples, punching walls, etc.
- When we use DOTS, it can help us avoid what we're feeling, that's why we do it, but it can also make it much harder for us to reach our goals.
- I personally use distraction a lot, like scrolling through social media, watching videos, and sometimes I don't get my work done because of it. Did any of those stand out for anyone else?
- What do you all think, do your DOTS work? How long do they work for? What else happens (e.g., keeps you from doing what you need to).
- The important thing to remember about DOTS is that the more that we fight with negative thoughts and feelings and try not to feel them, the more power we give them to get us off track from our goals and the values that we care about.
- It's a little bit like trying to get out of quicksand, the more we fight with it, the deeper we're going to sink. To get out of quicksand, we have to spread out our body weight and really feel that quicksand to inch our way out (*physically show openness),* not fight it. It's kind of the opposite of what you'd think. Thoughts and feelings are the same way.

Activity: Now we're going to do an activity that helps us see this more clearly (**DOTS Worksheet;** may need to help them see long-term outcomes/potential negatives).

Conclusion:

- We are out of time for today, but let's review what we learned this week.
- We all face negative thoughts and feelings, and we all try to fight them using our DOTS, Distraction, Opting out, Time-Traveling, or Self-Harm.
- We also learned that fighting with them can have not so great consequences sometimes and can make you sink deeper and move away from your goals!
- In the rest of this group, we'll be learning what we can do to stop ourselves from sinking.

- Try to notice again this week if you catch yourself using DOTS and try to label which letter it is.

Name _____

DOTS Worksheet

DOTS… Are they working?			
What have you done to try to stop negative thoughts or feelings? (DOTS — **D**istraction, **O**pting out, **T**ime-travel, and **S**elf-harm)	Short-term: did the thoughts/feelings go away? Did you manage to get rid of them and do what you needed to do?	Long-term: did those feelings ever come back? Did they get worse or increase?	What was the impact of using DOTS?

<u>Examples</u>

Distraction – Daydreaming, playing on our phones, scrolling through social media, trying to make our friends laugh, fidgeting, walking around.
Opting out – Skipping class, not doing our work, not paying attention, avoiding something we're worried about like talking to someone new.
Time-travel – Thinking about the past/or future, imagining things that have already happened or that might happen later.
Self-harm – Sleeping too much or not enough, not exercising, or exercising too much, punching things, over or undereating, hurting ourselves.

Week 3: Defusing

Script

Review Group Rules/Check-in:

- Review group rules.
- Last week, we talked about DOTS and how they can sometimes push us in the wrong direction. Did anyone notice themselves using DOTS?
- (*Provide examples from your own life if you can*).

Psychoeducation

- Now that we've talked about values and goals in Week 1 and started to get a feel for DOTS and how they can get in the way in Week 2, it's time to start learning what we can do instead.
- It's sort of goofy, but when negative thoughts and feelings start to show up and get in our way, we want to use an acronym called LLAMA.
- LLAMA stands for (**L**abel, **L**et go, **A**llow, be **M**indful, and **A**ct).
- Today, we're going to talk about the first few letters of LLAMA and why they're so important, but first, it's important for us to understand something about the way our brains work.
- Mary had a little… (wait for answer; lamb). ABCDEF… (wait for answer; G).
- Our brains are learning machines, and you'll probably notice that you didn't really have to go searching for those answers. They just came to you, and you really didn't have much control over the process.
- This seems to be true in a lot of situations, we can't always control the things that pop up in our head. So, what do we do when the things that pop into our heads or bodies that make us use DOTS and get in the way of our values and goals?
- Well, one thing we can do is to learn to Label them as what they are, thoughts and feelings. (e.g., I'm having the thought that…, I noticed that I'm feeling…)
- Just because we have an automatic thought or feeling doesn't mean it's always going to be the right answer, it's kind of like predictive text on a phone, it's just a suggestion. By labeling these experiences as a thought or feeling, we remind ourselves that just because we feel it or think it, doesn't make it "true" or doesn't mean it's the *only* way we can react.
- Once we label thoughts and feelings, <u>we can decide if they're going to be helpful for us,</u> and then let them go. Let's try this now using a couple of short activities.

Activity: Transparencies

Activity: Defusion

Conclusion:

- That's all for today, remember, we can't control what we think or feel, so it's important that we're able to use those first few steps of LLAMA to **l**abel them as what they are and **l**et go of the ones that aren't helpful. We **a**llow them to be there, but not blocking our view!
- Next week, we'll be talking about the rest of the LLAMA letters.

Activity: Transparencies

Direction: Using the provided projector transparencies, have students write some negative thoughts and feelings they might have during the day. If they have trouble thinking of some or don't want to because it feels too vulnerable, you can lead this activity as a demonstration instead. Try to make this activity interactive, even if it's a demonstration, have students help you think of negative thoughts and feelings that someone might encounter during their day.

Once negative thoughts have been written down, hold up the transparency to show the students that the "world" as you see it through the transparency is now "clouded" by all of these negative thoughts and feelings written on the transparency. Explain to the students that it might be hard to see your goals, or to navigate the world effectively with all these things in your line of sight.

After explaining this concept, remind students that these are thoughts and feelings, and when we label them as such, we don't have to look through the transparency the same way. Now, because they've been "**L**abeled," we can choose to "**L**et go." You can demonstrate this point by having students all hold up the transparency and then physically let it drop to the floor.

Note to the students that although you let the transparency go, the thoughts and feelings are still there, they're still written on the transparency, but the difference is you're no longer looking at the world through it. This is the "**A**llow" in LLAMA. You've labeled them as thoughts and feelings, and if they're blocking your vision, you can choose to put them down for an easier time getting to your destination. It doesn't mean they won't still be there, but they're not blocking your view!

Activity: "Defusion"

Let students know that while it's easy to let go of the transparency in this exercise, it can be **a lot** harder when it's a real thought or feeling we are experiencing. Tell them that there are many strategies for reminding themselves in these moments that thoughts and feelings don't have to always be taken seriously. As a group, pick a thought from the feeling to demonstrate some of these strategies, and invite each student to try one of these strategies. Encourage them to notice how this makes the thought seem less intimidating.

3. Simply state "I notice I'm having the thought that…" before reading the thought.
4. Say the thought over and over again as fast as they can aloud for 30 seconds.
5. Say the thought in a funny voice or while doing an impression.
6. Sing the thought to the tune of a song they know or to their own tune.

Week 4: Self-As-Context

Sample Script

Check-In/Review:

- Last week we talked about starting to unstick from our thoughts using the first letters of the LLAMA acronym, **L**abeling, **L**etting go, and **A**llowing.
- Our transparency activity showed us why these steps are important and how doing them can help us focus more clearly on our goals.
- We also talked about some ways we can practice letting go when it's difficult.
- This week we are going to talk about the rest of the LLAMA acronym, **M**indfulness and **A**ct, and answer an important question. If we are not our thoughts and feelings, what are we?

Psychoeducation:

- How many of you are familiar with checkers or chess? What do those games look like?
- Sometimes, we act like we are playing one of these games in our head. One side is our good thoughts, and one side is our bad thoughts, and we are trying to get the good side to win, right?
- But as we have learned in the last couple of weeks, we really don't have much control over our thoughts and feelings. We aren't our good thoughts, or are bad thoughts, if it were chess or checkers, we'd be the board!
- When we realize that we're the board, and thoughts and feelings are not *who we are*, we can stop fighting, just like we put the transparencies down. We "Accept" that thoughts and feelings are going to happen, but those thoughts and feelings are not who we are. That helps us keep our focus on what really matters, our behavior.
- Are any of you familiar with mindfulness? Mindfulness is a way for us to remind ourselves that we are the chess or checkerboard, and not the pieces playing on top (the thoughts and feelings). Mindfulness can really be anything, as long as you are practicing noticing your thoughts and feelings and keep yourselves focused on our goals and values in the moment.
- Now, this is important, **mindfulness isn't about getting rid of anything**; it's about not getting caught in fighting thoughts and feelings that you can't control. When you let go of the fight and stay in the present, you've got more control and can make a choice to **A**ct in a way that's helpful.
- Let's try an exercise, and really try to focus on thoughts and feelings that come up. Notice them and keep focused on the activity.

Activity: Mindful eating (*may need to narrate the activity, guide them through and explain how thoughts are coming up for you, and audibly direct yourself back to the activity*)

- That was difficult, wasn't it? It was probably really easy to get distracted, you might've had a hard time slowing down, but you can't be bad at mindfulness as long as you're noticing. It's all about being aware. Get bored? Use that "Label" from LLAMA to say, "okay, I'm noticing I'm having feelings of boredom, let me get back to what I'm focusing on, this candy!" Mindfulness helps us to see what's going on, so we can **A**ct in a way that helps us in the present moment. Great job with that activity, everybody!

Conclusion:

- Okay, that is all for today! Remember, we are not our thoughts and feelings, and mindfulness is a great way of remembering that and staying in the moment. Mindfulness is a great way to remember that we are not our thoughts, and it helps to keep us in the present so we can make decisions and do the final letter of LLAMA, **A**ct in a way that helps us meet our goals!

Week 5: Putting It All Together

Sample Script

Check-In:

- Last week we talked about how mindfulness can be a great way to notice your thoughts and feelings and bring yourself into the present. Did anyone practice that this week?
- (*Give a personal example if you have one*).

Psychoeducation:

- Today we're going to be going over everything we've discussed so far just as a final refresher, really putting everything together.

- The first thing to remember from group is that we don't have much control over what we think or feel. We pick things up everywhere, we're learning machines, but not everything that pops into our head or body is going to be useful to us and our goals.

- If we get caught up in these negative thoughts and feelings that pop up, we may be tempted to use DOTS that don't help us in the long run. Who remembers what DOTS stands for? (Distraction, Opting out, Time-traveling, and Self-harm.) What are some examples of DOTS?

- Right! And these things could cause us to act out and work against our goals instead of for them. That's just going to bring on more negatives. We may end up behind on our work, yell at a friend when we want to resolve a conflict or hurt someone when we just want space to calm down.

- Instead of DOTS, what do we want to do? We can use LLAMA to remember to **L**abel our thoughts and feelings, **L**et go of them, **A**ccept that they may still run in the background, be **M**indful, and finally, **A**ct according to our values. Right?
- Let's say I'm having the feeling of intense anger. What would I do first? First, I would label it as a feeling. As we all know, that doesn't get rid of the anger, but it allows me to see it and accept it. If I need to, I can choose to engage in some mindfulness to help me stay aware and keep myself here in the moment. Once I'm in the moment, I decided that I should ask for a break because that lines up with my goals of making my day. Right? It's hard. 100%, BUT it can make a world of difference if you learn to use it.

- This is a process that we all have to practice to get better and more consistent!

- Because today is all about putting LLAMA together, the big thing that I want to do today is to show you all what this looks like in action.

Activity: "The Walk"

Conclusion:

- Remember, we don't have much control over our thoughts or feelings, so LLAMA can help us stay focused on our goals where DOTS might hurt us in the long-term. When you're going throughout your days, try to think back to this activity. How does it feel to take a step back? What can we do to move forward?
- Next week, our last week, we're going to talk about being kind to ourselves when this is hard or we forget to use these strategies. It's also our last week, so we'll have a little celebration!

Activity: "The Walk"

In this activity, students will go through the LLAMA steps in a game like Red Light, Green Light. To set up this game, a student will make the walk toward a designated "goal" (sticky note). As they take steps with the permission of the facilitator, the facilitator will toss paper wads at them to mimic intrusive, unhelpful thoughts and feelings and the students will be asked to label them as thoughts/feelings in order to step forward. The facilitator will point to the paper wads on the ground to point out that the thoughts are still there, but the participants will have made a choice to continue stepping forward toward their goals. To highlight mindfulness, the facilitator may ask participants to reflect on all the "experiences" on the ground around them and utter a statement like, "I am not my thoughts and feelings." Once participants are close to the goal, the facilitator will ask the group how it would feel to turn back. Ideally, students will realize that it would be hurtful to have to turn back, and that it's worth pushing on, even if it's difficult.

Week 6: Wrapping Up, Self-Compassion

Sample Script

Check-In:

- Okay everyone, congratulations on making it this far, this is the last group!

Psychoeducation

- Before we celebrate this week, we're going to talk quickly about the idea of self-compassion or being understanding to ourselves when we get caught up in thoughts and feelings.

- The things that we've been talking about over the course of the groups take a lifetime to master. Most adults don't even have these tools. It's hard to learn to "unstick" from the things we're thinking and feelings, and the ugly truth is that none of us, even me, will do it perfectly all the time.

- We may catch ourselves getting bored while trying to do work, so we give up, and we end up bombing a test, making the teacher mad, or not making our day, whatever it might be.

- It's disappointing, but it happens, and when it does, it's more important than ever to be able to take the thoughts and feelings you're having "I'm so bad at this," "I really can't control myself," "I'm not good enough" and treat those just like the thoughts ones we talked about earlier. Those are just thoughts and feelings. They aren't you. You are always writing your story, and there is **always** time to get back on track.

- When you find yourself in these positions, remember to use LLAMA, **L**abel the experience, **L**et go, Allow them to be there running in the background, be mindful, and then finally, Act according to your values and goals. The things that are truly important to you will always be the most fulfilling thing. It feels good to distract ourselves, but it feels GREAT to meet a goal, to accomplish something we thought we couldn't, etc.

- Last thing before we celebrate all of your hard work, I want you to give you a helpful tool to remember to be kind to yourself.

- Imagine you've just had a really rough day. Nothing went your way, you got in trouble, failed a quiz, yelled at your friend, just all around bad, and you're not feeling great about it. You might start having thoughts like, "this was my fault," or "I never do anything right," but before you let yourself believe that kind of thing, I want you to imagine yourself at 6 years old. Imagine little, kindergarten you, and think, "would I say these things to this kid in front of me? Or I would I be kinder; would I tell them they can still turn it around."

- The truth is, all of us make mistakes and will struggle with this. The most important thing you can do is stick with it, give yourself grace, and keep trying. Sometimes we are meaner to ourselves than we should be. Shake it off, keep using LLAMA, and make kindergarten you proud of who you are becoming.

Activity: End-of-Group Celebration!

Appendix C
Fidelity Checklists

Week 1: Introduction

Introduce group:

☐ Thoughts and feelings can get in the way of our goals/values.

☐ Trying to get rid of thoughts and feelings rarely works long-term.

☐ The goal of this group is to learn to meet your goals/live up to your values even when you're being challenged by thoughts and feelings.

Group rules/Reinforcer Assessment:

☐ Establish group rules with input from the group.

☐ Identify things each student would like to work for during group.

Goals and Values Worksheet:

☐ Worksheet.

Total: /

Percentage:

Week 2: Creative Hopelessness

Review Group Rules/Check-in:

☐ Recap Previous Week.

Psychoeducation:

☐ Introduce DOTS.

☐ D.

☐ O.

☐ T.

☐ S.

☐ Explore effectiveness of DOTS.

☐ DOTS Worksheet

Conclusion:

☐ Session Summary.

☐ Notice your DOTS homework.

Total: /

Percentage:

Week 3: Defusing

Review Group Rules/ Check-In:

☐ Recap Previous Week.

☐ Discuss Homework

Psychoeducation:

☐ Introduce LLAMA.

☐ Activity: Don't Fill in The Blank.

☐ **L**abel

☐ **L**et go

☐ **A**llow

Activities

☐ Transparencies

☐ Defusion Exercises

Conclusion:

☐ Session Summary.

Total: /

Percentage:

Week 4: Self-As-Context

Check-In/Review:

☐ Recap Previous Week.

Psychoeducation:

☐ Checkers or Chess Self-As Context Metaphor

☐ Mindfulness introduction (What is mindfulness?)

☐ Mindfulness is not about getting rid of thoughts/feeling, but noticing them, and redirecting your attention to the present moment where you can Act.

Activity

☐ Mindfulness Practice

Conclusion:

☐ Session Summary

Total: /

Percentage:

Week 5: Putting it All Together

Check-In/Review:

☐ Recap Previous Week.

Psychoeducation:

☐ We don't have much control over our thoughts.

☐ DOTS can distract us in the moment but may not help us meet our goals and may make things harder on us long-term.

☐ LLAMA can help us in place of DOTS

☐ **Activity:** The Walk

Conclusion:

☐ Session Summary

Total: /

Percentage:

Week 6: Wrapping Up/Self-Compassion

Check-In/Review:

☐ Recap Previous Week.

Psychoeducation:

☐ None of us will use these skills perfectly.

☐ When we fail to "unstick" it is easy to get disappointed, but those are thoughts and feelings too, it's not who we are.

☐ **"**Younger You" strategy for self-compassion

Conclusion:
☐ Celebration!

Total: **/**

Percentage:

Appendix D

Social Validity Measures

Student Name _____

Social Validity Survey – Student

Directions: Circle your response for each question.

1. This group was too much work for me.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
2. I understand why this group was picked to help me.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
3. I could see myself using the skills from this group.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
4. This group is a good way to help students.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
5. It is clear what I had to do in this group.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
6. I would not want to try this kind of group again.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
7. This group took too long to do.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
8. If my friend was having trouble, I would tell them to try this kind of group.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
9. I was able to do every step of this method.	I totally disagree	I kind of disagree	I kind of agree	I totally agree

10. I felt like I had to come to group too often.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
11. Coming to group gave me less free time.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
12. There are too many steps to remember.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
13. Coming to group got in the way of doing other things.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
14. I understand why coming to group was important.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
15. This group focused too much attention on me.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
16. I was excited to try this method.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
17. This group made it hard for other students to work.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
18. I would volunteer to come to a group like this again.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
19. It is clear what the leader of the group needed to do.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
20. I was able to use the methods taught in this group correctly.	I totally disagree	I kind of disagree	I kind of agree	I totally agree
21. I liked this group.	I totally disagree	I kind of disagree	I kind of agree	I totally agree

Name _____

Social Validity Survey – Teacher

Directions: Circle your response for each question.

1. This was an acceptable intervention to help meet my students' needs.	Strongly disagree	Disagree	Agree	Strongly Agree
2. This intervention seemed to be effective or useful.	Strongly disagree	Disagree	Agree	Strongly Agree
3. Students seemed to enjoy participating in the intervention.	Strongly disagree	Disagree	Agree	Strongly Agree
4. This intervention was a good way to help students.	Strongly disagree	Disagree	Agree	Strongly Agree
5. This intervention did not result in negative side effects for students.	Strongly disagree	Disagree	Agree	Strongly Agree
6. I would want my students to try this kind of group again.	Strongly disagree	Disagree	Agree	Strongly Agree
7. This intervention took too long to do.	Strongly disagree	Disagree	Agree	Strongly Agree
8. Most teachers in my position would find this intervention acceptable.	Strongly disagree	Disagree	Agree	Strongly Agree

Source: Adapted from Witt, J.C. & Elliott, S.N. (1985). Acceptability of classroom intervention strategies. In Kratochwill, T.R. (Ed.), Advances in School Psychology, Vol. 4, 251 – 288. Mahwah, NJ: Erlbaum. Reproduced under Fair Use of copyrighted materials for education, scholarship, and research. 17 U.S.C. § 107.

Appendix E

Parent Consent Forms

IRB #: MOD01_2021-0475

Approved: 12/22/2022

Parent Permission for Child's Participation in Research University of Cincinnati College of Education, Criminal Justice, and Human Services School Psychology Department
Principal Investigator: Skyler VanMeter, MEd Faculty Advisor: Renee Hawkins, PhD

Title of Study: Effects of Group-Based Acceptance and Commitment Therapy (ACT) on Classroom Externalizing Behaviors in an Alternative School Setting

Introduction:

You are being asked to allow your child to take part in a research study. Your child has been identified as a student who may benefit from an additional behavioral intervention. Please read this paper carefully and ask questions about anything that you do not understand.

Who is doing this research study?

Skyler VanMeter M.Ed., is a doctoral student at the University of Cincinnati (UC) Department of School Psychology. He is being guided in this research by Dr. Renee Hawkins.

There may be other people on the research team helping at different times during the study.

What is the purpose of this research study?

To find out if Acceptance and Commitment Therapy might improve classroom behaviors of students.

Who will be in this research study?

9 children ages 12-15 will take part in this study.

What will your child be asked to do in this research study, and how long will it take?

· Your child will be asked to meet with an Acceptance and Commitment Skills Group to talk about their behavior and their overall well-being.

o They will meet once per week for 30 min over 8 weeks in these groups.

· Your child will also be asked to rate their mood/feelings daily.

- Your student's behavior will be observed and recorded by trained UC graduate students.

  Your student's data will be used for research purposes.

- Data will be collected for up to 12 weeks of the 2022-2023 school year.

Are there any risks to being in this research study?

It is possible that your child will experience mild discomfort, frustration and/or embarrassment when participating in this study because ACT group activities will include role play, journaling, discussions about behavior, etc.
In order to monitor and ensure safety, the researcher will:

o Meet weekly with your child's teachers to check for any discomfort.
o Inform you of any distress or changes in your child's interventions be a meeting that takes place either face-to-face or over the phone.

o Change the intervention or remove your child from the study if any risk or discomfort is suspected.

o Provide access to the school counselor if needed for your child

Are there any benefits from being in this research study?

Because the intervention is planned to improve behavior at school, your child's point-sheet level and grades may improve.

Does your child have choices about taking part in this research study?

If you do not want your child to participate in the study, then he or she will not be asked to participate. They will not be treated any differently.

How will your child's research information be kept confidential?

· Your child's information will be identified with a random ID number, instead of your child's name.

· All data will be kept in a locked file cabinet.

· After two years, all raw data files will be shredded and/or deleted. Consent forms will be shredded after three years.

· University of Cincinnati may inspect study records for audit or quality assurance purposes.

What are your and your child's legal rights in this research study?

Nothing in this consent form waives any legal rights you or your child may have. This consent form also does not release the investigator, the institution, or its agents from liability for negligence.

What if you or your child has questions about this research study?

If you or your child has any questions or concerns about this research study, you can contact:

· Skyler VanMeter: vanmetsr@mail.uc.edu

· Dr. Renee Hawkins: hawkinro@ucmail.uc.edu.

The UC Institutional Review Board reviews all research projects that involve human participants to be sure the rights and welfare of participants are protected.

If you have questions about your child's rights as a participant, complaints and/or suggestions about the study, you may:

· Call the UC IRB at (513) 558-5259

· Call the UC Research Compliance Hotline at (800) 889-1547

· Write to the IRB at 300 University Hall, ML 0567, 51 Goodman Drive, Cincinnati, OH 45221-0567

· Email the IRB office at irb@ucmail.uc.edu

Does your child HAVE to take part in this research study?

No one has to be in this research study. Refusing to take part will NOT cause any penalty to you or your child. You may give your permission and then change your mind and take your child out of this study at any time. Your child will be asked if he or she wants to take part in this research study. Even if you say yes, your child may still say no.

To take your child out of the study, you should tell:
o Skyler VanMeter: vanmetsr@mail.uc.edu
o Dr. Renee Hawkins: hawkinro@ucmail.uc.edu.

Agreement:

I have read this information and have received answers to any questions I asked. I give permission for my child to participate in this research study. I will receive a copy of this signed and dated parent permission form to keep.

Your Child's Name (please print) _____
Your Child's Date of Birth _____ (Month / Day / Year)
Parent/Legal Guardian's Signature _____ Date _____
Signature of Person Obtaining Permission _____ Date _____

Appendix F

Child Assent Forms

IRB #: MOD01_2021-0475

Approved: 12/22/2022

Child Assent Form for Research
University of Cincinnati
College of Education, Criminal Justice, and Human Services School Psychology Department
Principal Investigator: Skyler VanMeter, MEd Faculty Advisor: Renee Hawkins, PhD

Title of Study: Effects of Group-Based Acceptance and Commitment Therapy (ACT) on Classroom Externalizing Behaviors in an Alternative School Setting

You are being asked to do a research project. You may ask questions about it. You do not have to say yes. If you do not want to be in this project, you can say no.

This project might help you improve your behavior at school.

Including you, about nine students will participate in this research project. If you decide to do this research project, you will do these things:

1. Once per week, you will meet with the Acceptance and Commitment Skills Group to discuss topics about your well-being and behavior at school.
2. You will rate your mood daily.
3. Graduate Students will observe your behavior in the classroom.

At the end of the study, you can see your results if you want to.

If you have any questions, you can ask the UC Student working with you or Skyler VanMeter.

You do not have to be in this project. You may start and then change your mind and stop at any time. No one will be upset with you if you choose to stop. To stop being in the project, talk to the UC student who conducts the group or your school mentor.

If you want to be in this project, fill in the blanks. If you do **not want** to be in this project, leave the lines blank.

Your Name (please print) _____
Your Birthday _____ (Month / Day / Year)
Your Grade _____ Your Teacher _____
Your Signature _____ Date _____
Signature of Person Obtaining Assent _____ Date _____