Addressing Adolescent Stress in School: Perceptions of a High School Wellness Center

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Abstract Adolescents are often burdened with academic, home, and peer stressors. With adolescent mental health issues and suicide on the rise, administrators have worked with nonprofit organizations and the community to address stress and internalized behavior problems. School-based wellness centers are tranquil rooms with various sensory activities, calming nature scenes, and sounds for relaxation purposes. School-based wellness centers may have behavioral effects by reducing exposure to aversive events and increasing access to positive and negative reinforcers. There has not yet been a formal study of school-based wellness centers published in the literature. In the present study, we used questionnaires to examine the perceptions of 752 students, 124 parents, and 69 school staff of their high school wellness center. Results indicated that stakeholders had positive perceptions of the wellness center. In particular, results implied that stakeholders believed the wellness center contributed to students’ academic success, elevation of mood, confidence, and coping skills. Results also suggested that attendance at the wellness center was associated with a decrease in student stress and anxiety, though recommendations for improvements were noted. Implications and limitations of this study are discussed.

Keywords Wellness · High school · Adolescence · Stress

Introduction

Adolescence is a challenging time of independence for youth to develop positive coping mechanisms to deal with the stressors that they face. A stressor is a natural occurrence or persistent circumstance that endangers the internal and external welfare of a person (Grant et al., 2003; Grant et al., 2004) and can contribute to suicidality (Miller & Prinstein, 2019). Stressors can function as aversive events that lead to individuals attempting to escape or avoid the stressful situation. The diathesis stress model suggests that adolescents may have various reactions to identical stressors (Belsky & Pluess, 2009; Eldik et al., 2020; Zuckerman, 1999). This model considers a mental health disorder to be the result of the interaction between a predisposition or vulnerability and stress.
caused by life experiences. Home, academic, and peer stressors are three common stress domains for adolescents that, if severe and not coped with positively, can contribute to internalized behavior problems and suicidal behavior (Byrne et al., 2007; Carballo et al., 2020; Manor et al., 2004; Miller & Prinstein, 2019).

Home Stressors

Home is not always a relaxing and supportive environment that is associated with high rates of reinforcement for adolescents. Youth do not have control over events such as loss of a loved one, a parent’s employment problems, dissolution of a marriage, or parental friction (Chappel et al., 2014). Byrne et al. (2007) found that a factor labeled stress of home life was comprised of the following: arguments at home, disagreements between parents, lack of understanding by parents, abiding by petty rules at home, living at home, and not being taken seriously by parents. There was also a positive correlation between adolescent depression and stress of home life. After comparing males to females with identical home stressors, the results showed females were affected more negatively than their male counterparts. Females have also shown a higher susceptibility to interparental stress and reduced self-efficacy (Eldik et al., 2020). In their review of the literature, Carballo et al. (2020) found that, for children and adolescents, the stressful life events preceding internalized behavior that may contribute to suicidal behavior are frequently family conflicts, academic stressors, trauma, and other stressful live events such as romantic breakups.

Academic Stressors

Academics can be a stressor for many adolescents. Byrne et al. (2007) discovered a strong positive correlation between a perceived lack of respect from teachers and the perceived stress of teacher interaction. Positive correlations with academic stress were also found for the following: having to study things not easily understood, teachers having excessively high expectations, difficulty with academic subjects, keeping up with schoolwork, rising early in the morning for school, compulsory school attendance, school transportation, not being listened to by teachers, not getting along with teachers, disagreements between students and teachers, and teacher hassles about physical appearance. In terms of gender, female students were significantly more likely to experience school performance stress than their male counterparts. However, males were significantly more likely to report experiencing stress about balancing school and leisure activities.

Students may see their teacher’s remarks as representative of how the general adult population thinks of them. It is essential for teachers to do their part in supporting students’ positive behavior as opposed to belittling or reprimanding them (Caldarella et al., 2021; Simonsen et al., 2008). To do this, teachers and school administrators could identify ways to increase students’ access to reinforcers within the school environment rather than relying on punishers like school office referrals, detentions, and suspensions.

Peer Stressors

Adolescence is a time for students to learn how to form peer acquaintanceships, friendships, and romantic relationships. However, these experiences are not always positive and can become stressful. For example, adolescents who encounter peer victimization, self-report more internalizing behavior problems and psychological distress in comparison to those who do not have these experiences (Biebl, 2011), which aligns with the diathesis stress model. One such peer victimization experience is social exclusion. Arslan (2018) noted that social exclusion is critical in predicting psychological distress. Peer rejection, a form of social exclusion, is associated with higher stress responses and may result in reduced abilities to self-regulate (Stroud et al., 2009). Byrne et al. (2007) identified several other peer-related events that were perceived as stressful for adolescents, including getting along with significant others, breaking up with significant others, making the relationship with significant others work, and not having enough time for significant others. Moderate positive correlations with adolescent peer stress were pressure to fit in with peers, being hassled for not fitting in, peers hassling about physical appearance, and being judged by friends. In terms of gender, female adolescents were more likely to experience romantic relationship stressors and peer stressors compared to males. Miller and Prinstein (2019) found that peer stressors, including peer alienation, romantic breakups, and bullying, are frequent triggers to adolescent suicide.
Adolescent Suicide

Suicidal thoughts and behaviors are defined as a series of actions composed of a death wish, ideation, intention, or an endeavor (Thompson et al., 2012). When all these steps are carried out to their conclusion, untimely death can occur. Suicide is a leading cause of adolescent death in the United States (Kuehn et al., 2019), which increases significantly during the high school to young adult years. According to the National Institute of Mental Health (n.d.), in 2019 there were 534 cases of suicide among children aged 10 to 14, increasing dramatically to 5,954 among those aged 15 to 24. There may be several environmental predictors of suicidal ideation and attempts. Manor et al. (2004) suggested that suicidal expression often emerges before teenagers engage in suicidal acts. Manor et al. reported that 40% of teenagers who engage in an unsuccessful attempt at dying by suicide will make further attempts. In their review of the literature, Miller and Prinstein (2019) concluded that suicide is more likely when adolescents experience stressors that are unusual or severe, exceeding their capacity to cope. Thus, it is important to examine distressing factors that influence adolescent suicide. These stressors include bullying, depressive symptoms, drug use, and academic trouble.

Kuehn et al. (2019) quantified data from 10,404 high school students across the United States who answered the Youth Risk Behavior Survey (Centers for Disease Control & Prevention, 2015) to measure adolescent suicide attempts, bullying, and electronic bullying (e-bullying). Statistically significant covariates that correlated with suicide attempts included depressive symptoms and academic trouble. Depressive symptoms alone were associated with an approximately 10-fold increase in suicide attempts. Another adolescent suicide study was conducted by Klomek et al. (2011) on 236 high school students in New York State. These researchers identified at-risk students as those who had a history of suicidal conduct, medium to serious depression, and/or substance abuse impairment. The at-risk bully group was operationalized as students who were at-risk and experienced bullying by either being the bully, victim, or both. Students in the at-risk bully group were statistically more likely to report depressive symptoms, suicide attempts, suicidal ideation, substance abuse, and functional impairment than other students. Bullying victims had statistically higher scores for depression and suicidal ideation than the bullying perpetrators. The studies by Klomek et al. (2011) and Kuehn et al. (2019) suggest that bullying, depressive symptoms, substance use, and academic trouble are all significant factors in adolescent suicide attempts and ideation.

Wellness Centers

School-based wellness centers have been developed to address student’s school-based stressors. A wellness center is defined as a place created to bolster alleviation and mindfulness, providing a serene haven where individuals can learn relaxation techniques and self-regulate from the burdens and stressors of life (Burkholder, 2020). From a behavioral perspective, wellness centers can provide a location for students that may reduce their contact with aversive or stressful aspects of the school environment and increase their exposure to reinforcers in school. Wellness can be part of multitiered systems of support (MTSS) encompassing prevention, wellness promotion, and interventions, based on principles of applied behavior analysis, that increase with intensity based on students’ needs (Smith, 2015). For example, a student at high risk for suicide could enter a behavioral contract with a school faculty member to attend the wellness center to learn relaxation and positive coping skills when they experience stressful life events.

There has not yet been a formal study of stakeholder perceptions of school-based wellness centers. However, there are anecdotal reports of benefits to students who attend wellness centers inside some schools in the United States. Guerra and Williams (2003) described the steps taken to implement, plan, and evaluate five school-based wellness centers, funded by Riverside School District in California. Guerra and Williams discussed multiple models of wellness centers consisting of targeted counseling groups, tutoring, advising, events for both students and parents, after school activities, solo counseling sessions, and campuswide programs. No evaluation data were presented.

Stoddard (2020) wrote a news article focusing on a small high school’s wellness center in rural southwestern Utah that began operation after two student suicides. This high school received a grant and donations to stock their wellness center with items such as Zen boards, stress balls, coloring books, and a
wellness room counselor for students to talk to if they desired. Stoddard reported that students use of this wellness center increased as more students became aware of it, increasing from 5 to 6 students during the 1st year to 16 additional students the 2nd year. Most students who came into the school wellness center reported feeling calmer after participating in the wellness center activities.

Wellness centers often use a MTSS approach that was pioneered in the Bay Area (Kadvany, 2016). The first tier is universal wellness center availability for all students. A wellness outreach worker conducts assemblies, classroom workshops, and health fairs for students to learn about anxiety, depression, and coping strategies. If Tier 1 is not enough, Tier 2 can be implemented by offering therapy services within the wellness center or having a student success team put in place. If Tier 2 intervention is not effective, wellness teams can either do suicide risk assessments if necessary or a formal individual education plan (IEP) evaluation. Tier 3 options include referring students to an outside therapist or mobile suicide crisis hotline options. For example, Richardson (2019) reported on a small middle school in southwestern Utah that designated a wellness center on their campus using a MTSS approach to address student internalizing behavior. The first tier was visiting the wellness center to cope for a short period of time and then returning to class. Students were administered a questionnaire on their way into the wellness center and on their way out. Richardson reported that students often entered the wellness center reporting stress levels of 7 to 9 on a 10-point scale, but typically left reporting levels of 3 to 4. The 2nd tier was assigned to students who used the wellness center multiple times a week who were then referred to a school counselor or social worker for follow-up. If a counselor met with a student and realized the student needed more assistance, the student was moved to the third tier and referred to an outside provider for more long-term counseling.

We interviewed two licensed professional clinical counselors who work inside high school wellness centers in California’s Bay Area, E. Spector (personal communication, November 17, 2020) and G. Dixon (personal communication, November 20, 2020). Both described their centers as hubs of mental and physical wellness that were implemented due to a history of student suicides at their schools. Both wellness centers contained a variety of employees including a school nurse, mental health counselors, and a wellness outreach worker. Students could be formally referred by parents, school staff, or self-referred. Both wellness centers used sensory activities including sand trays, arts, and crafts. Also, there were healthy snacks and decaffeinated hot tea available for students. These wellness centers were primarily funded via a partnership between the school district and community organizations.

Based on a review of the Bay Area and Utah wellness centers, there appear to be some common elements. First, most of these wellness centers were implemented in response to student suicides. Second, students needed a school pass or a referral to use the wellness center. Third, wellness centers had healthy snacks and hot decaffeinated beverage options. Fourth, there was at least one licensed mental health professional working in the wellness center during the school day to supervise and support students. Fifth, wellness centers were often integrated into schools using an MTSS approach. Finally, there was a section of the wellness center allocated to taking a break with various calming sensory objects and activities.

Research Questions

Given the lack of research on wellness centers, the purpose of the current study was to evaluate student, staff, and parent perceptions of the wellness center at a Utah high school via surveys. The specific research questions were as follows:

1. What are stakeholders’ (student, staff, and parent) perceptions of the wellness center?
2. Are there differences between student, staff, and parent perceptions of the wellness center?
3. Are there differences in student perceptions of how the wellness center affects their academic success among those who use the wellness center more frequently?
4. Are there ethnic differences in student perceptions of how often they attend the wellness center and how their attendance affects their academic success?
5. Are there gender differences in student perceptions of how often they attend the wellness center and how their attendance affects their academic success?
Method

Project Background

Wimmer (2020) reported on a large Utah high school, the focus of the present study, where three students died by suicide prior to the opening of a wellness center. The assistant principal (personal communication, October 27, 2020) stated that she had visited the California bay area high school wellness centers to gain inspiration for her own center. Shortly after the wellness center opened, another student entered and shared his plan for attempting suicide. This student accessed the wellness center and was able to work with a counselor to deescalate the situation and prevent the school’s fourth suicide of the year. According to data collected by school, within the 1st month of implementation, 4,000 students utilized this wellness center and 80% were ready to return to class after spending 20 min there. Unlike wellness centers in California that receive funding from the district and have strong partnerships within the mental health community, the Utah school wellness center was funded primarily from a local nonprofit organization, the IM (Impacting One Million) Foundation (https://www.theimfoundation.org/), and fundraising within the community. After approximately 1 year of operation, the assistant principal was interested in assessing stakeholder perceptions of the wellness center to determine what adjustments needed to be made and what worked for the student population. The assistant principal met with the school board to obtain permission for an anonymous questionnaire to be sent to students, staff, and parents. University and school district institutional review board approvals were also obtained.

Setting and Participants

This study was conducted in a Utah high school serving 2,340 students in 10th to 12th grades. Across all grades, 9.7% of students were on free/reduced priced lunch. The ethnic composition of the student population was 87.60% Caucasian, 6.71% Hispanic/Latinx, 2.05% Black, 1.67% Pacific Islander, 1.62% Asian, and 0.34% Native American. Of the entire student population, 49.83% were biological males and 50.17% were biological females. Demographic data on study participants are presented in the sections below.

Pilot Participants

The high school’s wellness center counselor recruited five student participants to answer the student questionnaire and provide feedback on the accessibility and clarity of questions, and to communicate if there were any edits needed. The pilot students were recruited from attendees in a “Wellness Tuesday” that the wellness center counselor organized. The only suggestion from the pilot student participants was to include a QR code in the cover letter to make the survey smartphone accessible, which was done for the final survey. Three adults (with experience in school psychology, program evaluation, and statistics) provided pilot group feedback on the staff and parent questionnaires but did not have any suggestions for needed changes.

Students

The student respondents (n = 752; 32.1% of the total school population) included students from all grades at the school. Their gender identity was 60.64% female, 35.24% male, 2.8% genderqueer, and 1.33% preferring not to say. In terms of ethnicity, the composition was 78.82% white/Caucasian, 7.76% Hispanic/Latinx, 4.24% Asian, 2.59% Black/African descent, 2.47% Pacific Islander, 2% Native American, 0.82% East Asian Indian, and 1.29% preferring not to say.

Staff

A total of 69 school staff (38.1% of the total school staff) participated. The staff gender identity was 72.46% female, 24.64% male, and 2.9% preferring not to say. The staff ethnicity was 88.73% white/Caucasian, 5.63% Hispanic/Latinx, 1.41% Pacific Islander, and 4.23% preferring not to say. We recruited the principal, assistant principals, social workers, guidance counselors, teachers, secretaries, advocates, and paraeducators. We did not administer questionnaires to cafeteria or janitorial staff as they lacked a direct educational connection with students. Of the staff respondents, most (84.62%) were teachers.
Parents

A total of 124 parents (approximately 5% of the total parent population) participated. The parent gender identity was 90.24% female, 8.13% male, and 1.63% genderqueer. In terms of ethnicity, 91.41% were Caucasian/white, 3.13% Hispanic/Latinx, 2.34% Asian, 1.56% Pacific Islander, 0.78% Native American, and 0.78% preferring not to say. When asked about student status, 7.75% reported that their student qualified for Section 504 of the Americans with Disabilities Act, 6.2% for free/reduced-priced lunch, 5.43% Special Education/Individualized Education Program, and 80.62% were not involved in any of the above. A total of 37.76% respondents marked their children were sophomores (10th grade), 35.66% juniors (11th grade), and 26.57% seniors (12th grade).

Wellness Center Program Description

This Utah high school implemented their wellness center beginning in the spring of 2020 using an MTSS model to address students’ emotional needs. Tier 1 consisted of classroom-based teacher interventions, Tier 2 consisted of the wellness center, and Tier 3 consisted of referral to school social workers and/or outside mental health providers. The setting chosen for the wellness center was a classroom previously used for math instruction. The sensory objects, decorations, and comfortable seating inside the wellness center (see supplemental materials) were donated and/or secured by fundraising in the local community.

The wellness center was first implemented three days before the COVID-19 shutdown in March 2020. To open the wellness center, classes took a trip to the center so they could familiarize themselves with the center location, purpose, and features. This open house lasted approximately 1 week. Students were told that they would need to obtain a wellness center pass from their classroom teacher, fill out a school-created mood questionnaire on an iPad when entering the center (these data were not available for analysis at the time of this publication), and use a 10-min sand timer up to two times to track their time away from class. There were no criteria to receive a pass. They were told that the wellness center counselor would track the students’ time just in case they forgot to use the timer. In accordance with the school district COVID-19 protocols, students were asked to wear masks when near others in the wellness center and use hand sanitizer when entering. If students were socially distanced, they were allowed to remove their masks.

The options for students spending their time in the wellness center were numerous. Students could take advantage of weighted blankets, a lavender scented teddy bear, relax while listening and watching a nature scene displayed on a smart board, and breathe in aromatherapy. If students wanted to be actively doing something, a variety of sensory activities were provided including puzzles, putty, sensory balls, makeshift “rain sticks” (water bottles with rice and beads), a miniature sandbox, a miniature Zen Garden, Playdoh, coloring books, and a Buddha board (for temporary paintings with water). Students were also able to enter the wellness center for hot cocoa or snacks. According to the center’s counselor (personal communication, December 1, 2020; 4 months after the wellness center reopened), she supervised students in the wellness center and was available to help them talk through their stressors if sensory activities were not an easy solution. She had an associate degree in counseling, previous experience working in a psychiatric hospital, and was completing a bachelor’s degree in social work. She was an IM employee, as the school district did not have wellness centers in their budget.

If a student surpassed the 20-min mark, and used the wellness center multiple times per week, the center counselor could triage the student and refer them to a school counselor or social worker for follow-up. Once per week during a 30-min lunch period, on Wellness Tuesdays, students could bring their lunch and discuss relevant mental health topics and participate in activities for students to increase student connection. Activities included having students acknowledge the communities that they were part of brainstorm mental health topics that affected their school, share anonymous compliments about others in the room, and answer questions on a card to share fun facts about themselves.

Measures

Questionnaires

ERIC, PSYCINFO, and Google Scholar were searched for wellness center questionnaires used by
other researchers. Because there were no questionnaires located in this search, we created three separate Qualtrics (https://qualtrics.com) surveys to assess students’, parents’, and teachers’ anonymous perceptions of the wellness center (see copies of the questionnaires in the supplemental materials). Survey questions were developed collaboratively by the school administration and the researchers. Likert-style questions had five options (e.g., ranging from strongly disagree to strongly agree). Open-ended questions asked the participants the following: “Why do you think students go to the wellness center?,” “How do you think the wellness center can be improved?,” “Is there anything else you would like to add about the wellness center?”

A gender identity question on all questionnaires had options such as male, female, transgender, nonbinary, intersex, and prefer not to say. Because we had a smaller representation of transgender, nonbinary, and intersex identifying stakeholders, we grouped these demographics into a genderqueer category because they were not the traditional cisgender sex responses of male or female. A genderqueer identity consists of anyone who identifies differently than their sex assigned at birth. This could mean identifying as somewhere in between male and female (transgender or intersex) or neither (nonbinary; Richards et al., 2016). A question asking ethnicity had options of white/Caucasian, Hispanic/Latinx, Black/African descent, Asian, Pacific Islander, Native American, East Asian Indian, and preferring not to say.

**Student Questionnaire** The student questionnaire had 19 items consisting of 11 Likert-style questions, 3 open-ended questions, 3 demographic questions, 1 forced choice question, 1 sliding scale question, and 1 ranking question. The questionnaire asked students about their use of the wellness center and perceptions of students who use the wellness center. If a student marked that they never attended the wellness center at the halfway point of the survey, they were not presented with any other questions.

**Staff Questionnaire** The staff questionnaire had 21 questions that consisted of 11 Likert-style questions, 4 open-ended questions, 2 forced choice questions, 2 demographic questions, 1 sliding scale question, and 1 ranking question. The questionnaire was designed to skip nonapplicable questions depending on how a staff member responded. For example, the second question in the survey asked if a staff member was a teacher: If they responded “no,” then subsequent questions pertaining to students in a classroom setting were skipped.

**Parent Questionnaire** The parent questionnaire had 21 items including 11 Likert-style questions, 2 forced choice questions, 3 open-ended questions, 4 demographic questions, and 1 sliding scale question. The questionnaire introduced the wellness center in the first question in case parents did not have prior knowledge about it, and then queried parents’ perceptions of their child’s use of the wellness center. If parents did not think their student used the wellness center at the halfway point of the questionnaire, they were advanced to the end of the survey.

**Procedure**

The assistant principal sent out an email cover letter with individual Qualtrics survey links and QR codes to all students, staff, and parents via the school district’s management software (Skyward.com) requesting their completion of an anonymous survey. Students and staff were told that if they completed the survey, they could obtain a treat from the wellness center. Approximately 1 week after the survey was initially sent out, a reminder email was sent to students, parents, and staff. The questionnaires were answered between March 1, 2021, and March 12, 2021. Students had access to the wellness center for approximately 6 consecutive months before the surveys were administered.

**Data Analysis**

Triangulation was used to assess agreement among the multiple stakeholder groups’ attitudes regarding the wellness center. To answer the question “What are stakeholders’ (student, staff, and parent) perceptions of the wellness center?,” data analysis involved compiling descriptive statistics to quantitatively summarize participants’ perceptions of the wellness center on the Likert-style questions. Forced choice questions were analyzed using percentages. There were 10 Likert-style questions that overlapped among students, parents, and staff, so we compared stakeholder perceptions on these questions using a one-way ANOVA.
with a Bonferroni post-hoc test between groups to answer the question about possible differences between student, staff, and parent perceptions of the wellness center. We conducted a Spearman correlation to examine whether students’ reported frequency of wellness center usage was associated with their perceived academic success. We computed independent samples $t$-tests and standardized mean differences (Cohen’s $d$) between students’ individual ethnicities and the rest of the sample regarding students’ perceptions of academic success and wellness center attendance. We used a one-way ANOVA with a Bonferroni post-hoc test between groups to answer the research question about the possible influence of students’ gender on their perceptions of wellness center attendance and their academic success.

We qualitatively analyzed participants’ responses to the open-ended questions to determine main themes. The open-ended comments were analyzed following the grounded theory methods of Corbin and Strauss (2008). The student, staff, and parent comments were initially analyzed separately and then compared in cross-case analysis. The comments were sorted by coding to uncover patterns associated with stakeholders’ perceptions of the wellness center. The researchers discussed responses that were unclear until consensus could be reached. The researchers also utilized qualitative data visualization in the form of Qualtrics word clouds created to aid in the identification of main themes in response to the question regarding why students went to the wellness center. Qualitative data visualizations such as word clouds have been successfully used in evaluations, including formative, summative, developmental, and mixed method approaches (DePaolo & Wilkinson, 2014; Henderson & Segal, 2013).

Results

Approximately 32% of all students, 38% of all staff, and 5% of all parents completed their respective wellness center questionnaires. Approximately 36% of the participants responded to the open-ended question regarding why they thought students went to the wellness center, approximately 25% responded to the question about suggested improvements, and approximately 21% had other comments to make about the wellness center.

Stakeholder Wellness Center Perceptions

Results for stakeholders’ perceptions of the wellness center and results are shown in Table 1. Students, staff, and parents similarly agreed on the following survey statements: (1) All schools should have a wellness center; (2) The wellness center helps students feel better about themselves; (3) Students come back from the wellness center in a better mood. Results for stakeholders’ perceptions of the wellness center and results are shown in Table 1. Students, staff, and parents similarly agreed on the following survey statements: (1) All schools should have a wellness center; (2) The wellness center helps students feel better about themselves; (3) Students come back from the wellness center in a better mood.

Table 1 Stakeholder responses to overlapping survey items ANOVA

| Questions – rated on a scale from 1 Strongly Disagree to 5 Strongly Agree | Students\((N = 752)\) | Staff\((N = 69)\) | Parents\((N = 124)\) | \(F\) |
|---|---|---|---|---|
| Having the wellness center helps students be successful in school. | 3.82 (0.94) | 4.09 (0.78) | 4.04 (0.95) | 8.74*** |
| All schools should have a wellness center. | 4.18 (0.93) | 4.15 (0.85) | 4.14 (0.92) | 0.23 |
| Students feel embarrassed to go to the wellness center. | 2.94 (1.08) | 2.20 (0.81) | 2.76 (1.09) | 27.57*** |
| I like having a wellness center at our school. | 4.06 (0.90) | 4.32 (0.79) | 4.19 (0.85) | 6.32** |
| Students come back from the wellness center in a better mood. | 4.41 (0.75) | 3.65 (0.68) | 4.36 (0.75) | 28.30*** |
| The wellness center helps students feel better about themselves. | 3.98 (0.92) | 3.87 (0.68) | 4.12 (0.88) | 2.12 |
| Students are learning valuable coping skills from going to the wellness center. | 3.90 (0.94) | 3.79 (0.76) | 3.83 (1.02) | 0.52 |
| Students come back to class from the wellness center more focused for school. | 4.08 (0.85) | 3.32 (0.76) | 3.93 (0.86) | 17.75*** |
| Students go to the wellness center to skip class. | 2.61 (0.86) | 2.78 (0.73) | 2.65 (0.86) | 2.34 |
| I refer students to the wellness center. | - | 2.83 (1.06) | 2.15 (1.25) | 8.36** |

**p < 0.01. *** p < 0.001
learning valuable coping skills in the wellness center; and (4) Students (do not) go to the wellness center to skip class. The qualitative data had the following overlapping themes as to why students used the wellness center: to experience calmness, decrease stress, relieve anxiety, take a break from class, relax, and cope with depression (see supplemental materials for the word clouds). The overlapping themes for suggested improvements were as follows: improve advertising and increase counselor availability. Below are results specific to each respondent group.

Student Perceptions

Student respondents were asked if they knew a student who used the wellness center: 61.30% responded Yes. When asked how often per week they themselves used the wellness center, 57.45% indicated wellness center attendance less than once per week, 18.62% went between one to five times per week, 1.72% went six or more times per week, and 22.21% left the question blank. The grade level of students who attended the wellness center were 49.26% sophomores, 29.06% juniors, and 21.67% seniors. Students were asked to “Mark the resources of the wellness center that are useful in order of ranking with number 1 being the most helpful” on a scale of 1 to 10. The peaceful environment was ranked as the most popular resource with 46.46% of student respondents, followed by tea, hot cocoa, and snacks at 12.63%, meeting with a counselor 11.62%, weighted blanket 11.11%, comfortable seats 8.59%, arts and crafts 5.05%, toys/gadgets 3.03%, and noise-cancelling headphones at 1.52%. Regarding what could be improved in the wellness center, students did not appreciate the nonmandatory mask rule inside the center during the COVID-19 pandemic, wanted the volume level controlled when multiple people were using the center, more snacks, and more time allotted to use the center.

Staff Perceptions

Of the staff respondents who answered that they were teachers, 100% reported that they had students in their classes who attended the wellness center. When teachers were asked how often students left their classes to go to the wellness center, 65.52% marked one or two classes per month, 24.14% one class per week, and 6.9% multiple classes per week. When teachers were asked if they felt students leaving class for the wellness center was disruptive, 57.14% disagreed. Staff reported that students who used the wellness center the most were juniors (44.23%) followed by sophomores (42.31%), and seniors (13.46%). In the qualitative data regarding why staff thought students attended the wellness center, common themes were coping with self, peer, or family suicide ideation, attempt, or completion. Regarding suggested improvements for the wellness center, staff commented that there should be more comfortable seating options as well as improved advertising and counselor availability.

Parent Perceptions

Parents were asked if they were aware their school had a wellness center: 87.10% responded Yes. A total of 32.26% of parents reported that they knew a student who used the wellness center. Parents were asked how often per week their child went to the wellness center; 42.74% marked never, 27.42% marked once or twice a week, and 8.07% marked three or more times per week. Regarding suggested improvements for the wellness center, common themes in parental feedback were improving advertising, decreasing stigma, and improving counselor availability.

Differences between Stakeholders

Regarding the second research question concerning differences between stakeholders’ perceptions, there were statistically significant differences between respondent groups on six overlapping quantitative survey questions (see Table 1). Staff and parents’ perceptions were significantly higher than students that the wellness center helped students be successful in school. Student and parent perceptions were significantly higher than staff that students were embarrassed attending the wellness center. The staff ratings were significantly higher than students that they liked having a wellness center at the school. Students’ and parents’ perceptions were significantly higher than staff that students returned from the wellness center in a better mood and that students came back from the wellness center more focused for school. Staff referred students to the wellness center significantly more often than parents.
Student Wellness Center Usage and Academic Success

There was a positive correlation ($r = .37, p < .001$) between the frequency of students’ reported use of the wellness center and their perceptions of how it helped them succeed in school.

Student Ethnic Differences

As shown in Table 2, Black/African American students reported that the wellness center benefited their academic success significantly more than was reported by other students ($p < .01$). Black/African, Asian, Native American, and Asian Indian students also reported significantly more frequent use of the wellness center than was reported by other students (see Table 2).

Student Gender Differences

As shown in Table 3, Genderqueer and Female students reported that the wellness center benefited their academic success significantly more than males ($p < .01$). Genderqueer students and those who preferred not to report their gender reported attending the wellness center significantly more often than both males and females (see Table 3).

### Discussion

The purpose of this study was to evaluate student, staff, and parent perceptions of their affiliated high school wellness center. To our knowledge, this was the first systematic study of stakeholder perceptions of a school-based wellness center. Students, staff, and parents all reported that high schools should have a wellness center, that the wellness center helped students feel better about themselves, that students learned valuable coping skills, and that the students did not go to the wellness center to skip class. Qualitative results had the following overlapping themes as to why students used the wellness center: to experience calmness, decrease stress, relieve anxiety, take a break from class, relax, and cope with depression. These results can be considered from the diathesis stress model (Belsky & Pluess, 2009; Eldik et al., 2020; Zuckerman, 1999) in that if schools can help students learn positive coping strategies this can

### Table 2

| Items                      | White ($n = 668$) | Hispanic ($n = 66$) | Black ($n = 22$) | Asian ($n = 36$) | Pacific Islander ($n = 21$) | Native American ($n = 17$) | Asian Indian ($n = 7$) | Prefer not to say ($n = 11$) |
|----------------------------|-------------------|--------------------|------------------|-----------------|----------------------------|-------------------------|-------------------------|-----------------------------|
| Academic Success           | .06               | .09                | .60**            | .27             | .10                       | .07                     | .51                     | .19                         |
| Wellness Center Attendance | .04               | .03                | .76**            | .45**           | .32                       | .73**                   | .91*                    | .03                         |

Note. Students had the opportunity to mark all ethnicities that applied to them to be sensitive to those who were multiracial

*p < 0.05; **p < 0.01

### Table 3

| Items                      | Male M (SD)       | Female M (SD)    | Genderqueer M (SD) | Preferring not to say M (SD) | F       |
|----------------------------|-------------------|------------------|--------------------|-------------------------------|---------|
| Academic Success           | 3.56 (0.96)       | 3.96† (0.87)     | 4.00† (1.14)       | 3.50                          | 11.36** |
| Wellness Center Attendance | 1.32 (0.81)       | 1.49 (0.80)      | 2.86† (1.62)       | 2.33†                         | 24.23** |

†Post hoc comparisons yielding a significantly higher mean than the other groups

**p < 0.01
help students decease their vulnerability to stressors caused by challenging life events. These results are also consistent with the findings of Byrne et al. (2007) that adolescents struggle with various academic pressures inside and outside the classroom: it appears that a wellness center may provide temporary refuge from such struggles. From a behavioral perspective, wellness centers may provide a source of negative reinforcement (time away from aversive aspects of school) or positive reinforcement (through access to preferred activities).

The overlapping themes regarding possible improvements for the wellness center were to improve advertising and increase counselor availability, with parents also reporting some stigma associated with the wellness center. The need for additional counselor availability aligns with reports from others that more counseling support is needed in schools (Mullen et al., 2021). It should be noted that the parents seemed to know the least about the wellness center, yet they were the only ones who were substantively concerned about stigma. Neither students nor staff, who had the most direct contact with the center, shared parent concerns about stigma. This may be a place for parent education about the wellness center rather than additional programs for the students and staff. The parent-reported stigma that surrounded this high school wellness center might benefit from DeLuca et al. (2021)'s discoveries with End the Silence (ETS), a program developed by the National Alliance on Mental Illness. ETS curtailed adverse stereotypes, enhanced mental health awareness, and fewer expected risks in communicating with a counselor compared to those who were not exposed to the program. The overlapping themes for the open-ended comments question were having nothing to add and general appreciation towards the wellness center. These results suggest that the implementation of the wellness center was deemed mostly beneficial for students by students themselves, staff, and parents.

As shown in the results to the second research question, there were some differences between student, staff, and parent perceptions of the wellness center. Staff and parents agreed that the wellness center helped students be more successful in school than did students. The reasons for this finding were unclear and could benefit from a follow-up study. The staff also agreed that they liked having a wellness center at their school and they referred students to the wellness center more often than parents. This finding makes sense, as staff had greater familiarity with the wellness center than did the parents. Students and parents scored significantly higher than staff that students were embarrassed attending the wellness center, and that students returned from the wellness center in a better mood and more focused for school. It could be that students are sharing more information with their parents about how the wellness center impacts them. The unique student qualitative themes of reasons that they used the wellness center were to cope with panic, improve focus, and seek advice from a counselor. Differences between student, staff, and parent perceptions of school-based programs have also been found by other researchers (see, e.g., Adams et al., 2010; Howell et al., 2014). Unique suggestions for improvements that students had were controlling volume levels of conversation when multiple people were using the wellness center, a larger variety of snack options, and not having to adhere to time limits in the wellness center during the school day: these are areas worthy of follow-up.

There was a positive correlation between the frequency of students’ use of the wellness center and their perceptions that it helped them succeed in school. Such findings are important given that students who struggle with internalizing behavior problems are more likely to experience social and academic problems (de Lijster et al., 2018; Hanson et al., 2004): Wellness centers may help with student anxiety and depression thus helping with school success.

Students of Black/African American, Asian, Native American, and Asian Indian ethnicities reported more frequent use of the wellness center than other students. Black/African American ethnicity students also reported that the wellness center benefited their academic success more than other students. Such findings are important given the increased stressors that minoritized students can experience in high school such as being treated worse by teachers, being more likely to be suspended, having the school more likely to call the police on them, having greater adjustment problems, and an inferior sense of belonging compared to white students (Bottiani et al., 2017; Ruck & Wortley, 2002). Minoritized students may appreciate having a place to cope with their emotions during the school day in the hope of addressing school discipline issues and negative school experiences.
Students who identified as genderqueer reported attending the wellness center significantly more often than both males and females. This is important given the added stressors faced by these students. For example, Toomey et al. (2012) found that 66.67% of transgender students reported bullying due to not conforming to gender stereotypes. Johnson et al. (2014) found that one of the common locations for such students to experience bullying was the bathroom, as school staff were not present to the same extent of the more public areas of school. Genderqueer students also face paranoia and often avoid the bathroom to decrease chances of being easy targets and wish that they had gender neutral bathrooms, safe locker spaces, and teachers to support their gender pronouns and educate other school staff on the subject (Johnson et al., 2014). Because genderqueer students do not fit the status quo, their life inside and outside school also suffers. Eisenberg et al. (2017) found that suicidal ideation increased 10-fold for genderqueer students compared to students who identified with the gender they were assigned at birth. Genderqueer students also have a higher percentage of risk behaviors than their gender-conforming peers such as substance abuse, sexual behaviors, and emotional distress (Eisenberg et al., 2017). Such findings suggest that genderqueer students need a safe space to avoid a hostile environment to cope with emotions so they can return to class, enjoy learning, combat suicidal ideation, and decrease their engagement in risky behaviors. Students who did not disclose their gender identity in the survey also attended the wellness center significantly more than males and females.

In addition, females reported that the wellness center contributed to their academic success significantly more than males. Both Byrne et al. (2007) and Arslan (2018) found that females experience more academic stress than males. Nilsen et al. (2013) discovered that as female students progress through adolescence, insufficient friend support predicted higher depressive symptoms compared to males. Such findings suggest that females may be more susceptible to social insecurities and may benefit more from the support provided by wellness centers.

Interpretation from a Behavioral Perspective

School-based wellness centers can be interpreted from a behavioral perspective. The stressors that students’ experience can be conceptualized as antecedents or setting events (e.g., environmental, social, or psychological) that lead to the behavior of attending the wellness center, for which students’ experience the consequences of positive reinforcement (e.g., attention, snacks, sensory) or negative reinforcement (e.g., escape from distressing events). Students may also experience check in-check out, behavior contracting, or mentoring in the wellness center as least restrictive behavioral interventions (Smith, 2015). Students who learn appropriate coping strategies (e.g., relaxation techniques, social skills) may then be able to return to the classroom with new behaviors which can be used to self-manage the distress they experience in school settings.

Limitations and Future Research

There were several limitations of the current study. The purpose of the study was to determine stakeholders’ perceptions of the wellness center. To this end, we only collected survey data, and not quantitative data on the usage of the center. In addition, our data on the relation of wellness center usage to academic performance relied on student recall and perspective taking. A useful follow-up study would be to gather data from school records that could directly address the relation between wellness center usage (measured through sign-in logs) and improvements in student performance (through gradebooks or report cards). We did not obtain grades or standardized testing scores to determine if school or individual student academic achievement increased since the wellness center was established. We encourage future research comparing academic progress and perceptions between similarly represented high schools with and without wellness centers.

Within the evaluation of perceptions, the questionnaires used were not evaluated for reliability or validity, so results must be interpreted with caution. The response rate was low, particularly for parents. The fact that only one third of students and staff participated in the survey may not be representative of the entire school population. Perhaps those who were more invested in the wellness center were more likely to participate. The school notified students, staff, and parents electronically, which may not have been ideal for parents who may not have checked their emails regularly. Another possibility is that the
emails might have only been sent to one parent in the home, reflected on the contact information provided from first day of school packets. Also, a treat was provided as an incentive for students and staff to complete the survey, but no incentive was provided to parents. Ideas to increase school stakeholder buy-in to completing a survey could be to organize assemblies and workshops to further the advertisement and use of the wellness center. Another limitation was that we only surveyed participants at one high school in Utah. Other schools may differ in socioeconomic status, ethnicity, and/or perceptions. We encourage research examining perceptions of school-based wellness centers in other geographic areas.

We conducted this study during the COVID-19 pandemic before vaccinations were widely available, so there may have been students who were more cautious about attending the wellness center. Also, some students were online for school and may not have had opportunities to physically attend the wellness center. We encourage replication studies when the COVID-19 pandemic has subsided.

Regarding minoritized students, we are aware that the sample size was small compared to the rest of the student sample. We encourage future research that targets those who identify as genderqueer and people of color, to obtain more information about why such students may benefit and utilize the wellness center more than others.

We did not ask respondents to disclose student mental health diagnoses: If we had we would have been able to determine common comorbidities of the student population and if certain diagnoses were perceived as better served by the wellness center than others. In addition, we did not ask participants how many visits or length of a visit was necessary to deal with an emotional stressor, though this is an area that could be addressed in future research. We also only asked three qualitative questions, so stakeholders were limited in what comments they could share: This could be addressed in a future qualitative study going into greater depth via interviews or focus groups.

Conclusion

This study is considered exploratory as it is the first examining stakeholders’ perspectives of a school-based wellness center. Because wellness centers are such a new phenomenon, it is important to understand how they are perceived by stakeholders. The perceptions of the wellness center were generally positive across student, staff, and parent perspectives. Students who identified as female, genderqueer, or Black perceived the wellness center as more beneficial than students in other demographics. These findings add further support that minoritized and female students have an increased need for coping with academic, peer, and internalizing stressors. Stakeholders agreed that the wellness center was generally used to experience calmness, decrease stress, relieve anxiety, take a break from class, relax, cope with depression, and address school pressures. Regarding wellness center suggested improvements, increasing both advertisement and counselor availability, and decreasing stigma were common themes. A behavioral perspective can be used to understand the mechanisms by which a wellness center may work. We encourage additional studies of school-based wellness centers to further strengthen the literature in this area.

Declarations

Conflict of Interest On behalf of the authors, the corresponding author states that there is no conflict of interest for the first five authors. The last author has a financial interest in the promotion of school-based wellness centers; however this author was only involved in a consultative role during the study planning stages, and he was not involved in data collection, data analysis, or data interpretation activities, nor was he involved in the write-up of the study results.

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