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Qualitative Outcomes of MindBridge: Group CBT Curriculum for Transitional Aged Youth with Developmental Disabilities

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ABSTRACT: Transitional-aged youth (TAY; 16–26) with developmental disabilities (DD) often experience greater mental health comorbidities than other young adults, partly due to gaps in mental health services during the transition from pediatric to adult care. While Group Cognitive Behavioral Therapy (GCBT) is effective for many psychiatric conditions, research on its use for TAY with diverse developmental disabilities is limited. This pilot study examined whether an 8-week brief GCBT intervention (MindBridge) could improve emotional regulation and social awareness among TAY with DD. We recruited 10 participants via opportunity sampling and implemented pre- and post-intervention surveys (18 items) as well as interviews with participants and educators. Sessions were 60 minutes weekly and incorporated CBT-based psychoeducation and art therapy. Only 5 of 10 participants had complete quantitative data; the resulting analyses yielded no statistically significant changes in survey scores. However, qualitative analysis identified two significant themes: (1) Increased Self-Regulation Skills and (2) Enhanced Social Confidence. The study highlights the value of qualitative assessment in research of this type and recommends integrating adapted measurement tools, expanded sample sizes, and longer interventions in future research. These findings contribute to research on adapting evidence-based mental health interventions for youth with DD and suggest that community-based GCBT can offer psychosocial benefits, even if not captured in quantitative data.

KEYWORDS: Social and Behavioral Sciences, Mental Health, Intellectual and Developmental Disabilities (IDD), Transitional-aged Youth (TAY), Group Cognitive Behavioral Therapy (GCBT).

Introduction

In our research, we explored the extent to which *Brief Cognitive Behavioral Therapy* (GCBT) curricula can be effectively implemented to address emotion regulation and social awareness challenges faced by Transitional Aged Youth (TAY) with developmental disabilities and the impacts of such curricula. Our study aims to expand on the limited research regarding the impact of GCBT on the mental health of transition-aged youth with a variety of developmental disabilities—addressing areas such as social awareness and emotion regulation. Unlike existing studies, our research uniquely examines how a brief, 8-week CBT-based program called MindBridge can improve mental health outcomes across TAY with a range of developmental disability types and symptom profiles in individuals aged 18 to 24.

Background on Group Cognitive Behavioral Therapy:

CBT centers on the idea that our thoughts, feelings, and behaviors are all interconnected. By identifying and challenging unhelpful thought patterns, CBT helps individuals change how they act and feel, thereby reducing psychological distress and improving emotional resilience. GCBT further supports the tenets of CBT, focusing on cognitive restructuring through behavioral tasks, normalization through identifying with others, cooperative therapeutic relationships, and positive reinforcement in a safe group environment. GCBT is often delivered in sessions with co-therapists, allowing for more flexible monitoring and content delivery. Although GCBT approaches date back to the late 1980s and 1990s, targeting substance use disorders and comorbid mental health conditions, over the past couple of decades, there has been a large body of evidence supporting the usage of GCBT for young adults with depression, generalized anxiety disorders, obsessive compulsive disorder, social phobias, and PTSD.[1]

For example, one of the earlier studies in 1993 by Heimberg *et al.* examined the long-term effectiveness of GCBT for social phobia, assessing outcomes 4.5 to 6.25 years after treatment.[2] The study involved 19 participants and compared GCBT to a credible alternative, Educational Supportive Group Psychotherapy (ES). Results showed that patients who received GCBT maintained greater improvements in social phobia than those who received ES, as measured by self-report questionnaires, behavioral tests, and structured interviews. Group settings can be more accessible, less stigmatizing, and more approachable compared to an individualized CBT setting.

Early randomized controlled trials demonstrated that GCBT, including models like Relapse Prevention and Guided Self-Change, could produce lasting reductions in substance use and associated psychiatric symptoms, particularly among individuals with mental health comorbidities. A leading 1990s GCBT study, using a 27-session relapse prevention model, found that participants with higher levels of comorbid psychopathology and sociopathy remained abstinent longer and gained greater long-term benefit from GCBT than from interactional group therapy. Additionally, survival analyses revealed better sustained outcomes for the CBT group two years

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post-treatment. These group-based approaches set the stage for modern interventions by emphasizing goal setting and skills training for complex, diverse clinical populations, with the additional benefit of being more cost-effective than treatments on the individual level.[3] However, group CBT presents limitations, including reduced individualization, higher dropout rates, a weaker evidence base compared to individual CBT, and potentially lower perceived acceptability among participants, particularly due to privacy concerns and discomfort with sharing personal issues in a group setting.[4]

TAY with Developmental Disabilities:

Interestingly, today, one of the specific age groups most impacted by high comorbidity rates of mental health disorders and developmental disabilities (DD) is transitional-aged youth (TAY). TAY are defined as individuals aged 16 - 25 navigating the transition from child-centered systems to increased adult services and responsibilities.[5] In a 2008 review published in *Current Opinion in Psychiatry* examining 85 studies on the co-occurrence of mental disorders in adolescents with developmental disabilities, among the four studies with a comparison group, the prevalence of co-occurring mental disorders in youth with Intellectual and Developmental Disabilities (ID/IDD) ranged from 30% to 50%, compared to 8% to 18% in typically developing peers.[6] In fact, 75% of serious mental illnesses (e.g., bipolar disorder or borderline personality disorder) show symptoms by the age of 25, overlapping with TAY developmental stages.[7] Furthermore, developmental disabilities often amplify stress responses to these transition-related demands. For example, Transitional-Aged Youth with DD are faced with demanding systemic and social challenges, often resulting in a concurrent mental illness due to service gaps with pediatric to adult care transitions, enhanced stigma and isolation as a result of their disability, and an overall loss of the structure that school-based support systems provide.[8] However, due to Diagnostic overshadowing—a cognitive bias where healthcare professionals mistakenly attribute symptoms of physical or mental health conditions to a person's pre-existing diagnosis—there exists an extreme amount of missed diagnoses and inadequate treatment for all adolescents and transitional-aged youth with developmental disabilities.[9] For example, a 2015 cross-sectional descriptive study on ADHD found that 38.8% of a cohort of 685 children with neurological disabilities met criteria for ADHD. However, only 28.2% of those were formally diagnosed—likely due at least in part to their syndromic or physical disabilities masking ADHD symptoms.[10] It is also important to note that TAY with developmental disabilities are disproportionately affected by adverse childhood experiences (ACEs) (defined as potentially traumatic events occurring before age 18) with a higher prevalence and adjusted odds of experiencing any ACE (72.1% vs 60.8%; adjusted odds ratio [AOR], 2.0) and four or more ACEs (26.8% vs 14.7%; AOR, 2.6).[11]

Limitations Within Current Treatment Options:

Currently, there are a range of treatment options for Transitional-Aged Youth with DD, including but not limited to occupation-based and advocacy interventions, behavioral and cognitive therapies, care coordination and community-based support, as well as assessment and transition planning.[12] However, there remain immense systematic barriers regarding transition issues with TAY who have developmental disabilities and financial hurdles such as limited insurance coverage and high out-of-pocket costs for many of these treatment options.[13] For example, while Applied Behavioral Analysis (ABA) or Cognitive Behavioral Therapy (CBT) are two commonly recommended forms of treatment, they are less universally accessed due to their high price points; One session of ABA can range anywhere from $120 - $150, one session of individual CBT can range from $100 - $250, and group CBT is often $30 - $75, making it a more affordable option.[14,15] Although costs may vary by region, group interventions are generally less expensive than individual therapies such as ABA or CBT. Moreover, along with the anticipated stigma that comes with a co-occurring DD and mental illness, there is a shortage of mental health professionals with expertise in this unique subset, resulting in long waitlists and difficulty accessing appropriate care.[16]

Current Studies in Literature:

Many modern-day psychology institutions and researchers agree that GCBT is particularly effective for transition-age youth (TAY) who have both mental health conditions and specific developmental or intellectual disabilities (such as autism spectrum disorder). Still, this effectiveness has not been thoroughly proven in GCBT settings with a variety of developmental disorders. For example, A 2013 study by Hesselmark *et al.* found that GCBT and group recreational activities led to similar improvements in quality of life for adults, specifically with autism spectrum disorder. A significantly higher percentage of CBT participants (67%) reported long-term benefits such as improved well-being and personal insight, compared to only 27% in the recreational activity group.[17] Moreover, a study conducted in 2011 by the University of Colorado, led by Dr. Judy Reaven, examined the effectiveness of a family-focused GCBT program specifically for anxiety in autistic adolescents, rather than a broader range of developmental disorders as included in our experiment. After completing the 12-week, family-focused GCBT program, participants demonstrated significant reductions in overall anxiety symptoms. These improvements were observed from pre-treatment through mid-treatment to post-treatment and were measured using clinician-administered ADIS-P assessments as well as parent- and youth-reported SCARED questionnaires.[18] Furthermore, in 2023, a systematic review and meta-analysis found that GCBT was effective in reducing anxiety in children and depressive symptoms in adults with ASD. The review examined 26 randomized controlled trials and reported that GCBT led to moderate reductions in anxiety among children and small but significant reductions in depression among adults.[19] These findings add to the growing body of literature supporting GCBT for individuals with ASD, while also highlighting the limited scope of existing studies, which often focus on specific disabilities rather than a more inclusive population.

Methods

Design:

This pilot study employed a mixed-methods design to evaluate the effectiveness of a CBT-informed program tailored for transitional-aged youth with developmental disabilities. This program was implemented in weekly lessons we led, including a slideshow, art activity, and corresponding exercises. Specifically, the study utilized an eighteen-question quantitative survey and qualitative interviews with participants and educators.[20] The integration of both methods enabled the exploration of both measurable changes and subjective experiences for the most comprehensive look into the perceived benefits of the MindBridge program. Furthermore, asking participants whether they had taken part in any other classes or programs during the past eight weeks, along with asking educators to compare the current participants' well-being to that of participants from a previous session without CBT, helped us account for potential confounding variables—such as improvements in emotional regulation or social awareness that could be due to outside influences rather than the CBT intervention itself. Thus, through their responses, we could identify whether improvements in mood, behavior, or emotion regulation could be reasonably attributed to the MindBridge curriculum versus external circumstances. It is crucial to note that all participants received verbal, emotional, and literacy support as needed to engage with simplified surveys and interviews.

Data was collected over 8 weeks. Prior to data collection, participants and their parental guardians provided informed consent through our "IRB Consent Form." All participants then completed an online 18-question pre-CBT survey to assess baseline levels of emotional regulation and social awareness. Surveys were administered in a supported format: staff assisted by reading questions and using visuals for those who needed it. Participants then engaged in the 8-week brief group CBT program, each session being 60 minutes long with a slideshow containing an instructive lesson, 2-3 exercises, and one art therapy activity. No formal data collection occurred during sessions. During week 8, participants completed an identical survey to the baseline pre-CBT survey. Participant and staff interviews were also conducted after the last MindBridge CBT session. We interviewed 5 randomly selected participants and all involved staff observers, totaling 3. The 10 - 12 minute interviews were recorded and transcribed for future analysis.

Participants and Recruitment:

We used opportunity census sampling to recruit participants. All individuals who were enrolled in the AbilityPath Stanton Sunset Social Recreation Program, an existing structured program that serves young adults 18-26 with developmental disabilities, during the 8-week summer duration of the intervention, were invited to participate in the pilot study.21 The final sample consisted of 10 adult participants (aged 18 - 26) with various identified developmental disabilities, including but not limited to autism spectrum disorders (ASDs), intellectual disabilities, Attention-deficit/hyperactivity disorder (ADHD), and Down syndrome. This method was chosen due to the natural accessibility of the population and the limited availability of similar populations within a defined timeframe. Opportunity sampling was both logistically feasible and time-efficient, and was beneficial as it directly showed how our findings apply to the real world. Finally, because educators and staff involved in AbilityPath were already closely observing participants throughout the program and had an understanding of how most of the participants behaved in previous AbilityPath programs, they were well-positioned to provide context through their interviews.

Results and Discussion

We conducted our 8-week pilot study to answer the question: In what ways can brief group CBT (in the form of the MindBridge Curriculum) effectively address emotion regulation and social awareness challenges faced by Transitional Aged Youth with developmental disabilities? We believed that Group CBT would improve emotion regulation and social awareness among participants. We ultimately found that our standard quantitative survey tools were largely ineffective in capturing meaningful changes in social awareness and emotion regulation, but our qualitative data suggests that participants had improvements in these two key areas.

Despite our intention to evaluate the effectiveness of Brief Group Cognitive Behavioral Therapy (CBT) through MindBridge for Transitional Aged Youth with developmental disabilities, we encountered significant challenges in collecting quantitative data. In this sample, we concluded that the five matched pre–post datasets do not represent valid measurements of emotion regulation or social awareness. Many participants were unable to accurately complete the survey instruments due to difficulties interpreting the questions or understanding rating scales, and, combined with our small sample size, given that this was a pilot study, we chose not to perform statistical inference or draw quantitative conclusions about the broader population to avoid false conclusions.

This aligns with existing research, which suggests that individuals with intellectual and developmental disabilities (IDD) often face barriers to self-report measures, potentially reducing the reliability and validity of quantitative findings. Research has consistently identified several specific response biases that affect individuals with IDD during self-report measures. Acquiescence bias, or "yea-saying," is particularly pronounced in this population, where respondents tend to agree with questions regardless of content.[22] Studies have also documented extreme response patterns, where individuals with IDD, especially those with more severe intellectual disabilities, tend toward selecting the most positive response options in Likert-type scales.[23] Studies examining the psychometric properties of self-report measures in IDD populations have found mixed results regarding reliability and validity. A systematic review of self-reported health measures for people with intellectual disabilities found that while some adapted measures showed promise, they often had only "fair to moderate" reliability and validity.[24]

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Our qualitative analysis of interview transcripts from therapists, educators, and participants themselves surfaced two primary themes:

1. Increased Self-Regulation Skills: Therapists observed behavioral indicators of improved emotion regulation, such as one participant taking more intentional breaks when feeling overwhelmed.
2. Enhanced Social Awareness and Confidence: Participants reported greater ease in making friends and identifying their own emotions, while lead therapists noted broader improvements in overall confidence and social engagement.

A. Increased Self-Regulation:

We saw an increase in self-regulation skills as reported by educators at AbilityPath. One example where we witnessed this change was when one participant experienced conflict with a peer and began to show early signs of escalation, including agitation and raised voice tone. Rather than continuing in this heightened state, the participant was observed to independently remove himself from the room, engage in a brief walk, and return when calm. A lead therapist identified this shift as evidence of an emerging ability to recognize internal signals of emotional distress—a critical skill that CBT interventions are specifically designed to strengthen. He described this participant more generally as being "able to take more breaks when he got stressed or overwhelmed."[25] Observing participants applying these skills in real-world contexts provides insight into how the curriculum translates outside of the structured program. While participants in our study struggled to self-report their use of cognitive skills on surveys, the observed behaviors and reported anecdotes suggest that these techniques were nevertheless being utilized.

Another participant reinforced this core aim of CBT, saying, "If I feel stressed or overwhelmed or nervous, I take deep breaths to calm myself down."[26] Individuals were able to recognize and address their internal states accurately and employ CBT coping strategies, corroborating Beck's cognitive theory of emotional disorders, which posits that increased self-awareness and cognitive restructuring can improve adaptive functioning.[27] Importantly, improved self-regulation is an outcome with real-world implications. Transition-aged youth who are unable to regulate their emotions may encounter difficulties in school settings and even in peer relationships. By contrast, the ability to pause and re-engage following distress can contribute to smoother interpersonal interactions and enhanced opportunities for autonomy in daily life. In this way, these skills are long-term developmental competencies for this population.

B. Increased Social Awareness and Confidence:

For Enhanced Social Awareness and Confidence, participants shared how the program enabled them to make friends comfortably and feel confident socializing with others. One participant, Vik, said, "I'm proud of coming with my own actions and feelings and how to meet people for the first time."[28] He also added, "I've learned how to share common interests with [friends] to see what we'd like to do for fun in the future."[29] Vik understood a more intentional, empathetic side of relationship-building by asking about others and working to form these common bonds, beyond just being more comfortable in social situations and making new friends. These statements similarly corroborate the claims from the educators at AbilityPath that participants typically gained general confidence and pride as a result of the program.

Both of our interviewed social recreational therapists reported that participant confidence improved throughout the sessions. Lead therapist of the day programs at AbilityPath, Kayla, shared a difference she noticed in one participant, Eldin: "Eldin has truly benefited from the mind bridge activities, he has shown growth in understanding feeling and emotion, and how to work through them. He has shown more confidence in himself and growth in areas he is working to improve."[30] Similar to what we noticed from participants like Vik, Kayla reported on the direct increase in confidence, along with Kai, an intern who attended all MindBridge sessions, who agreed that "some of their confidence has gone up—at least a little," as a result of MindBridge.[31] These findings align with research indicating that GCBT interventions tailored to social cognition can improve both emotional literacy and peer interactions among individuals with ASD and ADHD, who often find social awareness particularly challenging.[32]

Result Synthesis:

Our qualitative findings consistently showed that group CBT provided through the MindBridge model fostered meaningful improvements in self-regulation and social awareness, as perceived by therapists and participants. In a group setting, participants practice coping strategies, but also watch peers successfully deploy them, a mechanism consistent with Beck's cognitive model of emotional regulation and Bandura's social learning theory, emphasizing learning through observing others and group interaction.[33, 34] At the same time, adaptations that we implemented in MindBridge, such as simplified language, visual supports "such as pictures, drawings, and signs" for easier recognition, and repeated practice—"slower pace, using repetition" and "extra practice"—likely reduced cognitive load and made abstract CBT concepts more accessible for participants with IDD.[35-37] However, these insights were not reflected in significant quantitative score changes, likely due to barriers in survey completion and interpretation. This triangulation—significant qualitative gains contrasted with inconclusive quantitative results—illustrates the need for multi-method assessment in populations with developmental disabilities and supports the notion, echoed in recent scholarship, that qualitative data can be more valid and impactful in evaluating mental health interventions for people with IDD. Although more traditional self-report methods, as used in our study, often fail to capture meaningful outcomes among TAY with IDD, our findings qualitatively point to the core mechanisms of group CBT working as theorized.

Analysis of Data Collection:

A significant strength of our pilot study was the adoption of this mixed-methods framework, integrating both quantitative and qualitative sources. While utilizing a survey provided us with easily measurable data, relying solely on these survey responses would've prevented us from understanding the holistic picture of the program's impact, including the changes reported by the educators. Hearing directly from participants about their takeaways and highlights—alongside insights fromeducators—allowed us to apply our findings in a real-world context and deepened our understanding of the observed improvements. Additionally, the educators at AbilityPath were uniquely positioned to observe our pilot curriculum and, as a result, provided valuable and credible insight into the changes in the participants over the 8 weeks.

However, with a restricted sample population, we are unable to generalize our findings to the full subset of transitional-age youth with developmental disabilities and co-morbid psychiatric conditions. Self-enrollment may lead to a sample with higher social and general motivation, and thus may have led to potential skew in our findings. Additionally, we had no control group due to the complicated nature of this eight-week curriculum and the difficulty in finding representative participants. The lack of neurotypical controls made it difficult to isolate the effects of MindBridge's CBT curriculum from external factors like monthly timing or additional programs, but we attempted to mitigate the impact by asking educators for previous cohort observations, without the implementation of the curriculum. Without a control group, we cannot fully rule out the possibility that the observed improvements were due to maturation, concurrent experiences, or other factors. While our methodological choices were shaped by the practical constraints of working with a specialized population within a limited time window, future iterations of this research should aim to incorporate a waitlist control group and expand the sample through broader recruitment strategies.

Finally, finding an alternative method for quantitative research specifically adapted for people with IDD would've allowed us to look at the full, mixed-methods procedure successfully. For example, offering multiple modes of response, such as visual scales or presenting the questions in verbal interview form, or providing built-in clarification prompts, may help with misunderstandings. Simplifying the Likert scale to visual representations may make it easier to interpret each number, as well. As Cox and Nachman (2020) argue, trustworthy data collection for students with disabilities must go beyond standardized instruments and actively include adaptive, multimodal approaches tailored to the unique needs of this population.[38] As this research expands to a generalizable scale, we hope that data collection can become more precise quantitatively, working with participants with IDD.

Limitations and Ethics:

Opportunity sampling comes with notable limitations. Because participants were not randomly selected, our sample may not accurately represent the broader population of Transition Age Youth (TAY) with developmental disabilities, limiting the generalizability of our findings. Furthermore, due to confidentiality constraints, we were not informed of each participant's specific disability or co-occurring mental health conditions, making it difficult to tailor our curriculum to their individual needs. Overall, theoretical differences in treatment response would be expected, such that individuals with ADHD may show greater improvements in executive functioning, emotional regulation, and task-related coping strategies, and individuals with anxiety disorders may demonstrate more gains in cognitive restructuring, anxiety reduction, and tolerance of uncertainty. We were also only able to include participants ages 18-26, despite our previously defined range of TAY as 16-26, due to availability constraints. Finally, despite the final sample consisting of 10 participants, we were only able to collect pre- and post-intervention quantitative data from five participants, as some were absent during either week 1 or week 8.

Special attention was paid to ensuring ethical research practices. Surveys and interviews were designed to be accessible to all participants, with necessary assistance. We followed ethical guidelines and received formal approval from the North Star Review Board. To ensure confidentiality, participants were assigned a random pseudonym that would remain anonymous to all except an arbitrary staff member at AbilityPath with no further involvement in the study. An additional limitation of our study was that our observers—the educators who noted improvements—were aware of the study, and thus, there may have been bias in their recognition of improvements.

■ Conclusion

Our findings offer valuable qualitative insights into how the pilot curriculum, MindBridge, improved both emotional regulation and social awareness. Our feedback from participants and educators suggested perceived benefits, indicating that under our specific implementation, brief GCBT may be able to produce measurable change in this population; however, due to the nature of our pilot study, we cannot generalize.

Despite our limitations, our overall findings contribute to the broader conversation around equitable mental health access for neurodivergent youth and highlight the pressing need for evidence-based, population-sensitive interventions in community settings. Disability-focused nonprofit organizations, such as Ability Path, may consider supplementing GCBT with additional supports, including individualized sessions, family engagement, and ongoing feedback or training from caregivers and disability service staff. Thoughtful program evaluation may be helpful prior to broader implementation, particularly in more resource-constrained settings. For future research, we recommend exploring more intensive or extended versions of GCBT interventions (e.g., 12-week formats or daily sessions), utilizing outcome measures that are both sensitive and developmentally appropriate, and implementing additional assessment tools—such as longitudinal follow-up studies, digital self-monitoring apps, or caregiver behavioral checklists—to capture better more substantive, long-term, and overall perspectives on both objective and subjective outcomes.

We believe GCBT remains a promising and underexplored intervention for this underserved population. Its potential im-

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pact is especially relevant to policymakers, special education administrators, and researchers in clinical psychology and special education. We are committed to continuing the development and dissemination of MindBridge, and plan to share it with local nonprofits and schools serving individuals with co-occurring mental health disorders and developmental disabilities. We are eager to continue exploring and refining the CBT model across diverse settings to better meet the needs of the individuals we aim to serve.

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Authors

Kinsey Nam and Ariya Kaushek (classmates at Menlo School) both discovered a passion for mental health and education through personal experiences with Cognitive Behavioral Therapy (CBT). Both are passionate about making CBT accessible to adolescents with developmental disabilities and mental health challenges, while raising awareness of CBT's wide-ranging applications. Through MindBridge, they are committed to helping all children and young adults build resilience, confidence, and access the tools they need to succeed.

Appendix

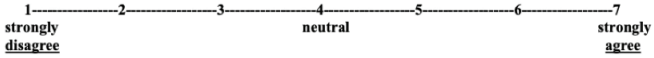
[A] - Transitional Aged Youth Participant in MindBridge Survey

Please take 3–5 minutes to complete the self-report survey below. It asks about your behaviors, thoughts, and emotions over the past 8 weeks, based on your own observations. Be sure to refer to the scale provided as you answer each question.

What is your given (fake) name?

Response Scale: A number indicates the level of agreement expressed in the response

Note - Select 0 to Opt-Out of Response



Questions:

- In the past 8 weeks, whenever I've wanted to feel joy, I've shifted my thoughts to something more positive: ***(Note - Select 0 to Opt-Out of Response)***

- In the past 8 weeks, I have felt in control of my emotions and able to manage how I feel: ***(Note - Select 0 to Opt-Out of Response)***

- In the past 8 weeks, I have tried something that scared me: ***(Note - Select 0 to Opt-Out of Response)****

- In the past 8 weeks, when I felt nervous or worried, I used a CBT strategy to help me cope with my emotions: ***(Note - Select 0 to Opt-Out of Response)****

- In the past 8 weeks, the risks I have taken have had positive outcomes: ***(Note - Select 0 to Opt-Out of Response)***

- In the past 8 weeks, I have openly communicated my emotions with others: ***(Note - Select 0 to Opt-Out of Response)***

- In the past 8 weeks, I have had conversations with other people about their feelings: ***(Note - Select 0 to Opt-Out of Response)***

- In the past 8 weeks, when I want to feel less angry or sad, I change what I am thinking about: ***(Note - Select 0 to Opt-Out of Response)****

- In the past 8 weeks, I have recognized when others need support, and I have offered my help: ***(Note - Select 0 to Opt-Out of Response)***

- In the past 8 weeks, when I have felt strong emotions, I have thought about the consequences of my behaviors before acting on my emotions: ***(Note - Select 0 to Opt-Out of Response)****

- In the past 8 weeks, I have listened when others are speaking and engaged with what they were saying: (Note - Select 0 to Opt-Out of Response)

- In the past 8 weeks, I have made goals that I have stuck to: ***(Note - Select 0 to Opt-Out of Response)***

- In the past 8 weeks, I have noticed when people around me seem confused: ***(Note - Select 0 to Opt-Out of Response)***

- In the past 8 weeks, I have felt proud of my actions and who I am as a person, and I feel that I have supported and uplifted others: ***(Note - Select 0 to Opt-Out of Response)****

- In the past 8 weeks, I've been able to understand how others are feeling without them having to say anything: ***(Note - Select 0 to Opt-Out of Response)***

- In the past 8 weeks, I've found myself curious about how others have felt in certain situations: ***(Note - Select 0 to Opt-Out of Response)***

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- In the past 8 weeks, I've found myself curious about other people's thoughts and opinions: ***(Note - Select 0 to Opt-Out of Response)***

[B] - Interview Questions

Interview Questions - (Participant)

I. General:

- What do you like most about coming to MindBridge?

- What's one thing you've accomplished during MindBridge that made you feel proud?

- Can you share an example of a time when you used a skill you've learned—such as a coping strategy, mindfulness technique, or thought reframing—in your everyday life?

II. Changes or Growth:

- Have you noticed any changes in the way you think or act compared to before you started the program? If so, can you share one example?

- What skill that you learned during MindBridge helps you the most when you're feeling upset, stressed, or overwhelmed?

- After going through MindBridge, what's something that used to feel difficult but now comes easily to you?

III. Reflection:

- What would you tell someone who is thinking about joining MindBridge?

- How would you describe MindBridge in one word?

- Do you feel happier or more confident after the program? Why or why not?

Interview Questions - (Educators / Facilitators)

I. Experience with the Curriculum:

- What has it been like implementing the MindBridge CBT curriculum? More specifically, what was successful, and what were some challenges?

- Can you share any surprising or memorable moments during sessions?

- What behavioral or emotional changes have you observed in your students or participants since implementing MindBridge?

- Can you describe a success story that stands out?

- How have participants grown in terms of confidence, communication, coping skills, and emotional regulation or awareness?

- Why is a program like MindBridge important for individuals with developmental disabilities?

- What would you say to another school or organization thinking about using MindBridge?

- How has this program impacted you personally as an educator?