2015

# Social Participation: An Occupational Therapy Guide to Intervention for Youth with Depressive Disorders

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# SOCIAL PARTICIPATION: AN OCCUPATIONAL THERAPY GUIDE TO INTERVENTION FOR YOUTH WITH DEPRESSIVE DISORDERS

by

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Master of Occupational Therapy, University of North Dakota, 2015

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A Scholarly Project

Submitted to the Occupational Therapy Department

of the

University of North Dakota

In partial fulfillment of the requirements

for the degree of

Master of Occupational Therapy

Grand Forks, North Dakota
May
2015

This scholarly Project Paper, submitted by Alexandra L. Marvel, MOTS, in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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Abstract

**Purpose:** The purpose of this scholarly project is to present an intervention guide for occupational therapists working with children and adolescents diagnosed with or experiencing depressive disorders. This guide will focus on the occupation of social participation.

**Methods:** An extensive literature review of evidence-based journal articles addressed the definition of depressive disorders in both adults and children and adolescents, the impact symptoms have on occupations and daily functioning, current treatment approaches, and the role of occupational therapy.

**Results:** The product of this scholarly project is an occupational therapy intervention guide to promote social participation for children and adolescents diagnosed with or experiencing depressive disorders. Concepts from the Ecology of Human Performance model provide the foundation for this intervention guide. Reproducible handouts addressing social participation with peers, family, and within the community are provided.

**Conclusion:** Social participation is a key area of occupation that is affected by symptoms of depressive disorders. The intervention guide created for occupational therapists promotes child and adolescent social participation amongst peers and family, as well as within the community.

# CHAPTER I

## INTRODUCTION

Approximately 80% of mental illnesses begin during childhood or adolescence (Krieger, Leibenluft, Stringaris, & Polanczyk, 2013). Pfalzgraf et al. (2012) report that 10-15% of children and adolescents in the United States have at least 1 symptom of depression. Approximately 2% of those aged 6-12 and 4-8.3% of those aged 13-18 are diagnosed with a depressive disorder (Pfalzgraf et al., 2012). Symptoms associated with depressive disorders often impact daily functioning and participation in occupation in a variety of ways. For children and adolescents, the Substance Abuse and Mental Health Services Administration (SAMHSA) (2008) identifies 4 key areas impacted by depression, including home life, school or work, family relationships, and social life. Although the symptoms associated with depressive disorders often affect a variety of occupations, social participation appears to be the most widely affected (Bazyk & Brandenburger Shasby, 2011; Bonder, 2015; Desha and Ziviani, 2007). There are few occupation-based resources available to occupational therapists working with children and adolescents diagnosed with depressive disorders who demonstrate impairments in social participation.

## Purpose

The purpose of the scholarly project is to provide a guide for intervention for occupational therapists working with children and adolescents who have been diagnosed with or are experiencing depressive symptoms. Social participation, an area of occupation commonly addressed in occupational therapy, is often affected by depressive symptoms. Among the ten tasks identified by Simpson (2001) as pertinent to adolescent development, forming friendships and creating a more balanced relationship with family, (social interaction) emerges as a key area of adolescent development. The guide, *Social Participation: An Occupational Therapy Guide to Intervention for Youth with Depressive Disorders*, is intended to be adapted for a variety of settings, such as inpatient psychiatric hospital, outpatient psychiatric setting, or school system. For the purposes of this scholarly project, the Intervention Guide will be used to reflect *Social Participation: An Occupational Therapy Guide to Intervention for youth with Depressive Disorders*.

## Occupation-Based Model

The Ecology of Human Performance (EHP) model was chosen to support the development of the Intervention Guide. The model has three main focus areas, including person, environment, and occupation or task. By incorporating a holistic view, the EHP model acknowledges the body, mind, and spirit of an individual (Brown, 2009). Brown (2009) identifies variables such as values and interests, skills and abilities, and life experience as being associated with the person. The environment consists of the physical, cultural, social, and temporal components (Brown, 2009). According to Brown (2009), the EHP model incorporates the term *task* instead occupation. Task is defined as

"objective representations of all possible activities available in the universe" (Brown, 2009, p. 437).

One assumption of the model is that the relationship between the person, environment, and task is unique for each individual and that each area interacts in a time continuum (Brown, 2009). In addition, the EHP model considers environment as a major factor in predicting how successful an individual will complete a task and how satisfied they will feel with their performance. Emphasis is placed on assessing the environment to identify a better fit between the person and the environment, rather than changing the person (Brown, 2009). Brown (2009) describes the EHP model as client-centered, as the occupational therapy process begins with identifying tasks the individual finds meaningful and wants or needs to participate in. Collaboration between the client and occupational therapist is emphasized throughout the intervention process in the EHP model (Brown, 2009).

## Key Terms

The following are identified as key terms and concepts utilized throughout the scholarly project. The main terms and concepts are defined for consistent understanding.

- Child: "any human between infancy and puberty" (Taber's Cyclopedic Medical Dictionary, 2009, p. 429)
- Adolescent: "pertinent to adolescence" (Venes & Taber, 2009, p. 51); "a young man or woman not fully grown" (Venes & Taber, 2009, p. 51)
- Depressive Disorder: a disorder presenting with "lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of

energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide" (American Psychological Association, 2015, para. 1)

- Occupation: "life engagements that are constructed of multiple activities" (American Occupational Therapy Association [AOTA], 2014, p. S6); "central to a client's identity and sense of competence and have particular meaning and value to that client" (AOTA, 2014, p. S5)
- Intervention Approach: "specific strategies selected to direct the process of evaluation and intervention planning, selection, and implementation on the basis of the client's desired outcomes, evaluation data, and evidence" (AOTA, 2014, p. S33).
- Performance Skill: "goal-directed actions that are observable as small units of engagement in daily life occupations" (AOTA, 2014, p. S7)

## Conclusion

The scholarly project focuses on children and adolescents diagnosed with or experiencing depressive disorders. Children and adolescents with depressive disorders often experience impairment in the area of social participation. Occupational therapists working with children and adolescents can incorporate the Intervention Guide to address impairments in social interaction that their clients may be experiencing.

Chapter II presents an extensive literature review focusing on the definition of depressive disorders in children and adolescents, the impact of the symptoms on occupations and daily functioning, current treatment approaches, and the role of occupational therapy. Chapter III provides a description of the methodology used to

complete the scholarly project, including literature sources utilized, summary of the occupation based model chosen, and a brief description of the product. Chapter IV consists of the final product, which resulted in an Intervention Guide occupational therapists can utilize when working with children and adolescents with depressive disorders. Chapter V contains the conclusion of the scholarly project, key information found within the literature, limitations of the project, and recommendations for implementation.

# CHAPTER II

# REVIEW OF LITERATURE

## Introduction

The Centers for Disease Control and Prevention (CDC) (2014a) defines children as youth ages 4 to 11 and adolescents or teens as individuals ages 12-19. Simpson (2001) states the adolescent age is defined according to the achievement of biological milestones. According to Simpson (2001), there are ten tasks associated with being an adolescent. The tasks are based upon developmental changes that can be expected and require support during adolescents. The tasks focus on sexual maturation of both feelings and bodies, development and application of thinking skills, identifying values and beliefs, understanding and expressing emotions, forming friendships, establishing individualized identity, taking on roles and responsibilities, developing and applying coping skills, and creating a more balance role with parents (Simpson, 2001).

According to Lamber and Carley (2013), external and internal factors should be considered when working with adolescents, as these also impact their mental health. The adolescent's context is an example of an external factor. Internal, or personal factors, include heredity, family structure, ability to cope, self-efficacy, and availability of support systems. Adolescents experience increased psychosocial stressors, such as abuse,

traumatic events, social isolation, or dysfunctional families that can potentially impact mental health (Lambert & Carley, 2013).

In the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM 5) the American Psychiatric Association (APA) (2013) has divided the category of mood related disorders into specific categories. One of the categories includes depressive disorders. Three diagnoses in particular are reviewed, followed by behaviors commonly associated with depressive disorders, current treatment standards, and the role of occupational therapy.

## Depressive Disorders

Depressive disorders are commonly acknowledged as debilitating diagnoses, often presenting with sadness, a feeling of emptiness, and irritable mood, as well as decreased interest in activities (APA, 2013). As mentioned, the category of depressive disorders is further separated into eight diagnoses. The following are recognized as diagnoses that are included in the category of depressive disorders: disruptive mood dysregulation disorder, major depressive disorder, persistence depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. Each of the diagnoses affect a wide range of individuals and have varying effects on their ability to function in a variety of settings. Pfalzgraf et al. (2012) report that approximately 10-15% of children and adolescents in the United States have at least 1 symptom of depression. Pfalzgraf et al. (2012) state that 2% of individuals aged 6-12 and 4-8.3% of individuals aged 13-18 have depression. In

addition, they concluded that approximately $83.1 billion is spent on depression and that it is the leading cause of disability (Pfalzgraf et al., 2012). For the purposes of this scholarly project, the focus will be on major depressive disorder, disruptive mood dysregulation disorder, and persistent depressive disorder (dysthymia). The diagnostic characteristics, prevalence, development and course, risk and prognostic factors, and common treatment concerns will be reported for each diagnosis.

**Major Depressive Disorder**

Major depressive disorder is the most common depressive related diagnosis. According to the DSM 5 (2013), major depressive disorder entails symptoms of a depressed mood or loss of pleasure or interest which cause significant distress or impairment (see Appendix A for complete diagnostic criteria). For children and adolescents, there may be a presence of irritable mood, lack of corporation, and disinterest from previously enjoyed occupations (APA, 2013; Lack & Green, 2009).

Major depressive disorder is found to be the most prevalent mental illness that affects children and adolescents (Elmquist, Melton, Croarkin, & McClintock, 2010). Pfalzgraf et al. (2012) and Elmquist et al. (2010) report that 13-25% of children and adolescents will experience 1 episode of major depressive disorder prior to reaching adulthood. The DSM 5 (APA, 2013) reports that 7% of individuals living in the United States are affected by major depressive disorder, reporting that individuals aged 18-29 are three times more likely to be diagnosed than individuals over the age of 60; it is reported that the peak age of onset is 20 years of age. Elmquist et al. (2010) have concluded that major depressive disorder will affect 1-2% of children and 4-8% of adolescents. There

are many risk factors associated with major depressive disorder. The risk factors include negative affect, adverse childhood experiences, and stressful life events and that individuals who have a family member with major depressive disorder are 2-4% more likely to develop major depression (APA, 2013; National Institute of Mental Health [NIMH], 2011). Yip (2005) reports that females are at a greater risk for major depressive disorder with 10-25% of women experiencing symptoms and only 5-12% of males. The DSM 5 (APA, 2013), as well as Lack and Green (2009) report similar statistics that females are at a risk of 1.5-3 times greater than their male counterparts. There are other diagnoses that commonly co-occur with major depressive disorder. Common co-morbidities of major depressive disorders include, but are not limited to: substance-related disorder, obsessive-compulsive disorder, bulimia nervosa, anorexia nervosa, panic disorder, borderline personality disorder and other disruptive behavior disorders, such as conduct disorder and attention-deficit/hyperactivity disorder (ADHD) (APA, 2013; NIMH, 2011, Lack & Green, 2009). Due to the comorbidities, there is increased difficulty for accurate diagnosis and treatment (Lack & Green, 2009).

**Disruptive Mood Dysregulation Disorder**

Disruptive mood dysregulation disorder (DMDD) is often associated with irritability and extreme behaviors (see Appendix B for complete diagnostic criteria). Disruptive mood dysregulation disorder has recently been added to the depressive disorders category to avoid over-diagnosis of bipolar disorders in children (APA, 2013; Krieger et al., 2013; Margulies, Weintraub, Basile, Grover, & Carlson, 2012). Ryan (2013) and Margulies et al. (2012) reports that DMDD is relatively controversial due to

limited data and that it looks at relabeling potential diagnoses of bipolar disorders or other related mood dysregulation disorders.

According to the DSM 5 (2013), DMDD affects 2-5% of children and adolescents. It is estimated that DMDD is more commonly seen in males than females (APA, 2013). The DSM 5 (APA, 2013) reports that risk factors for DMDD include history of chronic irritability and potentially a genetic component. It is noted that the genetic component, however, is not as significant as it may be for individuals with a bipolar related disorder (APA, 2013). It is important to note that individuals may meet diagnostic criteria for additional diagnoses, such as oppositional defiant disorder, anxiety disorder, major depressive disorder, and attention-deficit/hyperactivity disorder (APA, 2013).

**Persistent Depressive Disorder (Dysthymia)**

The DSM 5 (2013) combines chronic major depressive disorder and dysthymic disorder into persistent depressive disorder (dysthymia). As the most chronic form of depression, dysthymia is often associated with a depressed mood for 2 years or more for adults and at least 1 year for children and adolescents (see Appendix C for complete diagnostic criteria) (APA, 2013). It is estimated that of the United States population, approximately 0.5% are affected by dysthymia and 1.5% are affected by chronic major depressive disorder (APA, 2013). The risk factors associated with the diagnosis are an increased negative affect, symptom severity, poor global functioning, comorbid anxiety or conduct disorders, and parental loss or separation. In addition, the DSM 5 (2013) reports that genetics play a main factor in dysthymia compared to others within the same

category. Diagnoses that often coexist with dysthymia include anxiety and substance use disorders, as well as personality disorders (APA, 2013).

## Impact of Depressive Disorders

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2008) identifies 4 key areas impacted by depression for children and adolescent, including home life, school or work, family relationships, and social life. For both children and adolescents, academic performance and participation is often impacted significantly by depression (Meadus 2007; Navalta, Goldstein, Ruegg, Perna & Frazier, 2006; Sadock, Sadock, & Ruiz, 2015; Wei, Cooke, Moyle and Creedy, 2010). Sadock et al. (2015) has identified that children in particular appear to present with a phobia of attending school, whereas adolescents are more likely to demonstrate decreased performance. Drug and alcohol abuse is noted to increase for children and adolescents with depression, as well (Meadus, 2007; Sadock et al., 2015; Wei et al., 2010). Decreased social interaction with peers and family is most commonly noted as an impact of depressive symptoms for children and adolescents (Bazyk & Brandenburger Shasby, 2011; Bonder, 2015; Desha and Ziviani, 2007; Yip, 2005). Sadock et al. (2015) notes that children with depression are often seen clinging to their parents, whereas adolescents with depression demonstrate antisocial behavior and social promiscuity, which may lead to impairments with peer relations.

Bonder (2015) has identified common treatment concerns for symptoms associated with depressive disorders. For major depressive disorder, Bonder (2015) reports that function in all areas of occupation are impacted, such as self-care tasks, work,

leisure, sleep, play, instrumental activities of daily living, and social interaction. Bonder (2015) identifies that executive functioning and memory, in particular, are impacted by depression, therefore, these areas should be a key focus for any health care professional working with a child or adolescent with major depressive disorder. Emotional regulation and sexual function are identified as being key areas to address, as well (Bonder, 2015). For children or adolescents with dysthymia, Bonder (2015) reports that impairment is considered to be mild or moderate in degree. Children and adolescents with dysthymia are able to hold jobs and to have social interactions, however, their lack of interest and depression affects those around them, including peer and family interaction (Bonder, 2015). In addition, dysthymia is associated with chronic impairments (Bonder, 2015). Bonder (2015) reports that DMDD impacts emotional regulation in children and adolescents, often leading to increased behaviors. Social impairment and increased school difficulty are noted for children and adolescents with DMDD (Bonder, 2015).

## Associated Behaviors

Many children and adolescents exhibit troublesome behaviors, especially individual's whom may have a diagnosis that was discussed above. Although severity and duration of each behavior may differ for each individual, associated behaviors contribute to impairment in a wide variety of contexts and areas of functioning. According to Jackson and Arbesman (2005), 1-5% of children and adolescents demonstrate problem behaviors, requiring increased supports from school personnel, family, and other potential caregivers. There are many behaviors that are particularly troublesome, but it appears that irritability is the most commonly reported. Ryan (2013)

reports that in addition to irritability, temper outbursts, depressed mood, or euphoric mood are the most impairing behaviors for school-aged children. Crowe et al. (2006) recognized that the most common symptoms for adolescents diagnosed with depression were sadness, crying, suicidal ideation, fear of failure, guilt, feeling unattractive, and self-dislike.

Irritability is defined as an annoyance or touchiness that may present with anger and temper outbursts (Stringaris, 2011). Brotman et al. (2006) concluded that 3% of the 1420 children participants who completed the Child and Adolescent Psychiatric Assessment (CAPA) met criteria for severe mood dysregulation, or chronic and impairing irritability. In comparison, however, Pickles et al. (2010) reported that 19.1% of male adolescents and 23.9% of female adolescents will experience irritability. Margulies et al. (2012) concluded that irritability in children and adolescents is difficult to treat and manage because there is no way to target explosive behaviors in a unified fashion. There have been a wide variety of treatment options available, but little research has been done to create a treatment approach that can be used by all (Margulies et al., 2012). Mikita & Stringaris (2013) propose that instead of looking at irritability as a diagnostic category, it should be viewed and treated as if it were on a spectrum of severity.

For adolescents diagnosed with or experiencing depression, symptom severity may lead to negative thoughts. Lack and Green (2009) state that individuals may feel inadequate due to the negative thoughts and be hesitant to seek help. Negative feelings can progress to feelings of worthlessness, which may lead to suicidal ideation or attempts. According to the Centers for Disease Control and Prevention (CDC) (2014b),

the third leading cause of death among children and adolescents is suicide, with approximately 4,600 children and adolescent lives lost each year in the United States. The CDC (2014b) reports the most common form for adolescents to commit suicide is with a firearm, followed closely by suffocation, and then poisoning. Male adolescents are most often reported committing suicide, at 81%, however, female adolescents are more likely to report attempting suicide than males. Approximately 157,000 children and adolescents receive medical care for injuries that were self-inflicted each year (CDC, 2014b).

## Current Treatment Standards & Approaches

As with most psychiatric disorders, there are many treatment approaches and standards employed for depressive disorders. Ryan (2013) has stated that it is vital to look at the symptoms each individual is experiencing while incorporating research-based treatment approaches for the best outcomes. The following have been utilized for treatment approaches for children and adolescents diagnosed with depressive related disorders: pharmaceutical, family-focused treatment, systemic therapy, cognitive behavioral therapy (CBT), and a strengths perspective approach.

### Pharmaceutical

In combination with other approaches, medications are often incorporated into treatment approaches for children and adolescents diagnosed with a depressive disorder. Waxmonsky et al. (2008) studied the combination of utilizing methylphenidate and behavioral modification therapy for children diagnosed with attention-deficit/ hyperactivity disorder and individuals experiencing persistent irritability. They report

that using a combination of methylphenidate and behavioral modification therapy was both tolerable and effective. In addition, the authors report that there was little acute risk leading to manic episodes (Waxmonsky et al., 2008). Pfalzgraf (2012) and Elmquist et al. (2010) concluded that the most common approach for treating children and adolescents with major depression disorder was a combination of psychotherapy and antidepressants. Lack and Green (2009) reported medication as being the most effective form of treatment, with selective serotonin reuptake inhibitors (SSRIs) being the most commonly prescribed to children and adolescents. There is potential for increase in suicidal thoughts or behaviors among individuals taking SSRIs. The authors conclude that the reason for the increase in suicidal thoughts or behaviors may be due to side effects of the medication but report these side effects may decrease with time (Lack & Green, 2009).

**Family-Focused Treatment**

Family-focused treatment is an approach that is often used for children and adolescents and is often used in conjunction with other approaches (Miklowitz et al, 2008; Miklowitz et al., 2014; Goldstein et al., 2014). According to NIMH (2008) family-focused treatment incorporates the client and family in psychosocial based treatment session. The sessions commonly focus on symptomology, course, and episodes of the diagnosis that the client has (NIMH, 2008). Family-focused treatment addresses communication between the client and family, as well as problem-solving skills and strategies for managing the illness (NIMH, 2008). Goldstein et al. (2014) reports that family-focused treatment has been proven to be effective in preventing recurrence of

mood episodes, improving medication adherence, and reducing manic and depressive symptoms. Family-focused treatment, when used in combination with pharmaceuticals, has the potential to be effective for adolescents diagnosed with bipolar and depressive related disorders (Miklowitz et al., 2008; Miklowitz et al., 2014).

**Systemic Therapy**

Systemic therapy is similar to family-focused treatment. Retzlaff, Sydow, Beher, Haun, and Schweitzer (2013) define the family-focused treatment approach as a form of psychotherapy that focuses on the behaviors and psychological symptoms an individual is experiencing within social contexts. Systemic therapy includes family members or others who may be involved in the life of the individual being treated. The individual's perspective on resources, problems, and preferred solutions is valued and utilized (Retzlaff et al., 2013). Retzlaff et al. (2013) completed a systematic review of 38 randomized trials to determine the efficacy of systemic therapy for children and adolescents diagnosed with a psychological disorder. Upon completion of the study, the authors concluded that systemic therapy was significantly more successful than control groups and that it was more efficacious than other interventions, such as CBT, group therapy, or family psychoeducation. Retzlaff et al. (2013) report that CBT can be used in a wide variety of settings, such as individual therapy, family group therapy, or multi-family group therapy and is most beneficial for children and adolescents experiencing internalizing psychological disorders.

**Cognitive Behavioral Therapy**

According to Mikita & Stringaris (2013), cognitive behavioral therapy (CBT) is well tolerated and often found to be the most effective for children and adolescents with irritability. Lack and Green (2009) concluded that CBT is most studied and is widely used for treatment. The goals, as described by Lack and Green (2009), is to help the child or adolescent understand how their thinking impacts the way that they feel and how to change their thinking patterns to better themselves. The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) includes many evidence-based approaches that healthcare professionals can take. They have included a wide variety of cognitive behavior interventions for varying ages and a wide variety of diagnoses. Some pertinent to children and adolescent with depressive disorders include CBT for Adolescent Depression, the Adolescent Coping with Depression (CWD-A) program, the FRIENDS Program, and the Family Intervention for Suicide Prevention (FISP).

Lasting approximately 12 to 16 weeks, CBT for Adolescent Depression is offered within an outpatient mental health facility (David, 2014). Each participant in the CBT for Adolescent Depression program will meet on a weekly basis. The program has adapted the traditional CBT approach for the adolescent population with depressive symptoms. There are five main points that the CBT for Adolescent Depression program emphasizes. The first is to provide concrete examples for the adolescent participants to clearly understand each of the points. Second, to educate the individuals in what psychotherapy is and how socialization is used within the approach. Third, the individuals are allowed

to actively explore autonomy and issues with trust, as well as focus on cognitive distortions and shifts in their mood throughout the sessions. The fourth main point places emphasis on skills training for problem-solving, social skills, and emotional regulation (David, 2014).

The Adolescent Coping with Depression (CWD-A) program focuses on interventions meant for adolescent individuals experiencing depressive symptoms (Rohde, 2014). The main focus of the CWD-A program is to identify problems associated with the symptoms, such as decreased social skills, limited involvement in activities due to decreased interest, negative or irrational thoughts, discomfort, and anxiety. The CWD-A program consists of an 8 week time period where participants meet for 16 two-hour sessions. Participants are placed within groups of 10. The CWD-A program provides each individual with a workbook consisting of structured learning assignments, quizzes, and homework (Rohde, 2014).

The FRIENDS program focuses on emotional resilience (Bekker & Cooper, 2014). The program has been intended as both intervention and self-development. Bekker and Cooper (2014) describe that there is a focus on developing emotional and social skills so that individuals are able to cope with situations that may be challenging. The topics covered include attachment, physiological, learning, and cognitive process that may interfere with development, experience, and maintenance of anxiety. The FRIENDS program is split into four different versions for each developmental level. The first is for children ages 4-7, the second is for children ages 8-11, the third is for adolescents ages 12-15, and the last is for older adolescents and adults ages 16 and older.

The FRIENDS program is split into 10 weekly session. Parents are typically involved at the beginning and midway point of the program. Bekker and Cooper (2014) report that the mode of implementation is through play-based activities, experiential learning, hands-on activities, and role-playing (Bekker & Cooper, 2014).

For ages 10-18, the Family Intervention for Suicide Prevention (FISP) program is for individuals who present with suicide ideation or who have had a suicide attempt (Asarnow, 2014). The main purpose of the cognitive behavioral intervention is to provide individuals an opportunity to develop coping skills, enhance motivation for mental health follow-up, and to improve the likelihood that individuals will seek outpatient treatment services. Asarnow (2014) describes five main areas that the program addresses. The first includes education for families, identifying that suicide is an action that requires attention, and to implement and receive commitment for a safety plan. The second area focuses on strengthening support within the family system. Third, triggers are identified to determine cognitive, behavioral, and physical reactions to each of the triggers. Asarnow (2014) reports that developing a plan for safety and practicing the safety plan is important within the FISP program. The fifth area that Asarnow (2014) describes is to create a card with the safety plan listed on it so that the plan can be used in times of crisis. To implement the FISP program, providers must have minimal training in mental health (Asarnow, 2014).

**Strengths Perspective**

Identifying one's strengths and potential areas needing improvement are important aspects of creating a treatment approach. Yip (2005) describes that by utilizing a

strengths perspective, an individual's strengths and will to recover are the main focuses of intervention. There are five principles to the strengths perspective approach include: (1) to focus on an individual's strengths, assets, and abilities; (2) client-centered goal setting and search for resources; (3) relationship with the individual's case manager is promoted; (4) community is not a barrier, but a resource; and (5) community-based activities are conducted in an active manner. Yip (2005) identified that the strengths perspective approach is beneficial when working with adolescents diagnosed with depression. Yip (2005) describes that interventions with adolescents with depression should not focus on labeling symptoms, common treatments for depressive disorders, and fixation of problems. A professional should instead utilize the five principles as listed above. In addition, the strengths based approach will require continuous assessment of an individual's strength, providing a positive environment, and promoting development of their capabilities (Yip, 2005).

## Role of Occupational Therapy

The profession of occupational therapy emphasizes the need for a client-centered intervention approach viewing the individual in a holistic manner. In order to provide effective and efficient treatment, Crowe et al. (2006) reports that providers must be aware of characteristics pertaining to depressive symptoms. The children and adolescents experiencing depressive symptoms face the risk of having their occupational performance and participation impacted. By receiving occupational therapy services, children and adolescents with depressive symptoms will have the opportunity to improve occupational performance and participation. Desha and Ziviani (2007) report that occupational

therapists can assist children and adolescents with depressive symptoms with modifying use of time habits, by providing them with community resources and opportunities within their communities, activity analysis, and grading the activity to meet their needs. Bazyk and Brandenburger Shasby (2011) state the goal of occupational therapy for children and adolescents with depressive symptoms is to reduce symptoms, build competencies, and minimize the risks they may face.

**Occupations Impacted**

There are many areas of occupations that are affected by symptoms associated with depression. According to Desha and Ziviani (2007), children and adolescents will face limitations primarily in the areas of social participation and academics. Bonder (2015) and Bazyk and Brandenburger Shasby (2011) report social participation to be a key occupation impacted by mental illness. In addition, activities related to productivity, self-care, leisure, and rest should be monitored, as they may be affected, as well (Bonder, 2015; Desh & Ziviani, 2007). Because each area of occupation is performed in a variety of settings, it is important for the occupational therapist to collaborate with the individual and identify which settings are being affected. Occupational therapy services should observe how depression impacts an individual's ability to participate in daily activities in a variety of contexts. The contexts that Desh and Ziviani (2007) report to be the most common include the home, an educational setting, and the community.

**Treatment Approaches**

There are a variety of treatment approaches occupational therapists can take to address potential limitations in occupations. Jackson and Arbesman (2005) conclude that

occupational therapists can intervene on an individual level through a direct one-on-one approach, as well as involving the family in the session. Jackson and Arbesman (2005) report that occupational therapists should be prepared to advocate on the individual's behalf. It is recommend that individual services are utilized due to the variety of personalities and temperaments of each individual, as well as how social behavior is influenced (Jackson & Arbesman, 2005). Individual approaches promote development of one's self-identify (Olson, 2011). Although taking an individual approach has its benefits, there are benefits to taking a group activity approach as well.

Olson (2011) reports that as social participation and interaction impact many occupations, group activities can be utilized by occupational therapists. Malekoff (2014) has provided a framework for groups involving adolescents. The five steps Malekoff (2014) listed include: discovering and defining the purpose, searching for common ground amongst the participants, awareness of the normative values of the culture, promotion of playfulness, and advancing mindfulness through rituals of the group. Malekoff (2014) explains that the five themes are important to incorporate during the implementation of a group because it is crucial that adolescents feel connected to both the cultural and spiritual aspects of the group (Malekoff, 2014). Jackson and Arbesman (2005) advocate for group activities, as they promote both verbal and nonverbal skills, receiving and giving feedback, and how to appropriately utilize the skills in a variety of situations. Group activities that promote social participation provide individuals with an opportunity to further develop supportive and collaborative relationships with peers and family members (Olson, 2011). Olson (2011) reports that children and adolescents,

development is positively affected when family and peer group activities are incorporated into the therapeutic process.

Bonder (2015) has complied a few activities for depressive disorders that are beneficial for occupational therapists to incorporate into the therapeutic process. For disruptive mood dysregulation disorder, as well as other disorders associated with difficult behaviors, it is recommended that emotional expression activities be implemented, which include creative art or craft activities. Bonder (2015) recommends implementing anger management utilizing alternative techniques, such as physical activities, and positive occupations that are age-appropriate be used with children and adolescents with depressive symptoms. Interventions focusing on education for occupational therapists working with children and adolescents diagnosed with depression, such as parents and school teachers, will be beneficial. Bonder (2015) recommends that for major depressive disorder, habits of the individual be addressed, as they may be affected by lack of motivation and interest. Physical activity, social and emotional support, and activities that promote self-esteem and motivation be used. Social skills training and self-expression are beneficial for individuals with major depressive disorder (Bonder, 2015).

## Problem Statement

Children and adolescents diagnosed with or experiencing a depressive disorder have the potential to significantly benefit from occupational therapy services. As mentioned, Crowe et al. (2006) report that although children and adolescents have the highest prevalence of mental health disorders, there are limited resources available.

Specific strategies that may be beneficial to children and adolescents with mental health disorders include identifying occupations that are meaningful, self-regulation, encouragement of active participation, as well as providing strategies for understanding and expressing emotions (Bonder, 2015; Olson, 2011). Although there are a variety of occupations impacted by symptoms associated with depressive disorders, social participation is most frequently mentioned within the literature. Occupational therapy services have the potential to provide children and adolescents with depressive symptoms with an opportunity to develop skills, establish productive habits, and increase performance patterns through meaningful activities. For children and adolescents with depression, both individual and group activities are beneficial, however, there is more support for implementation of group work. There appears to be a need for further resources for occupational therapists to implement group activities when working with children and adolescents diagnosed with or experiencing depressive disorders.

Therefore, the focus of the scholarly project is to provide occupational therapists working with children and adolescents diagnosed with or experiencing depressive symptoms with a guide to intervention focusing on social participation, as this was a key area of occupation most widely affected by depressive symptoms (Bazyk & Brandenburger Shasby, 2011; Bonder, 2015; Desha & Ziviani, 2007). According to the *Occupational Therapy Practice Framework: Domain & Practice* (3rd Ed.), social participation includes interaction with peers, family, and within the community (American Occupational Therapy Association, 2014). The Intervention Guide will include interventions for each of the three areas of social participation.

# CHAPTER III

## METHOD

An extensive literature review was conducted to understand the effects depressive symptoms have on children and adolescents, particularly occupational performance and daily occupations that may be affected. Literature was located through a variety of sources, such as the University of North Dakota Harley French Library, internet searches, occupational therapy textbooks, and other textbooks with a focus on depressive disorders and youth. Search engines utilized included CINAHL, EBSCOhost Databases, Google Scholar, PsychInfo, RefWorks, Psychiatry Online, and PubMed. Phrases such as youth with depression, depression in children and adolescents, adolescent depression, childhood depression, treatment of youth depression, and treatment of depression were used. Peer-reviewed journals focusing on children and adolescents, depressive symptoms, and affect of these depressive symptoms were reviewed, including but not limited to the American Journal of Occupational Therapy, the American Journal of Psychiatry, Australian Occupational Therapy Journal, Journal of Psychiatric Practice, International Journal of Mental Health Nursing, and Journal of Psychiatric and Mental Health Nursing.

The literature review resulted in a description of how youth are affected by depressive symptoms, current treatment approaches taken, and which areas of occupation are most affected. Although this population often faces impairments in a variety of

occupations, it was determined that social participation is the key area that is impacted (Bazyk & Brandenburger Shasby, 2011; Bonder, 2015; Desha and Ziviani, 2007). According to the Occupational Therapy Practice Framework (OTPF) the area of social participation consists of interaction with peers, family, and within the community (American Occupational Therapy Association [AOTA], 2014). Each of these environments will affect the performance range of social participation, or in other words, the tasks completed are dependent on the relationship between the person and the environment in which the tasks are being completed (Turpin & Iwama, 2011). There are limited resources available for practicing occupational therapists working with this population focusing on social participation.

Occupation-based models were considered and evaluated to determine which fit the most appropriately with this scholarly project. The models considered include Person-Environment-Occupation (PEO) model, the Model of Human Occupation (MOHO), and Ecology of Human Performance (EHP) model. Based on the emphasis of the environment and impact it has on the social context, EHP was chosen for this scholarly project (Turpin & Iwama, 2011). Turpin and Iwama (2011) report that EHP heavily emphasizes that the environment shapes both the personal variables, as well as the occupation, or task, that that individual participates in. The EHP model not only addresses social components of the environment, but also the physical, temporal, and cultural elements (Brown, 2009; Turpin & Iwama, 2011). The EHP model is relevant to this scholarly project as children and adolescents participate in social participation in a variety of contexts, including within the school, home, and community.

The Intervention Guide is intended for occupational therapists working with children and adolescents to promote social participation. With an emphasis on the social environment, occupational therapy interventions focusing on social participation were created to address peer and family interaction, as well as social participation within the community.

# CHAPTER IV

# PRODUCT

# Social Participation:

# An Occupational Therapy Guide to Intervention for Youth with Depressive Disorders

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**&**

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## Introduction

Children and adolescents are at risk for developing mental illness, especially depressive related disorders. As can be seen within the literature review, there is a need for an intervention guide that can be utilized by occupational therapists working with children and adolescents diagnosed with or experiencing depressive disorders. The symptoms associated with depressive disorders often cause significant impairments in daily functioning and participation in meaningful occupations. Although there are many areas of occupation impacted by the associated symptoms, this population often experiences significant difficulties with social participation (Bazyk & Brandenburger Shasby, 2011; Bonder, 2015; & Desha and Ziviani, 2007).

## Occupational Therapy Guide to Intervention for Youth with Depressive Disorders

Social participation, among other areas of occupation, are often addressed within the occupational therapy therapeutic process. There are minimal resources available to practicing occupational therapists focusing on this area of occupation, especially for children and adolescents with depressive symptoms. Therefore, an Occupational Therapy Guide to Intervention for Youth with Depressive Disorders has been created to be utilized by occupational therapists in a variety of practice settings in which the occupational therapist is treating youth with depressive symptoms. These include, but are not limited to, inpatient psychiatric hospital, outpatient psychiatric setting, and within the school system. The practicing therapist should use clinical reasoning to identify which of the following intervention approaches is applicable to the setting in which they are practicing and to modify them as needed. As social participation is an area of occupation that is

heavily influenced by the environment, the occupational therapist should promote a clinical environment that is both supportive and positive. In addition, the occupational therapist should continue utilizing his/her experience and current evidence-base practice to provide the best therapeutic approach possible.

As the occupational therapist begins to build therapeutic relationships with his/her clients, incorporating therapeutic modes, as described by Taylor (2008), will increase the ability of the therapist to relate with the client. The six therapeutic modes that Taylor (2008) identifies include: advocating, collaborating, empathizing, encouraging, instructing, and problem-solving. Taylor (2008) defines advocating as "ensuring that the client's rights are enforced and resources are secured" and collaborating as "expecting he client to be an active and equal participant in therapy" (p. 53). Empathizing is defined as an "ongoing striving to understand the client's thoughts, feelings, and behaviors with suspending any judgement" (Taylor, 2008, p. 53). Taylor (2008) describes encouraging as "seizing the opportunity to install hope in a client" and instructing as "carefully structuring therapy activities and being explicit with clients about the plan, sequence, and events of therapy" (p. 53). Lastly, Taylor (2008) defines problem-solving as "facilitating pragmatic thinking and solving dilemmas by outlining choices, posing strategic questions, and providing opportunities for comparative or analytical thinking" (p. 53). Although each of these therapeutic modes are equally important, it is recommended by Taylor (2008) that occupational therapists be prepared to utilize each of these modes by frequently shifting between the modes that best fit the needs of each client.

## Occupational Therapy Model Support

The occupation-based model chosen to support the development of this Intervention Guide was the Ecology of Human Performance (EHP) model. This model emphasizes the interaction of the environment, person, and task. This model places heavy emphasis on the environment in which an occupation, or task, is completed (Turpin & Iwama, 2011). In addition to the environment, EHP focuses on the person and the tasks being completed (Turpin & Iwama, 2011). As stated within the model, the environment shapes both the person and the task in which the person engages. Therefore, it is important as occupational therapists to create an environment that is supportive to development and participation within of task performance. The model defines the person as both complex and unique, as each individual has their own personal variables (Brown, 2009; Turpin & Iwama, 2011). Personal variables include interests, values, skills, and abilities (Brown, 2009; Turpin & Iwama, 2011). The task in which the person participates in is defined within EHP as objective possible activities (Brown, 2009). Instead of using the term occupation, like most occupation-based models do, the developers of EHP incorporated the term task to allow this model to be more accessible for other disciplines and to promote interdisciplinary collaboration (Brown, 2009).

The Ecology of Human Performance model presents five categories of intervention approaches, including establish or restore, alter, adapt or modify, prevent, and create (Brown, 2009; Turpin & Iwama, 2011). This model defines establish and restore as "developing and improving skills and abilities so that the person can perform tasks in context" (Brown, 2009, p. 438). Brown (2009) defines alter as not "changing the

person, task, or environment" but that they are meant to "make a better fit" (p. 439). The intervention approaches of adapting and modifying, are defined within EHP as "changing the environment or task to increase the individual's performance range" (Brown, 2009, p. 438). The fourth intervention approach, prevent, is defined as a change in "the course of events when a negative outcome is predicted" (Brown, 2009, p. 440). Lastly, create is defined within EHP to "promote performance in context" (Brown, 2009, p. 440). Within each of the interventions provided within this Intervention Guide, the intervention approach taken is listed.

This occupational therapy Intervention Guide incorporates aspects of EHP and the *Occupational Therapy Practice Framework: Domain and Practice* (3rd ed.) (American Occupational Therapy Association [AOTA], 2014) (OTPF) into each intervention. Within the group setting, the outcomes defined by the OTPF include increased self-awareness with emphasis on peer support, social interaction, and to gain a larger social network (AOTA, 2014). There are three components of social participation addressed. The OTPF includes peer, family, and community within the occupation of social participation (AOTA, 2014). Each of these interactions may be completed in a variety of contexts. For example, an individual may interact with peers at school, home, and in a variety of locations within the community.

**Peer**

Because of the many possible contexts an individual may interact with peers, this area is addressed within the Intervention Guide. Example contexts in which interactions with peers may include, but is not limited to, school, home, and other locations within an

individual's community. The components from EHP that are addressed in each of the peer interventions can be found in Table 4.1.

**Family**

As with social participation with peers, family socialization can also be completed in a variety of contexts. Those that may be defined within the family dynamic depends upon the cultural beliefs of that individual and his/her family. The family may include, but is not limited the immediate family, such as parents and siblings, as well as extended family including grandparents, aunts, and uncles. The components of EHP addressed with each social participation intervention for families can be found in Table 4.2.

**Community**

Depending on the culture and family dynamics, youth may be within the community a great portion of the day. Community includes, but is not limited to, school, restaurants, parks, shopping areas, and other areas outside of the family home. The components of EHP addressed with each social participation intervention within the community can be found in Table 4.3.

Table 4.1 Peer Social Participation & EHP Components

| Ecological Model Components | | Interventions |
|---|---|---|
| Personal Factors | Participants may be anxious or not interested in participating in this activity. | Establish/Restore: opportunity for promotion of self-esteem and social participation skills<br>Alter: incorporate interests to promote participation in activity |
| Environmental Factors | Occupational therapy room is positive and supportive of the participants and his/her values. Interaction with peers is promoted. | Modify: number of participants, where the activity is being completed<br>Adapt: grade activity to participant's cognitive and developmental level |
| Occupation | Social Participation, Leisure/Play | Establish/Restore: opportunity for promotion of social participation amongst peers |

Table 4.2 Family Social Participation & EHP Components

| Ecological Model Components | | Interventions |
|---|---|---|
| Personal Factors | Participants may be anxious or not interested in participating in this activity. | Establish/Restore: opportunity for promotion of self-esteem and social participation skills<br>Alter: incorporate interests to promote participation in activity |
| Environmental Factors | Occupational therapy room is positive and supportive of the participants and his/her values. Interaction with family is promoted. | Modify: number of participants, where the activity is being completed<br>Adapt: grade activity to participant's cognitive and developmental level |

| | | |
|---|---|---|
| Occupation | Social Participation, Education | Establish/Restore: opportunity for promotion of social participation amongst family members |

Table 4.3 Community Social Participation & EHP Components

| **Ecological Model Components** | | **Interventions** |
|---|---|---|
| Personal Factors | Participants may be anxious or not interested in participating in this activity. | Establish/Restore: opportunity for promotion of self-esteem and social participation skills<br>Alter: incorporate interests to promote participation in activity |
| Environmental Factors | Promotion of positive and supportive environment for participants and their families. Interaction with peers and family is promoted. | Modify: number of participants, where the activity is being completed<br>Adapt: grade activity to participant's cognitive and developmental level |
| Occupation | Social Participation, Leisure/Play | Establish/Restore: opportunity for promotion of social participation amongst peer and family members in the community |

**Intervention Format**

Each of the interventions provided within the Intervention Guide include:

- A brief description
- Objectives
- Materials required
- Performance skills addressed
- EHP model intervention approach
- Directions for implementation

The interventions do not need to be completed in a prescribed order; the occupational therapist is encouraged to use clinical judgement to determine use of the interventions provided. Reproducible handouts have been provided for the convenience of the practicing occupational therapist.

**Social Participation Group Activities:**

**Peer**

## Social Bingo

**Description:** This activity allows for group participants play a game that is often familiar and to have fun while exploring social participation with peers, as well as personal likes and dislikes.

**Objectives:**

1. Identify personal interests and meaningful activities
2. Identify positive aspects of social participation
3. Demonstrate ability to disclose personal interests and take turns with peers

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, takes turns

**EHP Intervention Approach:** Establish/Restore, Alter

**Materials Needed:** A Social Bingo card and Bingo markers (torn paper, pennies, paper clips, etc.) for each participant

**Activity:**

1. Distribute Social Bingo cards and Bingo markers to group participants.
2. Have each participant label an empty box with a number according to the numbers listed in that column. For example, if the "B" column should have numbers from 1-10 assigned to the box. Remind participants that only 5 numbers of this category from 1-10 will be used, as there are only 5 boxes.
3. Review instructions for the game of Bingo with the participants. The therapist will call out a random letter and number combination, i.e., B-5, G-31, etc. The participants will place a marker on the appropriate square. For each participant to mark the square called, he/she needs to do or answer what the space asks. For example, if the square asks the student to describe a personal accomplishment, he/she must share with the group one accomplishment that they are proud of. Participants will continue until someone has obtained a "bingo." Bingo variations that can be played include: 4 corners; blackout; and diagonal, vertical, or horizontal; etc.
4. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - How do you feel about interacting with your peers after this activity?
   - What is an example of a positive interaction you had with one of your peers during this activity?
   - How can you use what you learned in future interactions with your peers?

# SOCIAL

| B<br>1-10 | I<br>11-20 | N<br>21-30 | G<br>31-40 | O<br>41-50 |
|---|---|---|---|---|
| What is your favorite sport? | Say something positive about yourself. | Give the person on your right a compliment. | Stand up and let others applaud you. | Give the person on your left a compliment. |
| What are 3 things that you are grateful for? | Describe when you are at your best. | What is your favorite color? | Describe what you are grateful for. | What is your favorite leisure activity? |
| Tell about an event in your life that made you feel happy. | How could someone make you happy? | FREE | Share something you would like to do. | Say something about yourself that is positive. |
| Describe your item that you own. | Describe your favorite time of the year. | What is your favorite meal? | Describe a personal achievement. | Give someone a high five. |
| Describe a dream vacation. | What is your favorite movie? | Who is someone special in your life and why are they special? | Describe what you like to do to relax. | Share what makes you special. |

Adapted from: Khalsa, Azok & Leutenberg (1994)

## I Love Me

**Description:** Participants will have an opportunity to make positive comments about peers, as well as receive positive feedback themselves.

**Objectives:**

1. Identify positive personal characteristics
2. Increase self-esteem by receiving positive feedback and compliments from peers
3. Demonstrate ability to disclose and express emotions

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, thanks, takes turns

**EHP Intervention Approach:** Establish/Restore, Alter

**Materials Needed: "**I Love Me" T-Shirt handout and writing materials for each participant

**Activity:**

1. Discuss self-esteem and positive self-image with participants. Ask participants for a description of each of these topics and provide additional definitions when needed.
2. Provide instructions for the activity. Each participant should write their name on the collar of the t-shirt on their handout. Instruct participants to pass handouts out and have peers write 2 positive statements on each other's handout but not in the heart-shaped area. After each person receives their handout back, he/she will then write 6-10 positive statements within the heart-shaped area. Each person will read aloud the comments peers made about them, followed by the positive comments they made about themselves.
3. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - How did you feel when you read through the comments your peers made? How about when you made positive comments about yourself?
   - How do you feel about interacting with your peers after this activity?
   - How can you use what you learned in future interactions with your peers?

# I ♡ Me

Adapted from: Korb, Azok, & Leutenberg (1991)
Image from: Plain White T Shirt Drawing Kkedss - t-shirt female

## Dealing with the "Small Stuff"

**Description:** This activity allows participants the opportunity to identify everyday stressors and how they may react to them. Participants will interact with their peers to brainstorm possible coping strategies.

**Objectives:**

1. Identify major life stressors and everyday "small stuff" that cause stress
2. Brainstorm strategies with peers on how to cope with each stressor identified
3. Demonstrate ability to disclose and express emotions

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Alter

**Materials Needed:** "Dealing with the 'Small Stuff'" handout and writing materials for each participant

**Activity:**

1. Discuss the varying degrees of stressors, including major life events and "small stuff."
2. Provide each member with a "Dealing with the Small Stuff" handout. Instruct them to individually write down three examples of everyday stressors and how they react to this stress.
3. Have them participants form small groups or pairs and share their stressors and reactions. Next, have them brainstorm possible coping strategies that could be used.
4. Additional strategies may be provided by the therapist.
5. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - What are some of the common major life stressors? What are some of the common stressors that are considered "small?"
   - How did you feel when identifying coping strategies? How can you utilize these strategies in the future?
   - How do you feel about interacting with your peers after this activity?
   - How can you use what you learned in future interactions with your peers?

**Name:** _____

# Dealing with the "Small Stuff"

| What is the stressful situation? | How did I react? | What are possible coping skills I could use? |
|---|---|---|
| 1. | | |
| | | |
| | | |
| 2. | | |
| | | |
| | | |
| 3. | | |
| | | |
| | | |

Adapted from: Korb, Azok, & Leutenberg (1991)

## How to Solve a Problem

**Description:** This activity allows participants a chance to identify a current or past problem and brainstorm possible solutions independently. Following this, participants will interact with their peers to discuss their answers with in small groups and then also as a large group.

**Objectives:**

1. Identify a problem and to develop solving problem skills
2. Brainstorm with peers to identify problem solving skills
3. Practice disclosing and expressing emotions

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Adapt, Alter

**Materials Needed:** "Solving a Problem" handout and writing materials for each participant

**Activity:**

1. Discuss importance of solving problems using the steps included in the handout.
2. Distribute handouts to participants. Have each participant think of a problem they are currently having or have had to make recently and fill out the handout. Have participants pair up in small groups to discuss the problem and the steps they have taken. Allow participants time to brainstorm other ways the problem could have been solved.
3. Discuss each sequence as a large group. The therapist may provide additional input to each participant as they share their answers.
4. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - What were common problems identified within the group?
   - How can you incorporate the steps to solving a problem in everyday life?
   - How do you feel about interacting with your peers after this activity?
   - How can you use what you learned in future interactions with your peers?

**Name:** _____

# HOW TO SOLVE A PROBLEM

Directions: Answer each of the following questions.

1. What is the problem?_____

_____

_____

2. Brainstorm possible ways the problem can be solved. _____

_____

_____

3. Analyze each of the ideas brainstormed. _____

_____

_____

4. Decide which idea with the best choice. _____

_____

_____

5. Evaluate the decision - Did this idea work? Why or why not? _____

_____

_____

Adapted form: Khalsa (1996)

## My Favorite Things

**Description:** This activity allows participants the opportunity to identify personal interests and share a craft project (collage) demonstrating their interests with peers in a social setting.

**Objectives:**

1. Increase participants awareness of personal interests and uniqueness
2. Promote positive social interaction by identifying and sharing similar interests
3. Demonstrate ability to disclose personal interests and take turns with peers

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Alter

**Materials Needed:** scissors, glue, markers, variety of magazines, newsprint, and tape that group participants can share; and a large piece of art board for each participant

**Activity:**

1. The therapist will instruct the participants on the activity.
2. Each participant will receive an art board that they will identify sections of favorite things, such as: sports, places, animals, foods, etc. Participants will then share the art supplies to cut out pictures from the magazines or newspapers provided and glue the pictures into the appropriate categories.
3. After each participant has completed their project, they will be asked to share their categories of interest and what pictures they choose to fit under each category.
4. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - Were there any interests that were similar amongst group members and if so, what were these?
   - How do you feel about interacting with your peers after this activity?
   - How can you use what you learned in future interactions with your peers?

Adapted from: Khalsa (1996)

**Social Participation Group Activities:**

**Family**

## Forming & Maintaining Relationships: Part I

**Description:** This activity will provide the participant and their parents to identify unhealthy behaviors that are affecting their current relationship, as well as identify which behaviors they hope to have and to create a plan to work towards these behaviors.

**Objectives:**

1. Increase awareness of behavior and attitudes that may affect relationships
2. Identify healthy relationship patterns
3. Practice expressing and disclosing emotions

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Adapt, Alter

**Materials Needed:** "Part I: Breaking Down Walls Handout" and writing materials for each participant

**Activity:**

1. Distribute "Part I." Ask participants to identify which behaviors they exhibit in their current relationship with their parents. Discuss what continuing with unhealthy patterns may lead to in their relationships. Discuss what these patterns may cause the participants and parents if they continue.
2. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - What did you learn about your family throughout this activity?
   - What are some of the behaviors or attitudes that may affect a relationship?
   - What are two examples of healthy relationship patterns?
   - How do you feel about interacting with your family after this activity?
   - How can you use what you learned in future interactions with your family?

**Name:** _____

# FORMING & MAINTAINING RELATIONSHIPS

## PART I

Directions: Check the following attitudes and behaviors that may get in the way of you maintaining or forming relationships.

_____ overusing defense mechanisms, such as blaming others or denial
_____ manipulative tendencies, being dishonest
_____ irresponsible
_____ aggressive, hold grudges
_____ passive, non-assertive
_____ excessive loyalty to others
_____ cannot take things seriously
_____ inflexibility or controlling tendencies
_____ perfectionism
_____ compare self to others
_____ feelings of guilt
_____ fear of anger, confrontation, or criticism
_____ fear of being alone, rejection or abandonment
_____ increased anxiety in social situations, shyness
_____ dependence on others
_____ isolating or alienating tendencies
_____ addictions, illness, compulsions
_____ avoiding commitments
_____ jealous, envious
_____ not expressing self and own feelings or needs
_____ approval-seeking or people-pleasing tendencies
_____ difficulty having fun
_____ expectation of self or others is unrealistic
_____ low self-esteem
_____ other: _____

Adapted from: Korb-Khalsa, Azok, & Leutenberg (1994)

## Forming & Maintaining Relationships: Part II

**Description:** This activity will provide the participant and their parents to identify unhealthy behaviors that are affecting their current relationship, as well as identify which behaviors they hope to have and to create a plan to work towards these behaviors.

**Objectives:**

1. Increase awareness of behavior and attitudes that may affect relationships
2. Identify healthy relationship patterns
3. Practice expressing and disclosing emotions

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Modify, Alter

**Materials Needed:** "Forming & Maintaining Relationships: Part II" handout and writing materials for each participant

**Activity:**

1. Distribute "Forming & Maintaining Relationships: Part II" Have participants and parents fill this out together of behaviors they wish to have in their relationship. Next, have them create a plan on how to work towards achieving these positive behaviors versus the unhealthy behaviors they may currently have.
2. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - What did you learn about your family throughout this activity?
   - What are some of the behaviors or attitudes that may affect a relationship?
   - What are two examples of healthy relationship patterns?
   - How do you feel about interacting with your family after this activity?
   - How can you use what you learned in future interactions with your family?

**Name:** _____

# FORMING & MAINTAINING RELATIONSHIPS

## PART II

Directions: Check the following attitudes and behaviors that are present in your relationships.

_____ take responsibility for personal happiness and behaviors, not blaming others
_____ commitment
_____ can enjoy being alone
_____ willingness to be vulnerable by taking risks
_____ forgiveness of both self and others
_____ are able to balance of receiving and giving
_____ openness to feedback
_____ self-confident
_____ assertiveness, being able to express needs and feelings
_____ rules are clear, yet allow for flexibility
_____ balance of time together and separation from each other
_____ encouragement of personal growth, exploration, and change
_____ support ability to have other relationships
_____ mistakes are accepted, able to learn from mistakes
_____ fair negotiations
_____ trustful of each other
_____ are able to directly face conflict
_____ able to accept self and others
_____ able to have fun together
_____ enhancement of personal identify, freedom, and uniqueness
_____ communication is open and honest
_____ other:_____

Adapted from: Korb-Khalsa, Azok, & Leutenberg (1994)

## You & Relationships

**Description:** This activity allows participants and their parents a deeper look into how each views their relationship. It allows them an opportunity to create a plan to bettering the relationship between each other.

**Objectives:**

1. Provide insight into qualities that the participants will bring to each relationship
2. Demonstrate ability to disclose and express emotions

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Modify, Alter

**Materials Needed:** "You and Relationships" handout and writing materials for each participant and parent

**Activity:**

1. Distribute handouts. Discuss importance of healthy relationships and what the benefits are.
2. Allow participants and parents time to fill out their handout independently. Have each participant and parent read aloud their answers. Identify commonalities amongst the answers. Next, create a plan for parents and participants to reach their relationship goals.
3. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - What did you learn about your family throughout this activity?
   - How can you incorporate the plan you made into life at home?
   - How do you feel about interacting with your family after this activity?
   - How can you use what you learned in future interactions with your family?

**Name:** _____

# You & Relationships

What are three positive qualities that you bring to a relationship?

1. _____ 2._____ 3. _____

What are three negative qualities that you bring to a relationship?

1. _____ 2._____ 3. _____

What are three qualities you like to see in others?

1. _____ 2._____ 3. _____

What are three qualities that you do not like in others?

1. _____ 2._____ 3. _____

What are three accomplishments you'd like to tell somebody?

1. _____ 2._____ 3. _____

For participants: Describe what you would like your relationship with your parents to be like.

_____
_____
_____
_____
_____

For parents: Describe what you would like your relationship with child to be like.

_____
_____
_____
_____

Adapted from: Korb-Khalsa, Azok, & Leutenberg (1994)

## Evaluating Relationships

**Description:** This activity allows participants and their parents an opportunity to deepen their relationship with one another.

**Objectives:**

1. Evaluate both the positive and negative aspects of the parent-child relationship
2. Deepen communication between children and parents
3. Practice expressing and disclosing emotions

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Modify, Alter

**Materials Needed:** "Evaluating Relationships: Student Form," Evaluating Relationships: Parent Form," and writing materials for each participant and their parents

**Activity:**

1. Distribute handouts and allow participants and their parents time to fill out each handout independently. Have each participant and parent read aloud their answers for the first question, second question, etc.
2. Discuss that relationships take time, energy, and communication. Therapist may need to acknowledge difficulties of discussing potential changes in relationships.
3. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - What did you learn about your family throughout this activity?
   - How do you feel about interacting with your family after this activity?
   - How can you use what you learned in future interactions with your family?

**Name:** _____

# Evaluating Relationships

## Student Form

Name 2 things you like about your parents.

1. _____
2. _____

Name 2 things you dislike about your parents.

1. _____
2. _____

What are 3 aspects of a healthy relationship?

1. _____
2. _____
3. _____

Is your relationships with your family healthy? Why or why not?

_____

_____

_____

List 3 things that your parents are interested in.

1. _____
2. _____
3. _____

How do you know when your parents are feeling happy?

_____

_____

_____

List 3 ways that your parents have positively impacted the way that you think and act.

1. _____
2. _____
3. _____

Adapted from: Khalsa (1996); Korb-Khalsa & Leutenberg (2000)

**Name:** _____

# Evaluating Relationships

## Parent Form

Name 2 things you like about your child.

1. _____
2. _____

Name 2 things you really about your child.

1. _____
2. _____

What are 3 aspects of a healthy relationship?

1. _____
2. _____
3. _____

Is your relationship with your child healthy? Why or why not?

_____

_____

_____

List 3 things that your child is interested in.

1. _____
2. _____
3. _____

How do you know when your child is feeling happy?

_____

_____

_____

List 3 ways that your child has positively impacted the way that you think and act.

1. _____
2. _____
3. _____

Adapted from: Khalsa (1996); Korb-Khalsa & Leutenberg (2000)

## Who Should Be In Control?

**Description:** This activity allows participants and their parents to deepen their understanding and awareness of parental influence and control.

**Objectives:**

1. Increase of awareness concerning parental influence and control
2. Increase participant's understanding of parental influence
3. Demonstrate ability to express and disclose emotions

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, disagrees, takes turns

**EHP Intervention Approach:** Establish/Restore, Modify, Alter

**Materials Needed:** "Who's in Control?" handout and writing materials for each participant and parent

**Activity:**

1. Distribute handout to participants and ask for them to complete it independently. Have them read aloud their answers to their parents.
2. Discuss advantages and disadvantages of parent influence with both parental and participant input. Next, discuss responsibilities parents have while raising children.
3. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - What did you learn about your family throughout this activity?
   - How do you feel about interacting with your family after this activity?
   - How can you use what you learned in future interactions with your family?

**Name:** _____

# Who Should Be In Control?

1. Should parents have their children participate in activities that they do not like? Why or why not?

   _____
   _____
   _____

2. Should parents be able to have an influence in your life now? How about in the future?

   _____
   _____
   _____

3. Who is in control of your life?

   _____
   _____
   _____

4. What are two things that your parents have done that you didn't agree with?

   _____
   _____
   _____

5. What are two things that your parents have done that you are happy that they did?

   _____
   _____
   _____

6. How do you think that you and your parents can work together to make your relationship healthier?

   _____
   _____
   _____

Adapted from: Khalsa (1996)

**Social Participation Group Activities:**

**Community**

## Games 'N More Games

**Description:** This activity allows for participants to interact in a positive manner with their peers and family within the community.

**Objectives:**

1. Increase self-esteem and social participation
2. Promote positive social participation with peers and family
3. Demonstrate ability to take turns and initiate social interaction

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Alter

**Materials Needed:** large enough space to hold desired participants and their family, materials needed for each game chosen

**Ideas:**

1. This activity promotes social participation within the community. Set-up at a location that is easily accessible is required, such as gymnasium at a school or park. The therapist will provide games for participants and their families to participate in. The therapist should use clinical judgement on how many games to provide and what structure the event will have.
2. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - How do you feel after completing the activity?
   - How can you use what you learned in future interactions with your peers and family?

**Note:**

1. Obtain approval to utilize the facilities.
2. The therapist may ask local volunteers to assist with set-up and to ensure that the event runs smoothly.
3. For better participation, this should be completed after peer and family social participation interventions have been completed.

## Time to Clean Up

**Description:** This activity will allow for participants to be outdoors and help out the community.

**Objectives:**

1. Increase self-esteem by helping out within the community
2. Promote positive social participation
3. Demonstrate ability to take turns and initiate social interaction

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Alter

**Materials Needed:** garbage bags; vehicle if not within walking distance; other materials such as gloves, etc.

**Activity:**

1. Discuss the importance of keeping the environment clean, as well as volunteering.
2. Bring participants to local park or other area that may need volunteers to pick up trash, etc.
3. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - How do you feel after completing the activity?
   - How can you use what you learned in future interactions with your peers and family?

**Note:**

1. Obtain approval from parents of the participants and the park
2. May ask parents or volunteers to assist with the activity

## Let's Volunteer!

**Description:** The participants will have an opportunity volunteer at a local food bank.

**Objectives:**

1. Increase self-esteem and social participation
2. Promote volunteerism within the community
3. Demonstrate ability to take turns and initiate social interaction

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore, Alter

**Materials Needed:** vehicle if not within walking distance

**Activity:**

1. Discuss the importance of volunteering within the community
2. Provide participants with an opportunity to volunteer at the local food bank. Grade the level of social participation for each task the facility has the participants completing, such as teamwork, etc.
3. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - How do you feel after completing the activity?
   - How can you use what you learned in future interactions with your peers and family?

**Note:**

1. Obtain approval from parents and volunteer coordinator of the food bank
2. May ask parents or local volunteers to assist with the process

## Running & Playing

**Description:** This activity will allow participants an opportunity to socially interact with peers while participating in a physical activity, followed by having a chance to play board games with their peers. This particular activity may be completed multiple times to promote both physical activity and social participation.

**Objectives:**

1. Increase self-esteem and social participation
2. Practice taking turns and initiating social interaction

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore

**Materials Needed:** large enough space for students to walk or run, such as a gym; snacks if desired; and a variety of board or card games for participants to play with each other

**Activity:**

1. Participants will participate in physical activity, such as running or walking around a track. The therapist may choose for how long to have the participants complete physical activity, an example of how long they may walk or run for would be approximately 25 minutes.
2. Following activity, if chosen, a snack may be provided.
3. While participants are eating their snack or relaxing, the therapist may choose which game participants will play or allow them to choose. Depending on size of group, the therapist may choose to split the participants into groups or find a game large enough for all participants to participate in. Possible games to promote social participation include Social Bingo (as listed above) or any other games that the therapist has access to that will allow for participants to interact with each other.
4. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - How do you feel after completing the activity?
   - How can you use what you learned in future interactions with your peers and family?

**Note:**

1. Obtain approval from parents and location chosen to implement activity
2. May ask parents, staff at the location, and/or local volunteers to assist with the process

## In The Holiday Spirit

**Description:** This community activity allows participants to help fundraise for a local charity. With permission from the Salvation Army, the participants will volunteer for their annual Red Kettle Campaign during the holiday season.

**Objectives:**

1. Increase self-esteem and social participation
2. Promote volunteerism within the community
3. Demonstrate ability to take turns and initiate social interaction

**Performance Skills Addressed:** Social Interaction Skills - approaches/starts, regulates, discloses, expresses emotion, takes turns

**EHP Intervention Approach:** Establish/Restore

**Materials Needed:** permission from the Salvation Army and the location in which you are going to do the activity; additional materials required are provided by the Salvation Army

**Activity:**

1. Those participating and the therapist must be registered with the Salvation Army. To find locations, therapists are recommended to visit the Salvation Army website and follow the instructions given. Additional questions regarding this opportunity can also be answered online or through the contact numbers provided.
2. For this activity, participants will stand outside of the chosen location and participate in the Red Kettle Campaign. This consists of ringing bells and thanking individuals who decide to donate money. Singing carols during the activity is optional if if participants choose to do so.
3. Discussion questions:
   - What are the benefits of this activity?
   - What did you learn about yourself throughout the activity?
   - How do you feel after completing the activity?
   - How can you use what you learned in future interactions with your peers and family?

**Note:**

1. Obtain approval from parents, Salvation Army, and location in which you re going to do the activity
2. May ask parents, staff at the location, and/or local volunteers to assist with the process

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# CHAPTER V

## SUMMARY

Depressive disorders impact approximately 2% of those aged 6-12 and 4-8.3% of those aged 13-18 (Pfalzgraf et al., 2012). The symptoms associated with depressive disorder affect the participation and performance in daily occupations, especially for children and adolescents. For children and adolescents, the key areas impacted by depression are home life, school or work, family relationships, and social life (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). Social participation is noted to be the most widely affected by child and adolescent depression (Bazyk & Brandenburger Shasby, 2011; Bonder, 2015; Desha and Ziviani, 2007). There are few occupation-based resources focusing specifically on social participation available to occupational therapists who work with children and adolescents with depressive disorders. A guide to intervention was created to provide occupational therapists with a resource for implementing interventions that address the area of social participation for the identified population. The *Occupational Therapy Practice Framework: Domain and Practice* (3rd ed.) (OTPF) (2014) defines social participation as encompassing interactions with peers, family, and within the community. Social participation interventions were created to address each of the three concerns - peer family, and community for implementation within occupational therapy.

## Limitations & Recommendations

The Intervention Guide was created for and is intended for use with children and adolescents diagnosed with depressive disorders; it is not indented for use with adult populations. The occupational therapist should utilize clinical judgement to evaluate the usefulness of the interventions for adults and plan to adapt accordingly.

Social participation is the focus of the Intervention Guide. The professional literature indicates children and adolescents with depressive disorders face impairments in other areas of occupation, such as work, sleep, play, self-care, and academic performance and participation, as well (Bonder, 2015; Desh & Ziviani, 2007). Occupational therapists working with children and adolescents with depressive disorders should address these areas of occupation in addition to social participation. Clinical judgement should be utilized by the occupational therapist to determine all areas of occupation that should be addressed within the therapeutic process.

The Intervention Guide is designed for the profession of occupational therapy and the occupational therapists who work with children and adolescents with depressive disorders. Although social participation may be addressed by other professions who also work with children and adolescents with depressive disorders, the Intervention Guide is designed for use by occupational therapists. The occupation-based focus combined with the application of an occupation-based model of occupational therapy make the Intervention Guide especially suited for use by practicing occupational therapists.

The Ecology of Human Performance (EHP) model was used to support the development of the Intervention Guide. The model may affect the implementation of the

Intervention Guide into occupational therapy practice for those occupational therapists who work under other occupation-based models. The occupational therapist will need to assess the differences between the models and the application process of the models.

The Intervention Guide has not been field tested for efficiency with children and adolescents with depressive disorders. The activities have been adapted from credible sources but have not been tested. Pilot use of the activities included within the Intervention Guide is recommended to evaluate the effectiveness for children and adolescents with depressive disorders.

## Conclusion

An Intervention Guide has been created for occupational therapists working with children and adolescents diagnosed with or experiencing depressive disorders who have demonstrated impairments in the area of social participation. Although depressive disorders affects children and adolescent's ability to perform a variety of occupations, such as rest, work, leisure, play, and academic performance and participation, social participation is the key area affected. The OTPF (AOTA, 2014) identifies social participation as interactions with peers, family, and within the community. Therefore, the Intervention Guide provides interventions for each of these areas of social participation that are intended to be used with children and adolescents with depressive disorders. The Intervention Guide can be used in a variety of settings, including but not limited to an inpatient psychiatric hospital, outpatient psychiatric setting, or school system.

# APPENDICES

Appendix A

Diagnostic Criteria for Major Depressive Disorder

i. Five or more of the following symptoms for a two week period that demonstrate a significant change in functioning; one of these must be either a depressed mood or loss of pleasure or interest
    i. Depressed mood for most of the day and nearly every day
        i. Note: Can be irritable mood for children and adolescents
    ii. Diminished pleasure or interest in most or all of activities
    iii. Significant weight loss of more than 5% of an individual's body weight or fluctuation in appetite nearly every day
        i. Note: Children may not meet expected weight gain
    iv. Restlessness or hypersomnia nearly every day
    v. Psychomotor disturbance that can be seen by others nearly every day
    vi. Fatigue or decreased energy nearly every day
    vii. Feeling worthless or having feelings of inappropriate or excessive guilt nearly every day
    viii. Decreased ability to concentrate or think nearly every day
    ix. Thoughts of death, suicidal ideation, and suicidal plan or attempt
ii. Symptoms cause distress or impairment in a variety of areas
iii. Not caused by substance use or other medical conditions
iv. Not better explained by a diagnosis on the schizophrenia spectrum or other psychotic disorders
v. Never been a history of manic episodes or hypomanic episodes

Appendix B

Diagnostic Criteria for Disruptive Mood Dysregulation Disorder

i. Recurrent temper outbursts which may manifest either verbally or behaviorally that are out of proportion in duration or intensity to the situation
ii. Temper outbursts are inconsistent with developmental level
iii. Temper outbursts occur three or more times each week
iv. Irritable or angry mood between each temper outburst most of the day and occurs nearly every day
v. Above criteria has been present for 12 or more months without a period of 3 or more months without symptoms
vi. Criteria A and D occur in at least two of three settings and are considered to be severe in one of the three settings
vii. Diagnosis should not be made before age 6 for the first time or after the age of 18
viii. Age of onset for criteria A-E is before 10 years of age
ix. Manic or hypomanic episodes have not been met for a period lasting longer than 1 day
x. Behaviors are not occurring during an episode of major depressive disorder or cannot be explained by another diagnosis
    i. Note: Cannot coexist with intermittent explosive disorder, oppositional defiant disorder, or bipolar disorder but can coexist with major depressive disorder, conduct disorder, substance use disorder, and attention-deficit/ hyperactivity disorder
xi. Symptoms are not caused by substance use or other medical conditions

Appendix C

Diagnostic Criteria for Persistent Depressive Disorder (Dysthymia)

i. Depressed mood for most of the day, nearly every day
    i. Note: Mood can be irritable for children and adolescents for at least 1 year
ii. In addition to a depressed mood, presence of 2 or more of the following symptoms:
    i. Change in appetite
    ii. Insomnia or hyposomnia
    iii. Decreased energy or fatigue
    iv. Poor self-esteem
    v. Difficulty making decisions or decreased concentration
    vi. Feelings of hopelessness
iii. Over a 2 year time period (1 for children or adolescents), presence of Criteria A and B for 2 or more months
iv. Individual may meet diagnostic criteria for major depressive disorder for 2 years
v. Never had a manic or hypomanic episode or met criteria for cyclomanic disorder
vi. Not better explained by a diagnosis on the schizophrenia spectrum or other psychotic disorder
vii. Symptoms are not caused by substance use or other medical condition
viii. Symptoms cause significant impairment or distress in social, occupational, or other areas of functioning

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