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An Occupational Therapy-Based Curriculum for At-Risk Adolescents Transitioning from Mental Health Treatment Facilities into the Public School System

Jill Eide  
*University of North Dakota*

Jessica Welk  
*University of North Dakota*

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An Occupational Therapy-Based Curriculum for At-Risk Adolescents Transitioning from Mental Health Treatment Facilities into the Public School System

Jill Eide, MOTS and Jessica Welk, MOTS

University of North Dakota
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Chapter I

Introduction

Adolescence is a time of great physical, emotional and mental change; change that occurs on an individual and social level. On an individual level, adolescents must acquire their own self-identity and define who they are. On a social level, adolescents must define who they are within the larger society and amongst their peers (Newmann & Newmann, 1991). Adolescents in today’s society face a variety of challenges and situational stressors placing this population at-risk for engagement in maladaptive behaviors. When difficulties arise adolescents may be placed into mental health treatment programs both in and out of their community, by the health care system.

Research today indicates that when adolescents are transitioning from psychiatric facilities back into the public school system, services may not be directly available for this young at-risk population. Health and education changes in North America have encouraged a shift for adolescent occupational therapy mental health services into the school system. Occupational therapy professionals need to become more pro-active in community mental health interventions for adolescents in hope of aiding these young individuals in capturing a sense of meaning and control in their lives.

There are few resources currently available within the education system to guide this at-risk population. Currently the opportunities for learning vocational, social, and independent living skills are limited for psychiatrically impaired adolescents in the mental health system, making these young individuals vulnerable to a “revolving” cycle of professional care. This is a challenging issue affecting successful re-entry into the school system. Research also indicates that there is limited cohesiveness between school-
community interventions, which places a barrier on students in their learning process and interferes with healthy development (Taylor & Adelman, 2000). With the lack of a structured curriculum in the school system these at-risk adolescents are “thrown” back into the schools, potentially placing them at risk of being lost in the system of professional care.

There is evidenced based research indicating that schools are a sound setting for mental health intervention in that one has direct access to the adolescents during this vulnerable time in their lives (Pietro, G.D., Patton, G.C., Glover, S., Butler, H., Bowes, G., et. al. 2000). Providing a supportive occupation-based curriculum for adolescents transitioning from the mental health system will help promote a positive healthy school environment. Current research indicates that positive outcomes with psychosocial intervention have been reported in the schools as a benefit for the school, the society and the individuals (Taylor & Adelman, 2000). Bridging the gap between school and community intervention programs will help these young individuals during this vulnerable time and will help promote successful community reintegration. Based on the need to extend mental health services into the school system, an occupational therapy-based curriculum will be developed for future implementation into the public education system as a means of bridging this gap.

The written curriculum is to be used by an Occupational Therapist in a junior high or high schools setting as adolescents are transitioning between the criminal justice system and their regular educational system. The design of the curriculum is focused on reattaching at-risk youths to their schools, their families, and positive peer groups using the skills learned during intensive inpatient treatment and extending their meaning and
influence within the community setting, specifically within the school system (Mathias, 1997). The curriculum will consist of motivational activities delivered in a classroom on a daily basis to students who meet the entrance criteria.

Using the **Occupational Therapy Practice Framework** as a guide to the treatment process, students will be evaluated through a series of interviews and assessment protocols. Information gathered will allow the therapist to gain a better understanding of who the student is, what are the student’s strengths and weaknesses, past history information, and also to achieve an understanding of what the student’s goals for him/herself in order for the planned intervention/activities to provide personal meaning to each student. The occupational therapy based curriculum focuses on the development of performance skills, patterns, and client factors in order to promote successful engagement in personally meaningful areas of occupation. Areas of occupation are any occupations or daily life activities, which make up the individual’s life (i.e. bathing, meal preparation, education, job performance, leisure exploration, community participation, etc). Performance skills, patterns, and client factors are the smaller units of performance that allow an individual to perform the areas of occupation (i.e. motor/process/communication skills, habits, roles, routines, body functions/structures, etc) (AJOT, 2002).

The skills being taught are implemented through a variety of interactive teaching strategies, such as role playing, questionnaires, educational materials, group collaboration, 1:1 processing, and community involvement in order to allow for individual skill development to be an intrinsically motivating and influential process. Based upon the collaboration of the student and therapist’s desired outcomes or goals, a variety of intervention approaches can be taken in order to promote successful
achievement of the collaborative goals such as promotion, restoration and remediation, maintenance, compensation and adaptation, and prevention in order to meet the various needs of the entire student's within the classroom environment.

After each session and/or intervention implementation, a review session takes place in order to process what has been learned and allow for reflection on the development of specific skills targeted during that intervention. The therapist and students will determine progress made, modifications needed in order to more effectively achieve the desired outcomes, and personal meaning and carry over into community interactions. Outcomes will be measured through a collaboration of the student, family, faculty, and therapist communication in order to get a holistic view of the student. The family, student, and therapist will evaluate the individual's strengths and weakness, progress and regress, possible referrals, and the need to continue/discontinue participation with the provided curriculum.
Chapter II

Literature Review

Adolescent Development

Adolescence is a time of uncertainty and change in which a young individual grows physically, intellectually, socially and emotionally. When a child moves into his/her adolescent years, which is typically between the ages of 12 and 18, the expectation to meet peer and social pressures in their lives increases. The normal everyday pressures that are placed on adolescents are extremely challenging and when one is bombarded with influential outside pressures, this age becomes a critical time (CareNotes, 2000). The pressures that adolescents face include social pressures from their friends to “fit in” and pressures from their parents/teachers to succeed. There are also pressures from the society, including media that makes adolescents feel like they have to look or act a certain way.

Changes are a key factor in the lives of adolescents. Changes are occurring on an almost regular basis, both physically and mentally. The physical growth during adolescents consists of bones, muscles, fat, and skin growing at a rapid rate. During these years, adolescents are preoccupied with their bodies. They may worry about how their bodies are growing and all of the changes in how their bodies are functioning as puberty occurs. It is normal for early adolescents to be critical of how they look and to compare their looks with their peers, but by late adolescence, they will be much more comfortable with how they look and who they have become (CareNotes, 2000).

Another area to consider when exploring the development of adolescence is the rollercoaster of emotions in dealing with pressures from family, friends and society. At
this time adolescents are continuing to develop, their self-esteem and begin to search for
the truth about who they are. “Adolescents’ personality and emotions are constantly
changing; these ups and downs have to do with a teenager’s effort to become more
independent” (CareNotes, 2000). Eric Erickson (1990) argues “adolescents are often
preoccupied with what they appear to be in the eyes of other people and with the question
of how to connect earlier roles and skills with their new idealized views of themselves
and others” (p. 64). Adolescent development is directly linked to groups, experiences
and social interactions with others. Therefore, how others perceive an adolescent is
equally as important as how the adolescent views him or her self. An adolescent’s view
of who they are internally and what they perceive as others’ views of themselves are
equally important in the development of self-esteem.

As adolescents grow, family and social relationships in their lives change. It is
not unusual for a young teenager to reject earlier adopted family rules and values. At this
stage in their lives their peers play a major role in influencing how they act and think.
Though these young individuals may act against set rules and regulations, it is important
for them to receive love and support from their family and friends.

Intellectually and mentally, young adolescent’s minds are also developing and
changing. As a teenager they are able to think deeply in a more complex and logical
way. At this stage young individuals are also thinking about the future and what they
would like to do with their lives. Though young individuals may be thinking at times on
a more complex level, there is evidence that adolescents act impulsively without
considering the results of their actions (CareNotes, 2000).
There has been significant research completed on how the teenage brain works. When dealing with emotion in teenagers, their brains show increased levels of activity in the amygdala, which is correlated with "gut instinct" sort of thinking, whereas in adult brains research shows an increase in activity in the frontal lobe, which is involved with rational thinking. This may be an explanation contributing to the "emotionally turbulent teenage years." One thought is that the left hemisphere activation is more of a conscious processing of emotion, where the right amygdala is more unconscious. This research could mean that as we develop into adults we shift to more clear and thoughtful processing. This research might also help to explain why it is at times difficult for adolescents to clearly understand consequences of their own behavior (Personal MD, 2001).

Problems Facing Adolescents/Risk Behaviors

Adolescence in itself is a high-risk period and because individuals in this developmental stage are developing a sense of identity. They may become vulnerable to many environmental and societal influences in development of personal identity. External sources of pressure often place the adolescent at risk for engaging in unhealthy behaviors as a result. The following behaviors or characteristics support the definition of at risk behavior and can be caused by a variety of factors: depressed or withdrawn, uninterested in usual activity, involvement with drugs and/or alcohol, and anger/aggressive behaviors are complex and troubling issues. These behaviors need to be carefully studied and understood by parents, teachers, and other adults in order to provide a supportive, healthy environment to reduce vulnerability and decrease the possibility for engagement in harmful activities (Pfeffer, 2003).
The Guidelines for Adolescent Preventative Services, (GAPS), is a questionnaire developed by the American Medical Association in the early 1990’s to serve as a service tool for the provision of comprehensive adolescent health care. Parents and their children through identification of an inventory of healthy concerns and risky behaviors can independently complete it. According to the results of the GAPS questionnaire completed by Gadomski, Bennett, Young, and Wissow (2003), having a rifle or a gun in the home, peers using tobacco/alcohol/drugs, and peers engaging in sexual acts defined factors that placed older adolescents, ages 16-19, at risk for engagement in maladaptive patterns of behaviors. Younger adolescents, ages 11-15, had a higher prevalence for risky behaviors if there was a gun or rifle in the home, household tobacco use was observed, peers had tried tobacco/alcohol/drugs, and violent acts were observed by the adolescent. The GAPS questionnaire also indicated that female adolescents indicated higher numbers of risky behaviors and overall health concerns than male adolescents.

One of the most influential factors in the adoption of unhealthy behaviors and habits is peer pressure. According to Urberg (et. al) 2002, characteristics of the individual, the relationship with the friend, and the context are important factors leading the adolescent to conform to peer behaviors. The specific relationship adolescents have with a friend, as well as the environment in which the adolescent socially engages in most often, can contribute to the level of susceptibility to engage in peer-influenced activity. Adolescents tend to value high-quality relationships and may more readily adhere to the same behavioral practices of that friend than to the average peer, which may not have uniformly positive outcomes for an adolescent. In order to bond with general peers groups, adolescents may also be willing to compromise their social values to adopt the
homogenous feeling of being accepted and apart of a group. Other individual characteristics that place adolescents at risk for peer influence are personal perceptions of the harm of conform, sensation seeking, self-esteem, and a commitment to traditional social values (Urberg et al., 2002). In order to prepare effective prevention programs and materials to present adolescents, it is imperative that teachers, professionals, and parents understand what causes some adolescents to be more susceptible to peer influence and to present a broad scope of interventions and suggestions in order to successfully decrease maladaptive patterns of behavior and promote healthy lifestyles.

Peer influence may spark and adolescents interest in maladaptive behavior patterns or unhealthy activities, but addiction to these unhealthy patterns of behavior is out of the control of the peer. The onset of smoking or tobacco addiction occurs primarily among children, around the age of 12. Addiction to tobacco and alcohol at early developmental stages is more rapid than adult-onset addiction (Urberg, Luo, Pilgrim, & Degirmencioglu, 2002). Smoking and drinking remain major problems among adolescents within the United States. Sells and Blum (1996) have completed a metanalysis of research that has been conducted over the past fifteen to twenty years and have found the risk factors facing adolescents putting them at greater vulnerability for addictive behaviors include, lower socioeconomic status (i.e. availability of birth control, pregnancy, gangs), psychological distress (i.e. mental health, communication with peers/parents), exposure to violence and abuse (i.e. physical/emotional/sexual abuse), and family stresses (i.e. death of a family member/close friend, parental divorce, parental criminal activity). According to Seimantov, Schoen, and Klein (2000), nearly 80% of high school students report having used alcohol at some time in their lives and even more
alarmingly common is binge drinking, which is consuming greater than five drinks in succession on one occasion. The use of alcohol has been associated with the major causes of death in young adults, such as unintentional injury, suicide, and homicide.

The use of addictive substances can greatly alter the adolescent’s perceptions, feelings, emotions, and responses to a variety of stimuli, resulting in secondary conditions, such as behavioral and mood disorders. Adolescent onset depression may present more like adult depression, but can be masked by the adolescent’s tendency to self-medicate with drugs and alcohol in order to disguise common symptomology. Childhood onset depression accounts for a large proportion of cases viewed within psychiatric clinics, although it still remains one of the most under diagnosed group of illnesses in psychiatry. Risk factors identified by Dhavale (2001), which place adolescents at higher risk for depression include, family history of mental illness or suicide, abuse (i.e. physical, emotional, sexual), chronic illness, and loss of parent(s) at an early age support the environmental influences that can contribute to the onset of childhood depression. Diagnosis of childhood depression is difficult because children are not always able to clearly express their feelings, symptomology in children with depression differs from the adult diagnostic category, masked symptomology due to the presence of more than one psychiatric disorder, and the reluctance of psychiatrists to diagnose this disorder in children, as it is often thought of as an adult disorder.

Juvenile delinquents have been found by Kristiansson (2002), to have extremely high rates of conduct disorder, ADD (attention deficit disorder), and ADHD (attention deficit hyperactivity disorder), which are conditions that are influenced by biological, as well as environmental factors, meaning the dysfunction stems from an internal disruption
in the neuropsychiatric system and cultural, familial, and societal influences. Internal dysfunction in combination with environmental influence often contributes to increased vulnerability within the adolescent population for engagement in at-risk behaviors. Environmental influences which have a direct correlation with adolescent dysfunction include: socioeconomic status (i.e. poverty and education levels), community violence, family abuse and criminality, and malnutrition (Kristiansson, 2002).

**Adolescent Treatment within the Juvenile System**

The traditional aims of the criminal justice systems practice of service delivery are to address the criminal’s rehabilitation and retribution for crimes committed through punishment. Although imprisonment is viewed as the ideal mode of punishment, rehabilitation is an important element in the penological system. There has been little effort made by juvenile correctional system to include rehabilitative efforts into it’s programming. The criminal justice system has continued to focus on attempting to fit the crime with the illness, which has been believed to result in an increase in crime rates among this population. The mental health model suggests that the inclusion of services, such as drug and alcohol programming, diagnostic education and symptoms management services, behavioral modification, etc, would be beneficial in reducing the “revolving door” cycle of recommitting crimes and return to the criminal justice system.

Armstrong (2002) found that utilizing the cognitive-behavioral approach to treatment of juveniles was influential in the treatment of unhealthy thought processes and resultant dangerous and inappropriate behaviors. Because the cognitive-behavioral therapy (CBT) approach to therapy focuses on a multi-modal style of service provision, it has been adopted by the juvenile justice system as an effective service delivery as of
recently. The cognitive portion of this frame of reference points to insight and accountability for actions rendered, which begin the process to reducing undesirable behavior. According to this theory, the offender will likely explore feelings associated to the harmful behaviors and in turn gain a sense of remorse. The behavioral aspect of this theory is directly related to the juvenile justice system in that it aims at reducing anti-social behavior through individual accountability.

**Psychosocial Interventions in the Schools and Community**

Schools are beginning to look into community mental health avenues of treatment to assist adolescents with behavioral and or mental health issues (Taylor & Adelman, 2000). According to Pietro et al. (2000), there are many reasons to consider schools as a setting for mental health treatment. Educational professionals have direct access to young people at a time during which emotional problems and behaviors are beginning to emerge and young adolescents spend close to half their waking hours in school. In society today, there is movement towards preventative and population based intervention. As professionals working with young adolescents, the need to remove barriers to learning, resulting in enhancing development, health, and most importantly mental health in youth is optimal in the most universal natural setting, the schools (Weist, 2002). A study conducted by Kaplan, Calonge, Guensey and Hanrahan (1998) explored the use of physical and mental health services for adolescents who are enrolled in managed care and have access to a school-based health center (SBHC) compared with adolescents enrolled in manage care without access to an SBHC. A retrospective design was used in order to compare the use of health services to adolescents with access and those without access. In this study the researchers used mental health and substance abuse treatment services,
and comprehensive preventative health screenings to determine at-risk behaviors. The results of the study showed that adolescents with access to SBHC were 10 times more likely to seek help from a mental health service which, in turn shows that school-based health centers are an improvement to mental health and substance abuse treatment for adolescents (Kaplan et. al, 1998).

Benefits have resulted from psychosocial interventions in the schools not only the individual, but also for the society. Positive results of psychosocial intervention include: decreased crime rates, improved ambition for continued education and vocational readiness for the future. Few schools have sufficient resources to promote mental health, minimize psychosocial problems, and provide treatment to students that are at-risk. After school enrichment programs and links with community resources are seen as important, yet they remain underdeveloped along with school-based health centers and mental health clinical services. (Taylor & Adelman, 2000). Weist (2002) identifies a gap in the services provided to children and adolescents and a need for enhancing the partnerships between the school systems and the community to organize a full continuum of mental health promotion and intervention services for youth. The discipline of school psychology services and interventions is unique in that it includes a wide variety of professionals, including social workers, psychologists, behavioral therapists, and occupational therapists. School and community professionals also need to collaborate together to improve care, which is an essential piece in the prevention continuum.

According to Taylor and Adelman (2000), school and community resources need to become more cohesive. Unfortunately, this situation is not likely to improve as long as little attention is paid to the restructuring of schools and communities to deal with
psychosocial and mental health problems. A key factor in the restructuring efforts is the need to establish models to guide development for comprehensive approaches that can be used effectively at every school site.

**Occupational Therapists Role in School-based/Community Mental Health Treatment**


Occupational therapy needs to look into the area of school-based practice in mental health, and step out of just the physical and sensory integration realms of treatment (Taylor, 2003). Many practitioners suggest future practice will move into the school system, home health agencies, private practice, industry and an assortment of other community-based facilities (Fazio, 2001). Worldwide deregulation of mental health services is pushing the profession of occupational therapy in the direction of community-based interventions. It is important for occupational therapists to become more pro-active in the community and in regards to mental health, in hopes of assisting these young individuals plan for the future.

Scaletti (1999) proposes a community development role for occupational therapists for children, adolescents and their families. The need for community-based intervention is critical for this population and Scaletti proposes a five-step model of
community development in order to empower clients to take control of events that influence their health and lives, and expand on the development of their occupational roles. The five steps of this model include: developmental casework: goal is to enable individuals to link together with systems of support, mutual support systems: goal is to link family, friends, peer groups and the natural community such as after school programs to form a basis of support, coalitions of mutual interest: in this phase coalitions are formed with natural interests such as book clubs or art groups, pro-active community participation: encouragement to participate and gain control of local organizations/ being pro-active, and social commitment: people becoming socially involved to help promote healthy lifestyles. This model links together mental health, occupation and community. It illustrates the movement of occupational therapy departments into the community with the focus on multidisciplinary teams, which will greatly influence service delivery in the future.

Occupational therapy services provided to at-risk adolescents are geared toward changing behaviors before they significantly affect their occupational roles (Scaletti, 1999). In the school systems, occupational therapist may work on a variety of skills promoting their occupational roles in life including: coping skills, anger management, vocational readiness skills, social skills and promotion of health lifestyles. Environmental influences and social interaction are important for psychosocial development in adolescents because external influence has a dynamic interaction with an individuals occupational roles and the resultant performance in these roles. According to Olsen’s Psychosocial Frame of Reference (1993), she describes the importance of the primary environments of home, school and community. Society is moving towards
health and educational changes of shifting child and adolescent occupational therapy services into the school system, which is one of their primary environments (Scaletti, 1999).

**Theoretical Approaches and Models**

For the past 20 years occupational therapists have been studying, developing, and using client centeredness, as well as a humanistic approach, as an underlying basis for treatment. These approaches encourage the client to make choices with the therapist and team, in order to facilitate and guide interventions, which includes the person, environment and his/her daily occupations. Client-centered occupational therapy has been identified as an approach that holds a philosophy of respect and mutual collaboration with people receiving services. When a new client-therapist relationship is developing and evolving it is important that both parties understand the treatment process. Client-centered practice is a useful tool in developing rapport with a client and bringing the concept of client-centeredness into treatment allows the individual to feel like an active participant in their life, which will in return, increase satisfaction when accomplishments and gains are made (Law, Mills, & Baptiste, 1995).

As mentioned previously, the humanistic approach has been an influential guide in the provision of services using a holistic treatment perspective. This approach encourages a positive client-therapist relationship. It also focuses on the broad dimensions of an individual’s life experiences, and pays careful attention to the individual’s concept of self as well as their personal values (Davis & Adams, 1995). This approach aids in providing a theory base for individuals allowing them to find meaning through occupations. According to Cara and MacRae (1998) the client-centered
principles of the humanistic approach are useful in establishing rapport and trust between the client and therapist. This model also reflects the importance of creating a non-judgmental environment that allows young adolescents to feel safe in expressing themselves and in learning new skills and re-learning old skills.

The Occupational Adaptation Frame of Reference (OA) is a frame of reference designed to serve as a guide to practice across populations and treatment settings (Schkade & Shultz, 1992). This frame of reference looks at occupation and adaptation in a unique way, which explains the adaptation process experienced throughout and individual’s lifespan. The occupational adaptation frame of reference views the process of carrying out life roles through adaptation in order to determine role mastery. Because the tasks that make up life roles change throughout the lifespan, human beings must adapt in order meet the demands of the occupation and be successful in that role. The occupational adaptation process is a normal process, indicating it does not just happen in people who have experienced illness, injury, or disease. At one point or another, all individuals have operated to some degree of occupational dysfunction. The adaptation process involves energy levels, patterns that present challenges with time and experience, and behavior responses. The goal of this model is to help individuals gain increased relative mastery in all that they do in relation to their occupational roles. This model also ties in the concept of client-centered practice in that, the client is the primary contributor to developing a plan of treatment.

According to Schkade and McClung (2001) there are three types of behavior that can be present during an adaptive response; primitive, transitional, and mature. Primitive behavioral are frequently used when experiencing extreme stress and or challenge during
occupational performance. This response pattern is considered “normal” and individuals should not consider themselves dysfunctional when feeling overwhelmed. It is important for adolescents to understand that feeling overwhelmed and “stuck” in particularly challenging situations is a normal response and they should not shame themselves for these feelings. Transitional response patterns are often random, without a specific goal or direction. They often occur after primitive response patterns if the individual is unable to find a solution to the challenges that are presented. The individual may vary their response patterns during this stage and can result in a solution to the occupational challenge or serve as a bridge between primitive response patterns and mature responses. Mature adaptive response patterns are evident when an adolescent is utilizing behaviors that are goal directed, logical, and insightful. When an individual is presented with an occupational challenge and he or she responds with a mature behavior, the individual is utilizing a truly adaptive response. As a therapist, it is important to reiterate to the adolescent that emergence through each of these three patterns of behavior is necessary at their developmental stage. Adolescents should refrain from feeling discouraged during the trial and error process. Only after adaptation is not achieved after a reasonable amount of time should the adaptive response pattern be viewed as dysadaptive (Schkade & McClung, 2001).

Occupational role expectations are generated from two sources: the person and the environment. Personal expectations are the sensorimotor, cognitive, and psychosocial challenges that the individual views in regards to the occupation. Environmental expectations are physical, social, and cultural demands of the external environment in a particular situation. Adolescents face challenges from both an internal and external
perspective, meaning dysfunction can occur in either of these areas. The client or adolescent student in this program is considered the agent of change according to this theory. It is the therapist's responsibility to assist the student in empowering him or herself to change maladaptive behavior patterns by “setting the stage” in the environment for the adaptation process to be practiced and promote success. Another method for promoting a supportive environment for the adaptation process to occur is by having the therapist point out that each individual has the opportunity to achieve mastery in occupation. Also, the student is directing their path toward achieving mastery in their target occupations through motivation and personal investment in challenging themselves to put forth their best effort during occupational performance. As a result the adolescent will reap the benefits of satisfying performance.

Assessment materials, intervention planning, and evaluation of outcomes can all be effectively determined through utilization of the occupational adaptation frame of reference. The assessment process involves gathering data regarding the student’s occupational environments and roles, primary concerns, individual perspectives on role demands and status (i.e. cognitive, sensorimotor, psychosocial), specific features occupational roles (i.e. physical, social, cultural), and individual views on relative mastery in the identified areas of occupation and occupational environments. These questions may also be addressed with the individual’s family members and/or other influential members of the student’s life.

The intervention planning process involves the client and therapist collaborating on “what level of occupational readiness is needed in order to promote the occupational adaptation process, what help will the client need in order to assess occupational
responses and best utilize the results to affect the occupational adaptation process, and what is the best method to engage the individual in activity to promote adaptation? (Schkade & McClung, 2001). It is important to note that intervention planning should not be directly guided by skill deficits, but rather by the skills present in the individuals to complete occupational roles. When using the OA model, intervention principles are based on the concepts of, “evaluating the individual’s primary occupational roles and occupational environments, the degree of relative mastery in the performance of the roles, factors that may be interfering with relative mastery, and the occupational environments associated with primary occupational roles” (Cara & McRae, 2001). The intervention process looks at two modes; occupational readiness and occupational activity. For instance, instead of working on organizational skills (i.e. occupational readiness) because the client is continually losing homework assignments, the therapist would introduce organization activities to promote successful completion of assignments (i.e. occupational activities) in a timely manner in order to achieve a good grade in the class.

The evaluation of desired outcomes can be determined through identification of the most commonly used adaptive response method (primitive, transitional, or mature). Were the responses self-initiated? Has the client achieved relative mastery? Does the client generalize adaptive behaviors to other areas of occupation? Generally, interventions that are personally meaningful will promote more effective outcomes because they are intrinsically motivating and will promote generalization to other occupational areas and environments (Schkade & McClung, 2001).

A therapist invested in providing effective implementation of the occupational adaptation process will utilize skills, such as therapeutic use of self, understanding of the
measures to determine role mastery, providing environments to allow for practice and engagement in occupational roles, collaboration with the client to determine goals and expected outcomes, and a creative, understanding relationship with the client in order to promote a mutually satisfying relationship and overall successful outcomes.

Occupational adaptation is not a set of techniques; rather it is a method to view a client and assists with approaching each client in the most effective, efficient way (Schkade & McClung, 2001).

**Introduction to the Occupational Therapy Curriculum**

Theoretical models and approaches grounded in occupational therapy will be utilized in developing a curriculum for at-risk adolescents that are transitioning back into the school system. It is important to have a solid base of theory, including approaches and models, to guide intervention and treatment. There will be two approaches utilized in creating a holistic view of treatment for this vulnerable population including: having a client-centered and humanistic approach, these approaches will encompass every aspect of the individual’s life into the treatment process. Along with these approaches the Occupational Adaptation Model, will also guide treatment sessions, intervention selections, and this model will provide the therapist with a thorough perspective on the unique life experiences of these young adolescents.

Utilizing the occupational adaptation frame of reference is beneficial in designing a curriculum for at-risk adolescents, in that it incorporates the individual’s perceptions, perspective, and goals as well as the environmental (i.e. parents, teachers, employers, peers, social norms, etc) perceptions and expectations, allowing for a mutual collaboration and incorporating elements of client-centered occupational therapy practice.
It is the goal of this curriculum, that mutual collaboration between the client and therapist will be evident in the entire treatment process. The curriculum being developed will include: an evaluation process, an intervention plan, and a reflective process evaluating the educational and behavioral outcomes. Behavioral elements and topics of education delivery to be emphasized in this curriculum will include: self-awareness, risky behaviors, coping, social skills, and life skills.
Chapter III

Process

A comprehensive literature review was completed to highlight normal adolescent development, at risk behaviors, relationships between schools and communities in providing adolescent based services, and occupational therapy theory and approaches applicable to education-based community mental health programs. The information found in the literature review showed that due to the increase in unhealthy behaviors and challenges that adolescents’ face there are many adolescents that are being placed in juvenile treatment centers. When adolescents are transitioning from these psychiatric treatment facilities back into the public school system, services may not be directly available for this at-risk population.

The theoretical approaches that were researched served as a guide to the development and implementation of the curriculum. The Occupational Therapy Practice Framework from the American Journal of Occupational Therapy was used along with assessments and activity materials grounded in occupational therapy to guide the process of evaluation, intervention planning, and measuring outcomes.

Themes were identified throughout the literature and served as a guide for the development of the primary topic areas that make up the educational curriculum. The primary topic areas were compiled into five units of study:

- Self-awareness
- Risky Behaviors
- Coping
- Social Skills
- Life Skill
Within each unit, examples of a variety of activities will be provided to engage in the students in discussion and interaction regarding the unit topics. These activities were gathered from a variety of occupational therapy sources in order to develop a well-rounded curriculum. A couple of the sources consulted included, The Occupational Therapy Practice Framework and the Life Skills activity books by Wellness Production.

An occupational therapy-based curriculum was developed for implementation into the public education system. Goals of this curriculum are to provide improved mental health services to adolescents, in hopes of helping this at-risk population and putting an end to the revolving cycle of care that they are vulnerable to.
Chapter IV

Product: Occupational Therapy-Based Curriculum

In utilizing an outline for the development of the following curriculum, the Occupational Therapy Practice Framework was used as a guide. The Framework describes a summary of service delivery procedures that is dynamic and linked to the professions’ focus on and use of occupation. As occupational therapists move into new and expanded arena’s, such as the school system, the descriptions and terminology utilized in this document can help to communicate the unique focus this profession has on occupations and daily life activities to a variety of audiences. The summary is useful in new application of occupational therapy skills in emerging areas. The framework summary that will be utilized as an outline for this curriculum includes: evaluation, which includes the occupational profile and an analysis of occupational performance, intervention, which includes the plan and implementation, and outcomes, which includes processing results of the program. A copy of the Occupational Therapy Practice Framework Summary is located in Appendix A.

Occupational Profile

An occupational profile is information that describes a client’s, “occupational history and experiences, patterns of daily living, interests, values and needs” (AJOT, 2002 p.616). The occupational profile can be used as a means of describing a potential population group. The occupational profile can also be utilized to gain significant individualized insight on each potential client/student. It can be used as a semi-structured interview assessment to gain perspectives from each client and to gain insight into their backgrounds, experiences, goals, values and needs.
When using a client-centered, Occupational Adaptation approach in the exploration of the client’s occupational profile, the goal to reach mastery in life tasks is important to consider. Desire for mastery, demand for mastery and press for mastery are key concepts when using this approach. The desire for mastery begins at birth, and grows through the developmental phases of one’s life. The environment then will shape an individual’s demand for mastery. Characteristics of one’s environment will either act as a facilitator or as a barrier. When looking at the adolescent population environments may include; the home, the school, friend’s houses, and the community. These environments will facilitate a variety of influences including family, friends and society. The press for mastery involves occupational challenges that will evolve and grow over one’s lifetime, which includes the interactions between the person and the environment. Assessments will follow the pattern of 1) looking at the person and their desire for mastery in their life, 2) the environmental demands that may be affecting his/her ability to reach mastery and 3) the interaction between the demand for mastery and his/her desire (Schkade & McClung, 2001).

When clients enter into the mental health school based curriculum the focus will be to provide a safe, structured environment for these at-risk adolescents to gain knowledge regarding life situations. Information that will be collected will focus on gaining a perspective of who these clients are and where they are going in their lives.

The population that will be accessing occupational therapy services will include young at-risk adolescents. More specifically, the curriculum will be geared towards aiding young adolescents that are transitioning from juvenile systems back into the public school system. These clients will be referred to services through the process of being
mandated by family and or other school/community professionals. The curriculum will focus on skill areas needed to promote and facilitate a healthy lifestyle. The curriculum will focus on servicing adolescents that may be “lost” in the mental health system in hopes of closing that gap between the juvenile system of the community and the public school system.

In the process of gathering information about potential cliental, an exploration of occupations and activities that the clients view as successful and which ones they see as potential problems or threats to a healthy lifestyle. Throughout this process the therapist will continue to focus on a client-centered approach in letting the clients express why they feel certain activities are successful or problematic. The therapist will work with the client’s in exploring options to modify unhealthy occupations and activities and assist the adolescents in identifying risk factors that are present in his/her life.

The therapists will also explore and identify different context areas that are may be inhibiting or supporting these young adolescents’ present behaviors. The therapist will continue to follow a client-centered approach throughout treatment looking into all of the context areas that may be affecting the adolescent’s life. Context areas that will be considered include; cultural, physical, social, personal, spiritual, and temporal. (AJOT, 2002). All of these different contexts will be explored with each client through the initial evaluation process to determine which context areas affect that particular client’s life. The treatment will be individualized to meet each client’s needs and to encompass their unique living situation.

Along with gaining perspectives of our adolescent population in regards to occupations, activities, and different contexts, the area of life experiences, values and
interests in regards to occupational history will also need to be taken into consideration. In exploring the individual’s occupational history information will be gathered looking at previous patterns of engagement in occupations and daily life activities and the meanings that they feel are associated with them. In looking at the client’s entire occupational profile the client’s priorities and desires will be determined in the following areas; occupational performance, client satisfaction, role competence, adaptation, health and wellness, prevention and quality of life (AJOT, 2002). This information is essential in creating a client-centered treatment curriculum for these young at-risk adolescents.

Analysis of Occupational Performance

“Occupational performance is defined as the ability to carry out activities of daily life” (Occupational Therapy Practice Framework, 2002, p. 617), including ADL’s, IADL’s, education, work, play, leisure, and social participation. It is crucial for adolescents who are at risk and/or who have developed maladaptive patterns of occupational performance to examine skills and patterns involved with occupations in order to promote successful engagement and performance in the client’s targeted occupational areas. When occupational performance is analyzed, the performance skills and patterns are identified, as well as client factors, activity demands, and context(s) are evaluated.

The analysis process assists with identification of facilitators as well as barriers (i.e. strengths and weaknesses) in various aspects of daily occupational performance. In order for an occupational therapist to most effectively assess occupational performance, he/she must have an understanding of the dynamic interaction between performance skills, performance patterns, context(s), activity demands, and client factors. The
information identified during the analysis of performance will be used as a guide to the intervention process. During this process, specific assessments, such as an initial interview and The Adolescent Role Assessment (Black, 1982) will be utilized to more directly assess the client's needs, problems, and priorities from the information gathered in the occupational profile.

The therapist must select a theory or model to guide the evaluation process utilizing clinical reasoning. The occupational therapy approach that will be utilized as a guide to the intended curriculum is the occupational adaptation frame of reference. The occupational adaptation frame of reference views the process of carrying out life roles through adaptation in order to determine role mastery. Because the tasks that make up life roles change throughout the lifespan, human beings must adapt in order meet the demands of the occupation and be successful in that role. A standardized assessment that is directed at gaining the adolescent's view is the Adolescent Role Assessment (ARA) (Black, 1982). The ARA enables the therapist to view the adolescents past, present, and future role adjustment during engagement in occupation. This assessment serves as an intervention planning tool, rather than a diagnostic measure and provides an opportunity for the student and therapist to gain trust and respect for one another through casual conversation. A copy of this assessment can be located in Appendix A.

A semi-structured interview is a beneficial tool to utilize when first developing rapport with a student during the initial evaluation or meeting with the student. The interview should be geared toward establishing a picture of the student as a whole, meaning all aspects of the student's life should be considered. Utilizing the occupational adaptation frame of reference as a guide to developing an outline for the semi-structured
interview, which is located in Appendix B. The outline is an example of the types of questions and information that is pertinent during the initial phase of the treatment process.

The next step in compiling a complete analysis of the adolescent's occupational performance is to summarize the assessment data in order to determine which patterns, skills, contexts, and client factors need to be specifically addressed during the intervention process. The initial interview is geared at gaining information at the areas of occupation that are most important to the student and then addressing the psychosocial, cognitive, and sensorimotor factors impacting the student's occupational performance. The Adolescent Role Assessment addresses areas of occupation including play, role performance as a family member, student, and peer/friend, work, and future plans. Areas that are addressed in the Adolescent Role Assessment include: development of interests, responsibility, money management, social interactions, time management, energy, motivation, recognition of abilities and limitations, and role models. This is a collaborative process between the student and the therapist in which strengths and weakness are identified and goals are created to address desired outcomes. The therapist may ask the student, “What do you want to get out of this class?” and then provide the student guidelines and expectations of the classroom, including giving and receiving feedback, follow through with homework assignments, attendance, etc.

After all of the information has been gathered from the initial interview, the standardized assessment, and any other forms of communication with parents and/or guardians, the information must be synthesized into a list of strengths and weaknesses. The strengths and weaknesses format serves as a guide to the development of goal areas
to focus treatment upon. It is important that the therapist not develop goals based
primarily on weaknesses, but also incorporates the individual’s strengths as a basis for
good development. Utilization of each adolescent’s occupational strengths will help to
build confidence and motivation in working towards role mastery. Once again mutual
collaboration between the therapist and student is important in generating meaningful
goals in order to promote investment in the intervention portion of the treatment process.

**Intervention Plan**

After the evaluation process is completed and the data is compiled and
summarized for each student, an intervention plan is created and implemented. The
intervention plan is designed to outline the intervention approaches to be utilized, specify
intervention activities, and target desired outcomes. The therapist and student, as well as
other individuals involved in the student’s life (i.e. parents, teachers, etc), work
collaboratively in developing goal areas to target and methods to measure achievement.
The interventions to be utilized during the treatment process are aimed at engaging the
student in occupations and contexts that support their participation in identified life roles.
Most often interventions are geared toward the limitations or weaknesses discovered
during the assessment phase of the treatment process. Activities incorporate the
occupational roles and environments that involve the limiting behaviors and problem
areas and work toward achieving more appropriate, healthy responses to these roles and
contexts.

There are a variety of intervention approaches to consider when developing an
intervention plan. For the purposes of this curriculum targeting at-risk adolescents, three
approaches were chosen due to the variety of intervention implementation strategies and activities. Each of these approaches along with a brief example are listed out below:

- Remediation/restoration is "an intervention approach designed to change client variable to establish a skill or ability that has not yet been developed or to restore a skill or ability that has been impaired" (AJOT, 2002).

  *Example:* establishing or developing an effective morning routine in order to arrive at school on time each day.

- Compensation/adaptation is "an intervention approach directed at "finding ways to revise the current context or activity demands to support performance in the natural setting...[includes] compensatory techniques, including enhancing some features to provide cues, or reducing other features to reduce distractibility" (AJOT, 2002).

  *Example:* is to modify a birthday celebration to exclude drugs and alcohol as part of the party to support sobriety.

- Prevention is "an intervention approach designed to address clients with or without a disability who are at risk for occupational performance problems. This approach is designed to prevent the occurrence or evolution of barriers to performance in context. Interventions may be directed at client, context, or activity variables" (AJOT, 2002).

  *Example:* is to prevent social isolation and depressive symptomology through participation in extracurricular activities.

  Interventions will be implemented in a variety of ways utilizing the approaches discussed above. Types of occupational therapy interventions that will be used within the
activities include: therapeutic use of self, therapeutic use of occupations and activities, occupation-based activities, purposeful activities, preparatory activities, and education activities. Therapeutic use of self involves the therapist’s use of personality, insights, perceptions, and judgments as part of the process, meaning the use of clinical judgments to most effectively provide support to the student. Therapeutic use of occupations and activities is simply incorporating appropriate activities in conjunction with goals and populations being served. These occupational therapy intervention types are listed below followed by a brief example:

- Occupation-based activities are activities that allow the clients to actual engage in the real life situation of an occupation. Occupation-based activities are important because they allow the clients to perform the activity in the context it occurs and incorporate all activity demands.

  *Example:* purchasing own groceries, preparing a meal, and balancing a checkbook

  - Purposeful activities are activities that involve components that lead up to an occupation-based activity.

  *Example:* role-playing and practicing safety techniques

  - Preparatory activities are used in order to prepare for purposeful occupation-based activities. Preparatory skills are underlying skills that are required in order to complete or understand more occupation-based complex tasks.

  *Example:* discussion group on how to communicate effectively with others, paper pencil activities to gain skills such as assertiveness skills and appropriate anger management techniques.

  - Educational types of interventions provide new information or
knowledge about an occupation or activity without actual performance.

*Example:* providing the students with a handout to read over on proper communication techniques and skills.

In the development of a well-rounded course it was necessary to identify overall objectives for the entire curriculum, to act as a guide for the educational interventions. Because this course is designed more for personal development and gaining insight and experience into healthy occupations, behaviors, and environment, placing a numerical value on progress or achievement is not appropriate; therefore performance in this course will be evaluated as satisfactory or unsatisfactory. The overall objectives for the course are listed in *Figure 1* below.

<table>
<thead>
<tr>
<th><em>Figure 1. Course Objectives</em></th>
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<tr>
<td>Gain an awareness of strengths and weaknesses associated with overall occupational functioning</td>
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<td>Recognize self-motivating activities and occupational roles</td>
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<tr>
<td>Develop an understanding of components of a healthy lifestyle</td>
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<td>Demonstrate improved identification of unhealthy behavior patterns</td>
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<tr>
<td>Apply learned skills in natural environments and situations</td>
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<tr>
<td>Identify preventative methods and support system</td>
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<tr>
<td>Develop safety awareness skills and develop a plan of action</td>
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<tr>
<td>Begin to develop future plans and life roles</td>
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The curriculum is broken up into five units: self-awareness, risky behaviors, coping, social skills, and life skills. There are also specific objectives for each unit of material. The therapist will discuss unit objectives with the students at the beginning of each unit, which will provide the students with guidance and structure. Each unit is then broken down into a variety of activities and methods of education in order to meet the learning needs of each student and provide a stimulating, well-rounded curriculum.

**Intervention Implementation**

The intervention implementation phase of treatment involves the bulk of the interaction between the therapists and students through participation in activities individually and as a group. The majority of the activities will be group oriented, in that the students will all be given the same task or asked to participate as a group, but processing and discussion portion of the activity will incorporate the individual attitudes, opinions, and perspectives of each student. Because the intervention process is dynamic, in that many contextual factors (i.e. cultural, physical, personal, temporal, etc) may influence participation and achievement during occupational performance, it is important for the therapist to recognize a variety of contexts as possibly being influential to the students. Activities will be selected for each unit or topic that are specifically aimed at targeting a behavior or occupational role. In conjunction with these activities, reflective journals will be utilized for individual exploration and expression.

The therapist will ask that each student to keep a reflective journal throughout the semester. The journal will consist of a weekly journal entry in which the student will be asked to reflect upon any new knowledge learned, feelings, questions, reactions to activities or peers, as well as any other concerns they may be experiencing throughout the
week outside of the classroom. Students will be asked to turn in their journals periodically for the therapist to read and provide feedback. These journals will be confidential between the therapist and the student, unless circumstances are life threatening. For example, if information in the journal appears to put the student in an unsafe, unhealthy, or dangerous situation or position, the therapist will need to contact parents or other professionals.

The curriculum is broken up into five units: self-awareness, risky behaviors, coping, social skills, and life skills. Each unit is comprised of a variety of activities, which will be implemented in a variety of ways. Each unit is introduced with some introductory therapist materials followed by the activity. The following activities provide examples of a warm-up activity, a paper/pencil activity, and interactive group activity for each unit.

The warm-up activity is designed to introduce the topic for that session in order to prepare the students for more elaborate intense information. The warm-up is typically short 5-10 minutes and is a fun time for group interaction. The paper/pencil activity is designed to give the students time to reflect on their own thoughts and ideas regarding a certain skill. The paper/pencil activity typically utilizes a worksheet format. For the example activities listed below that require worksheets the worksheets will be available in appendix C. The activity is usually followed with discussion and processing of the group activity and how the content can be applied to their own lives. The interactive group activity is designed to allow all group members to engage in a “doing” task or activity. This type of activity is typically related to an occupation-based activity such as cooking a meal, role-playing, and grocery shopping. The interactive group activity is
also usually followed with discussion by all group members to reflect on the purpose of
the activity and the meaning it brings to them.
UNIT 1: Self-Awareness

Therapist Materials

Definition: This unit focuses on self-awareness. Self-awareness is the ability to judge one’s own abilities and limitations in relation to everyday life tasks. It involves building self-esteem, self-worth, self-expression, trust, motivation, and personal values. As an individual becomes more self-aware, he or she can then begin to have more control and focus in their lives.

Discussion: Many activities that focus on building self-awareness begin with the question, “Who am I?” Determining who we are is the key to gaining health, fulfillment, joy, and happiness because human beings are in control of surrounding themselves with the building blocks or components to achieving a fulfilling life. Because of the unhealthy environmental influences adolescents are often exposed to, defining who they are can be difficult. Adolescents often take on their peer’s, families, communities, or societies characteristics and define themselves with these outsider’s perceptions of who they are, rather than exploring their own perceptions, feelings, an activities in order to determine what is fulfilling to them. When we are not aware of who we are, we move through life on auto-pilot, living by habit and reacting unconsciously to people and events around us.

Self-esteem and self-worth are often characteristics that hinder development of the healthy adolescent. Self-esteem is opinion you have of yourself, your value as a person, how you think others see you, your purpose in life, your potential for success, your strengths and weaknesses, and your independence. There is a close relationship between low self-esteem and violence, alcoholism, drug abuse, eating disorders, school dropouts, teenage pregnancy, suicide, and low academic achievement, which are factors
that are directly related to the at-risk adolescent population. It is important for adolescents to know that just because they have felt bad about themselves in the past doesn’t mean that they are always going to feel that way. Once they learn to build self-confidence in an effective way which will be done through engagement in activities and discussion, they will surprise themselves at how easy it is to reframe self-defeating thoughts and develop a positive, motivating, healthy self-concept.

**Unit Objectives:**

- Identify positive self-attributes in group setting
- Engage in group discussion by giving and receiving feedback constructively with peers and teacher
- Demonstrate trust with peers by taking risks by sharing personal information/views

**Unit Activities:**

- **Warm-up:** “Trust Fall”
- **Paper Pencil Activity:** “Self-esteem Boosters/Busters”
- **Interactive Group Activity:** “What’s in a name”
Warm-up

Topic/Title: "Trust Fall"

Type of intervention: Therapeutic use of self and occupations/activities, preparatory

Time: 10 minutes

Objectives:
- Form trust between classmates
- Get to know you exercise
- Active participation
- Test individual's own limits

Rationale: This is a brief activity that allows the students to actively participate in an exercise, while getting to know one another. It also provides the opportunity for each student to examine their own levels of trust with others and their level of risk taking or limit setting with new peers. This warm-up activity is a prelude to a more involved group activity where self-awareness will be examined further.

Materials Needed:
- Open space

Activity Description:
This exercise must not be hurried nor be allowed to get silly. If it is not taken seriously, it loses its value. The group divides into pairs, spaced well apart, one person standing firmly behind the other. Keeping body and legs straight the person fall backwards against the supporting hands of the partner behind.

As trust builds up, the partner behind stands, progressively, a little further away. It may be helpful to demonstrate this with a colleague. The partner behind ‘catches’ the other’s shoulders and stands them upright again. Give each partner a turn at ‘falling’.

Resource:

**Paper Pencil Activity**

**Topic/Title:** “Self-esteem Boosters/Busters”

**Type of intervention:** Therapeutic use of self and occupations/activities, purposeful, and educational

**Time:** 30-35 minutes

**Objectives:**
- Improve insight into factors (positive/negative) influencing self-esteem
- Increase self-confidence through group sharing and communication
- Gain appreciation for self

**Rationale:** This is an activity that incorporates identification of individual characteristics that influence self-esteem. It also provides the students the opportunity to share their perceptions and feelings with classmates demonstrating self-confidence in communication within a group setting. The discussion portion of the activity is designed for students to give and receive feedback from one another in order to reduce any self-defeating or self-depreciating thoughts and/or behaviors.

**Materials Needed:**
- Self-esteem Boosters/Busters worksheet, Appendix C-1
- Writing utensil

**Activity Description:**
The therapist will introduce the activity to the students, giving specific examples of self-esteem boosters (ex. Having my hair done, going out with friends) and busters (ex. Calling myself stupid, not saying no). The therapist will ask the student to take 10-15 minutes to fill out the provided worksheet. Upon completion of the worksheet, the therapist will encourage discussion among the students regarding the impact of self-esteem boosters and busters on their current lifestyle. The therapist will also facilitate a discussion of how each student can possibly eliminate busters or modify them to positively affect self-esteem. As the activity is wrapping up, the therapist will ask the students to provide examples of benefits from participation in this activity.

**Resource:**
Interactive Group Activity

Topic/Title: “What’s in a name”

Type of intervention: Therapeutic use of self and occupations/activities, purposeful, and educational

Time: 30-40 minutes

Objectives:
- Explore and Identify positive self-attributes
- Identify positive peer attributes
- Give and receive positive feedback with peers
- Improve insight and awareness into positive characteristics and qualities of self

Rationale: This activity is directed at individual exploration and identification of positive self-attributes and qualities, as well as identification of positive characteristics of peers. This activity will promote group discussion, self-esteem, and self-confidence building through giving and receiving of positive feedback. Once an adolescent is able to identify positive characteristics of self, improved motivation and desire to achieve goals and success often follow, resulting in a healthier choices and lifestyles.

Materials Needed:
- Board
- Markers
- Index cards with each person's name written vertically
- Dictionary and Thesaurus

Activity Description:
The therapist will write on the board, “What’s in a name?” For an example, begin with volunteer printing the name of a famous person written on the board vertically. The therapist will ask for the students to come up with a positive, descriptive word for each letter in that person’s name.

Example:
T = thoughtful
O = optimistic
M = makes friends easily

The therapist will explain that the students are to think of positive attributes for each student or peer in the class. The students will then take turns putting their own names on the board and writing words or phrases suggested by their peers next to each letter. The therapist will redirect the students to use a dictionary and/or thesaurus if they are having difficulty coming up with descriptive words. A recorder will be asked to copy the attributes onto prepared index cards with each name written vertically on it. After the written portion of the activity is completed, the therapist will ask the students to make a circle on the floor and will pass out the index cards to each student. The students will be
asked to take turns sitting in the middle of the circle and reading the attributes out loud, utilizing the phrase, “I am...”. For example with Tom, he would state, “I am thoughtful, I am optimistic, and I make friends easily.”

Resource:

UNIT 2: Risky Behaviors

Therapist Materials

Definition: This unit focuses on risky behaviors affecting healthy adolescent development. Risky behaviors identified as most influential to the adolescent include: lower socioeconomic status (i.e. availability of birth control, pregnancy, gangs), psychological distress (i.e. mental health, communication with peers/parents), exposure to violence and abuse (i.e. physical/emotional/sexual abuse), and family stresses (i.e. death of a family member/close friend, parental divorce, parental criminal activity). Environmental influences which have a direct correlation with adolescent dysfunction include: socioeconomic status (i.e. poverty and education levels), community violence, drug and alcohol abuse, family abuse and criminality, and malnutrition.

Discussion: As adolescents grow, family and social relationships in their lives change. It is not unusual for a young teenager to reject rules and values. At this stage in their lives their peers play a major role in influencing how they act and think. These behaviors need to be carefully studied and understood by parents, teachers, and other adults in order to provide a supportive, healthy environment to reduce vulnerability and decrease the possibility for engagement in harmful activities. Though these young individuals may act against set rules and regulations, it is important for them to receive love and support from their family and friends. In order to prepare effective prevention programs and materials to present adolescents, it is imperative that teachers, professionals, and parents understand what causes some adolescents to be more susceptible to peer influence and to present a broad scope of interventions and suggestions in order to successfully decrease maladaptive patterns of behavior and promote healthy lifestyles.
Unit Objectives:

- Identify own risky behaviors demonstrating insight
- Verbalize and demonstrate understanding or healthy, positive behaviors
- Identify appropriate means of utilizing emergency services and professionals in dangerous situations

Unit Activities:

- **Warm-up:** “The HIV infection/AIDS Quiz”
- **Paper Pencil Activity:** “The Need for Structure to Stay Clean”
- **Interactive Group Activity:** “Emergency”
Warm-up

Topic/Title: “The HIV infection/AIDS Quiz”

Type of intervention: Therapeutic use of self and occupations/activities, purposeful, and educational

Time: 10-15 minutes

Objectives:

★ Gain insight into the importance of taking responsibility for one’s sexual health
★ Discuss risk factors specific to the youth population
★ Identify preventative methods

Rationale:

HIV infection is currently a life-threatening infectious disease with no known cure that is spreading rapidly among the adolescent population, due to unsafe sexual behavior. The mounting increase in HIV worldwide has led professionals around the world to focus on prevention as essential in stopping the spread of this devastating disease.

Materials Needed:

★ “The HIV infection/AIDS Quiz” Appendix C-2
★ pencil/pen

Activity Description:

The therapist will distribute the worksheet “The HIV infection/AIDS Quiz” and provide adequate time for the students to complete the worksheet individually. The group will then reconvene and review the answers as a group. The group will then spend approximately 5 minutes discussing risk factors involved in the transmission of HIV and AIDS before a more involved discussion is presented.

Resource:

Paper Pencil Activity

**Topic/Title:** “The Need for Structure to Stay Clean”

**Type of intervention:** Therapeutic use of self and occupations/activities, purposeful, and educational

**Time:** 30-40 minutes

**Objectives:**
- Define what is meant by “structure
- Understand how structure can help us stay clean
- Understand how lack of structure can result in relapse
- Gain insight into time management strategies to reduce stress

**Rationale:** In order for adolescents to maintain sobriety, a necessary change to make to promote success and healthy engagement in activities is a structured daily and weekly routine. Completing a daily and weekly planner from morning until nighttime is a structured method for the purposeful inclusion of healthy, productive activity into an individual schedule. If structure is absent from an addictive individual’s daily life, the tendency is to fall back into unhealthy routines and activities rather easily because of the familiarity and comfort.

**Materials Needed:**
- Paper
- Pencil/pen
- “Activity Analysis” handout

**Activity Description:**

The therapist will ask the students to take out a sheet of paper and to analyze a current activity that they enjoy, including what skills are needed to perform the activity, what environments are pertinent, and what type of friends/social network is associated. The activities must be alcohol and drug free that are realistic, meet their needs, and will help maintain sobriety and the students must make a commitment to adding one new activity to their lives.

The therapist will then provide the students with time to complete the provided handout answering any questions along the way. For each characteristic that was answered yes, the students will be asked to make a check mark next to the characteristic if it is an important characteristic to the student. The activity analysis activity will end with a short discussion of how the importance of including new and healthy activities into each day in order to distract from addictive substances and include productive, effective leisure activities into one’s daily/weekly routine.

The individual characteristics will help the students to gain perspective on the demands of each activity and allow for processing of possible negative and positive influences these characteristics may have on the activity performance.
Resource:

Interactive Group Activity

Topic/Title: “Emergency”

Type of intervention: Therapeutic use of self and occupations/activities, purposeful, and educational

Time: 30-40 minutes

Objectives:
- Explore appropriate actions to be taken during emergency situations
- Increase insight into healthy emergency responses
- Give and receive feedback from classmates and teacher

Rationale:
Emergency situations can present a variety of dilemmas for an adolescent. He/she might question whether to address the emergency situation immediately in fear that he/she may get in trouble and suffer consequences depending on his/her involvement in the situation. It is extremely important for adolescents to understand that emergency situations progress rather quickly and contacting the appropriate professionals and services immediately can impact the level of injury or impact the situation ultimately has upon and individual.

Materials Needed:
- Classroom with a door

Activity Description:
The therapist will introduce the activity as a group activity focusing on emergency situations and appropriate, healthy responses to these situations. The therapist will instruct the class that each student will take a turn exploring how they would react to a variety of situations. One at a time, one student will be instructed to leave the room. While he or she is out of the room, he or she must think of a question beginning: “What would happen if you...?” and add an emergency situation.

Examples are: “What would happen if you broke a leg, had a nose bleed, got lost at sea, found a thousand dollars?”

The students remaining in the room each think of a solution to the mishap, accident, or adventure. After a few moments students will be asked to whisper their solutions to the person on their left. The student waiting outside the room is then asked back into the room. He or she asks everyone in turn: “What would happen if you...?” (adding the situation he has dreamed up). Each student answers with the solution he or she has been given by their neighbor. When everyone has had a turn answering, another student can be asked to leave the room and think up a new emergency situation.

UNIT 3: Coping

**Therapist Materials**

**Definition:** Coping is a technique that involves learning and developing individual self-instructional methods for managing problems and or issues in one’s life. Coping mechanisms are important for adolescents to have, in order to manage life changes, deal with daily stressors and pressures from family and or friends, and to develop healthy behaviors in dealing with issues they face in their daily lives.

**Discussion:** Adolescents use coping skills in several aspects of their lives including many of their occupations. Coping skills are important to use at school, when dealing with peer pressures, teachers, grades, homework, and their friends. These skills are also important for adolescents at home and work, in that they will use them when dealing with conflicts with parents, other employees, their boss, and siblings. It is going to be difficult to find areas of these young adolescents’ lives where coping skills are not present. Utilization of positive healthy coping skills is very important to help ensure health and safety for this young population. If coping skills are not used, or are used in an unhealthy negative manner; further problems may develop including; alcohol/drug use, aggressive behaviors, criminal acts, self-inflicting behaviors, depression, etc.

There are many skills that fall under the term coping. Coping skills may include but is not limited to, anger management, stress reduction, relaxation techniques, problem solving, dealing with conflict and peer pressures. These are important skills for at-risk adolescents to learn and develop, in order to deal with the many pressures from today’s society and in order to live a healthier positive lifestyle. In order for these young adolescents to gain knowledge in the area of coping skills there are warm-ups, a written
group activity and an interactive group activity, that will give one an example of this unit, which will be used to guide treatment.

**Unit Objectives:**

- Identify healthy coping strategies to manage own feelings and emotions
- Distinguish between healthy and unhealthy coping behaviors
- Demonstrate ability to provide healthy, alternative coping strategies to manage conflict/stress to peers

**Unit Activities:**

- **Warm-up Activity:** “Relaxation”
- **Paper Pencil Activity:** “Alternatives to Anger”
- **Interactive Group Activity:** “Conflicts”
Warm-up

Topic/Title: “Relaxation”

Type of intervention: Therapeutic use of self and occupations/activities, preparatory

Time: 5-10 minutes

Objectives:
- Engage in self-expression of feelings
- Express interpretation of emotions to a trusting partner
- Gain insight into alternative methods to express emotions

Rationale:
Introducing relaxation at the beginning or the end of an intense group or topic, such as anger or suicide, can be used to provide a calm, open environment for these feelings to be discussed.

Materials Needed:
- Adequate space on the floor for sitting

Activity Description:
The therapist invites the students to choose a partner and find a spot on the floor to sit back to back. The therapist directs each student to take turns using their back as way to express how certain emotions and environments make them feel. Examples include: anger, love, happiness, safety, frustration, safety, cold, warm, sunshine, rain, etc.

Resource:
Title of activity: “Alternatives to Anger”

Type of activity: Therapeutic use of self and occupations/activities, preparatory, educational

Time: 30-40 minutes

Objectives:
- Explore reactions to anger in self and others
- Identify healthy and unhealthy reactions to anger
- Identify false beliefs about anger

Rationale:
Anger can result in a variety of unhealthy behaviors, such as temper tantrums, violent outbursts, and acting out behaviors in adolescents as a method to cope with the anger. If these behaviors are not addressed and discussed to promote more appropriate, healthy methods of dealing with anger, depressions and suicidal thoughts can result. It is important for parents, teachers, and health professionals to reinforce the idea that all emotions just are, they are not good or bad. How they get expressed can be good or bad.

Materials Needed:
- Copy of “Alternatives to Anger” worksheet, Appendix C-3
- “False Beliefs About Anger” worksheet, Appendix C-4
- Pens or pencils
- Marker board or chalk board

Activity Description:
The therapist will ask each student to complete the worksheet “Alternatives to Anger” independently and will also distribute “False Beliefs About Anger”. Ten to fifteen minutes will be provided for the paper/pencil activity. Afterward the group brainstorms to answer the question, “What do you do when your angry?”. The teacher writes about each technique, whether healthy or unhealthy, on the board and a group discussion through processing of the success or appropriateness of each response. Students will provide more successful, healthy coping responses to one another throughout the processing period. The therapist will then challenge the group to try something new the next time they feel angry.

Resource:
Interactive Group Activity

Topic/Title: “Conflicts”

Type of intervention: Therapeutic use of self and occupations/activities, preparatory, educational

Time: 30-40 minutes

Objectives:
★ Demonstrate insight into conflict and how it affects relationships
★ Identify positive, effective coping strategies to manage conflict
★ Give and receive feedback from classmates and teacher

Rationale:
Adolescents tend to respond to conflict with anger, defensiveness, and avoidance, which can result in the loss of friendships and maladaptive behavior patterns, such as drugs, alcohol, and/or self-harm to help cope with the confusion and/or anger involved. Although conflicting situations and relationships are present throughout the lifespan, there are effective, healthy ways to deal with conflict so as to reduce that negative effects on all areas of daily life.

Materials Needed:
★ Paper
★ Pencil

Activity Description:
The therapist will introduce this activity with the fact that life is full of conflicts and learning to cope with them is essential to survival. The therapist will ask that each student write about a conflict they have had with another person and have them describe what the relationship was before the conflict, how it began, what happened, and how did the conflict end? If the students do not feel comfortable describing personal conflicts, the therapist will allow the student to invent a conflict. Ten minutes will provided for the writing portion of the activity.

Each student will be asked to write about one of the following:
★ An inner conflict; a repressed urge, temptation, personal code, loyalty, guilt
★ A conflict with nature; the sea, the desert, ageing, disease, the weather, time
★ A conflict with social aspects of living; politics, religion, beliefs, morality, obligation, legal enforcements, financial situations, customs
★ A personal conflict with objects; machines, buildings, tools, traffic, furniture
★ A conflict with other living things; fish, insects, plants, animals, birds, reptiles
A conflict with the supernatural, fate, superstition, God, the devil, good, evil, magic, myth, taboos, antiquity

After each author has read their piece out loud, the other group members will asked to comment on how they might have handled the conflict or how they may have avoided the conflict. The students may also explore whether or not the conflict should be avoided or how each conflict could have been brought to a more satisfactory conclusion.

Resource:

UNIT 4: Social Skills

Therapist Materials

Definition: This unit focuses on social skills. Social skills are essential skills that focus on communication skills (both verbal and nonverbal), expressing one’s needs, being assertive, and providing/giving feedback to name a few. Adolescents are at a critical age in which many new skills are being learned and developed, social skills are at the top of many adolescents’ priorities. Being social, being popular, and trying to “fit in” with peers is often on adolescent’s minds. Adolescents think about social aspects as popularity rather than a skill.

Discussion: Adolescents utilize social skills throughout most of their daily occupations. They use them at school constantly, at home, at work, and most importantly when they are out socializing with their friends. It is important for adolescents to have a strong basis of knowledge in regards to social skills so that they are successful in today’s society. If an adolescent struggles in this area they may; feel isolated, become depressed, and may also have difficulties with vocational readiness skills such as interviews.

Skills that will be covered in the unit of social skills include; communication skills (non-verbal and verbal), assertiveness training, interpersonal skills, listening, and providing feedback. These skill areas will be covered through a number of means include warm-ups, written activities, and interactive activities. There will also be open discussions in order to facilitate further learning and development.

Unit Objectives:

- Demonstrate appropriate non-verbal communication skills during class interactions
• Distinguish effective and ineffective communication styles and
demonstrates appropriate communication to get needs met in class

• Verbalize understanding of assertive communication

• Demonstrate assertiveness skills within the classroom among peers

Unit Activities:

• **Warm-up:** “Wink”

• **Paper Pencil Activity:** “Changing My Communication”

• **Interactive Group Activity:** “Passive-Aggressive”
Warm-up

**Topic/Title:** “Wink”

**Type of intervention:** Therapeutic use of self and occupations/activities, preparatory, educational

**Time:** 10 minutes

**Objectives:**
- Gain awareness on ability to recognize non-verbal communication skills.
- Understand the importance of non-verbal communication to social skills.
- Develop awareness of one’s own body language.
- Develop an awareness of other people’s body language.
- Increase awareness of eye contact.

**Rationale:** This is a quick and fun activity that can be utilized as a prelude into a more serious topic related to communication/social skills. This activity allows group members to become aware of what non-verbals are and also how they play into the realm of social communication as a whole. This activity also allows the students to discover how people use their eyes to communicate and also increases their understanding of how to use eye contact. In addition to gaining insight into the use of non-verbal communication the individuals will also be able to become more aware of their own abilities to facilitate and receive this type of communication.

**Materials Needed:**
- Blank individual index card enough for all but one of the group members.
- One index card with the word “wink” on it.
- Jar or container

**Description of Activity:** The therapist will begin this activity (warm-up) by defining and giving an example of observation skills. Everyone will then sit in a circle so members can all see each other. Members pick folded pieces of paper from a jar. All of the pieces of paper are blank except one, which is marked “wink”. Members should not show each other their cards. The member with the “wink” card is to begin winking at other members one by one, discretely but making direct eye contact each time. Within 30 seconds after a member has been winked at, they are to close their eyes and lower their head until the game is over. Everyone who has not been winked at should try to guess who the winker is. Each member has two guesses.

Resource:

**Paper Pencil Activity**

**Topic/Title:** “Changing My Communication”

**Type of intervention:** Therapeutic use of self and occupations/activities, purposeful, educational

**Time:** 40 minutes

**Objectives:**
- ★ Discover appropriate ways of expressing one’s feelings.
- ★ Increase awareness of appropriate and inappropriate ways of communicating feelings.
- ★ Identify communication techniques that are presently used followed by a more positive communication technique.
- ★ Engage in self-report to the group on ways to communicate with others.
- ★ Provide feedback (both positive and constructive) to other group members regarding their ideas.

**Rationale:** This activity is appropriate and beneficial because it allows students to identify ways in which they currently communicate their feelings. Yet it also allows them to brainstorm ideas of how they could more appropriately express/communicate these feelings. This activity is especially useful in assisting emotionally immature group members to organize their thoughts and approach effective communication in a structured and non-threatening manner.

**Materials Needed:**
- ★ Copy of the “Changing my Communication” worksheet, Appendix C-5
- ★ Handout on “Conversation Skills”, Appendix C-6
- ★ Writing materials
- ★ Chalkboard or dry erase board

**Activity Description:** The group leader writes the heading “Angry” on the chalkboard and asks, “Who can tell me one way that you express yourself when you are angry?” After eliciting several responses, the leader asks if these are the best possible ways to respond when angry. The responses are written in column number one on the board. Group members are then asked to think of some alternative positive ways of handling anger.

These responses are written in a second column on the board. Members are then given the activity sheet, “Changing My Communication” and are asked to complete the sentences on the worksheet. When the members have completed the sheets, volunteers are asked to share their ideas concerning appropriate ways to express each feeling. The worksheet is followed by a group discussion in regarding how one can apply this activity to everyday conversation. In addition group members will each receive the handout title “Conversation Skills,” this will be given as a reference source of general communication
skills information and will be given to them to complete at home. This worksheet will briefly be discussed at the next group session.

Resource:

Interactive Group Activity

Topic/Title: “Passive-Aggressive”

Type of intervention: Therapeutic use of self and occupations/activities, purposeful, occupation-based, and educational

Time: 30-45 minutes

Objectives:

* Increase communication skills by being able to recognize passive-aggressive traits.
* Gain awareness into helpful strategies to deal with passive-aggressive behaviors.
* Increase communication skills by practicing assertive responses.
* Gain insight into all types of communication through discussion and interaction.
* Give and receive feedback among peers.

Rationale: This activity provides the students with an interactive yet educational experience. The group members are able to role-play real life scenarios that they can relate to, while learning different types of communication. It is important to explore the different types of communication in order for the students to gain an understanding as to why assertive communication is the most effective and to also discover strategies as to how it can be utilized.

Materials Needed:

* Passive-Aggressive worksheet, Appendix C-7
* Writing utensil
* Several sheets of paper
* Chalkboard or dry erase board

Activity Description: The therapist will begin this group with a brief introduction as to what passive-aggressive and assertive types of communication are. The therapist will then distribute the handouts and they will be read aloud as a group. The group of students will then be divided into groups of two asking each pair to write a brief 1-2 paragraph skit from their own observed experiences, (i.e. an interaction with a family member or a friend, or maybe an even that happened at school.)

Then each group will role-play their skit, first in a passive-aggressive style and then in a more assertive style, utilizing the helpful strategy suggestions. All students will be encouraged to engage in active listening in order to provide feedback to the individuals performing their skit. The group session will end by processing by identifying passive-aggressive traits discussed and also helpful strategies that can be utilized to increase assertiveness.

Resource:

UNIT 5: Life skills

Therapist Materials

Definition: Life skills are skills that allow one to carry out life roles and occupations in a variety of different environments with a variety of different people. The process of learning life-skills is a life-long never-ending process that is always developing and changing with one's life journey. Life skills are important to develop in order to engage in a routine of healthy behaviors.

Discussion: Learning life-skills is especially important for this adolescent population, because they are at that stage in their life in which they may be venturing out on their own and will be taking care of themselves in the real world. Adolescents are dealing with many life changes and having a basic knowledge of life-skills will better prepare them for the future.

Life skills encompass a variety of categories and tasks. For the purpose of this adolescent-based curriculum one should focus on the following areas: ADL’s, vocational readiness, IADL’s, job readiness skills and also how to live a healthy lifestyle. These skills are to be covered through a variety of activities with an emphasis on occupation-based interventions in order to promote learning in the appropriate context.

Unit Objectives:

- Demonstrate engagement in appropriate self-care activities by healthy, clean personal appearance
- Identify components of healthy lifestyle through development of an individual healthy lifestyle plan demonstrates follow through with plan
- Identify support networks in order to promote success with personal and community interactions/relationships
Unit Activities:

- **Warm-up:** “Food Collage”
- **Paper Pencil Activity:** “Step Up To a Better You”
- **Interactive Group Activity:** “Planning and Preparing a Meal”
**Warm-up**

**Topic/Title:** “Food Collage”

**Type of intervention:** Therapeutic use of self and occupations/activities, preparatory, and educational

**Time:** 15 minutes

**Objectives:**
- Promote group interaction through informal conversation while engaging in activity.
- Gain an increased awareness for likes and dislikes of food.
- Gain an awareness of healthy and unhealthy eating habits.

**Rationale:** This is fun and simple activity that is a good warm-up for perhaps the planning of a cooking group. It will allow students to thumb through magazines and select food items that they either like or dislike. Throughout the activity the group members will interact with each other on an informal basis. This activity is also an easy way to determine some of the eating habits among group members.

**Materials Needed:**
- Glue or Tape
- Construction paper
- Scissors
- Variety of magazines

**Activity Description:** This warm-up will be introduced briefly to the students, by asking the students about their favorite and least favorite foods. The therapist will provide each student with a piece of construction paper, a scissors, and a glue stick. A variety of magazines will be placed in the middle of the table. The students will be instructed to cut out pictures or phrases that relate to foods that they may either like or dislike the students will have about 7-10 minutes to complete their collages. The group will then revisit their collages prior to the interactive planning phase of the cooking activity, to discuss health and unhealthy eating habits.

**Resource:**

**Paper Pencil Activity**

**Topic/Title:** “Step Up to a Better You”

**Type of intervention:** Therapeutic use of self and occupations/activities, preparatory, purposeful, and educational

**Time:** 35-45 minutes

**Objectives:**
- Increase awareness of an individual’s level of self-care
- Gain independence with goal setting to improve level of self-care.
- Increase follow-through and enhance self-esteem.
- Gain an understanding of components of a healthy lifestyle

**Rationale:** This activity is beneficial for this adolescent population because it allows for the students to have an active role in working towards a healthier lifestyle. It gives the students the opportunity to see how well they take care of themselves currently and it also allows them to make influential goals for themselves. By giving the students the chance to develop their own personal goals, there may be an increase in follow through with the goals, because there is meaning behind each goal. This activity also allows the students to state an individual in which they will share accomplished goals with which may in turn increase the individuals self-esteem.

**Materials Needed:**
- Step up to a Better You! Worksheet, Appendix C-8
- Writing utensil
- Scissors
- Chalk board of dry erase board
- Tape or glue

**Activity Description:** The therapist will begin by distributing the handouts to the group. The students will then be encouraged to complete steps #1 and #2. The group will then discuss what causes a person to stop taking care of themselves and how that affects self-esteem, relationships, and one’s general outlook on life. The therapist will then ask the group members to cut out the ten boxes at the bottom of the pate and place a box on each step that is a self-care activity needing improvement for step #3 (use tape or glue to place boxes on steps).

Completing steps 4 and 5 on the handout will finish the activity. The group will end with processing, which will include group members sharing their goals and discussing the benefits of this activity. The therapist will encourage the students to place this handout in a conspicuous spot (bathroom, refrigerator, or bedroom mirror), in their home as a visual reminder.
Resource:

Interactive Group Activity

Topic/Title: “Planning and cooking a meal”

Type of intervention: Therapeutic use of self and occupations/activities, occupation-based activity, purposeful, and educational

Time: multi-day activity (will take about four 45 minute consecutive sessions)

Objectives:
- Gain an understanding of the planning and work that goes into preparing and cooking a meal.
- Demonstrate proper use of safety skills in the kitchen.
- Increase awareness as to why a budget/money management are important.
- Increase teamwork among group members to have a successful meal prepared.

Rationale: This activity allows students to engage in a real life occupations of cooking and meal preparation. This activity will allow students to experience the steps that go into planning, budgeting, and preparing a meal. This activity will expand the student’s knowledge regarding cooking skills, money management, teamwork, safety skills, and meal preparation. Students will gain an understanding of a variety of IADL skills while actual engaging in the occupation.

Materials Needed: (for example if students choose spaghetti)
- Pot for noodles
- Pot for sauce
- Pan for garlic bread
- Pasta noodles
- Sauce
- Spoons
- Strainer
- Garlic bread
- Kitchen with oven and sink

Activity Description: The therapist will introduce this activity by briefly discussing the importance of cooking skills for their future. This activity will take place over a four-day period. The first day will include a planning period in which the students will be given 3 choices of meals to cook (spaghetti, homemade pizza, or tacos). The students will then determine what materials they will need depending on what meal they would like to prepare as a group. Day 2 the students will be taking a trip to the grocery store in order to buy the items that they need for the meal. The students will be given a budget in which they will have to abide by, to practice money management skills. Day 3 is the day in which the students will cook the meal. The therapist will instruct the student’s that this is a group effort. Everyone will need to be included in the activity and meal preparation, cooking, and clean up are all the students’ responsibility. The last day will be a day to process how the activity went and what the students felt about the activity. They will
discuss any difficulties that came up and how the group was able to problem-solve their way through the activity in order to be successful. The group will also relate this activity to a real life situation.

Resource:

Outcomes

Outcomes will be measured through a comparison of progress toward goal achievement throughout the intervention process. Ultimately, the outcomes process is an analysis of each student’s overall engagement and level of participation in occupation through activity. General behaviors are expectations and guidelines for the students to adhere to throughout the entire semester. The following general behaviors are provided for the entire curriculum will be re-examined twice throughout the semester to determine and assess the students' progress and achievement at midterm and again at the resolution of the course. Figure 2 will be used to organize the information in a structured format at each of the evaluation periods.

**Figure 2: General Behavior**

<table>
<thead>
<tr>
<th>General Behaviors</th>
<th>Rating Scale</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attends regularly</td>
<td>1-Rarely 2-Needs Improvement 3-Satisfactory 4-Often 5-Always</td>
<td></td>
</tr>
<tr>
<td>Attends throughout class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regularly participates in class discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows directions as given</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbalizes emotions appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks appropriate questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Returns promptly from breaks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engages with classmates in positive manner</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In order to measure outcomes for each unit, the following figure will be utilized at the end of each unit in order to determine where progress and achievements have been made and where there is room to improve. Figure 3 will be used to organize and record information gathered during each unit.

**Figure 3: Unit Specific Behaviors**

<table>
<thead>
<tr>
<th>Unit Specific Behaviors</th>
<th>Rating Scale</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-Rarely</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2-Needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3-Satisfactory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-Often</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5-Always</td>
<td></td>
</tr>
</tbody>
</table>

**Unit 1**

Self-awareness

Identify positive self-attributes in group setting

Engage in group discussion by giving and receiving feedback constructively with peers and teacher

Demonstrate trust with peers by taking risks by sharing personal information/views

**Unit 2**

Risky behaviors

Identify own risky behaviors demonstrating insight

Verbalize and demonstrate understanding of healthy, positive behaviors

Identify appropriate means of utilizing emergency services and professionals in dangerous situations

**Unit 3**

Coping

Identify healthy coping strategies to manage own feelings and emotions
<table>
<thead>
<tr>
<th><strong>Distinguish between healthy and unhealthy coping behaviors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demonstrate ability to provide healthy, alternative coping strategies to manage conflict/stress to peers</strong></td>
</tr>
</tbody>
</table>

**Unit 4**  
**Social skills**

<table>
<thead>
<tr>
<th><strong>Demonstrate appropriate non-verbal communication skills during class interactions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Distinguish effective and ineffective communication styles and demonstrates appropriate communication to get needs met in class</strong></td>
</tr>
<tr>
<td><strong>Verbalize understanding of assertive communication and demonstrates assertiveness within the classroom</strong></td>
</tr>
</tbody>
</table>

**Unit 5**  
**Life skills**

<table>
<thead>
<tr>
<th><strong>Demonstrate engagement in appropriate self-care activities by healthy, clean personal appearance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identify components of healthy lifestyle through development of an individual Healthy Lifestyle Plan demonstrates follow through with plan</strong></td>
</tr>
<tr>
<td><strong>Identify support networks in order to promote success with personal and community interactions/relationships</strong></td>
</tr>
</tbody>
</table>
Chapter V

The purpose of the proposed curriculum is to provide support and guidance important in helping to fill the gaps in mental health care and to reduce the number of adolescents that are in juvenile treatment centers through implementation of preventative services. Occupational therapists are specifically trained in recognizing healthy vs. maladaptive patterns of behavior. They specialize in developing adaptive and/or compensatory strategies to improve safety and introduce healthy habits for an overall productive, meaningful lifestyle. Occupational therapists are an essential member of the mental health treatment team and are significantly underused within the school system in order to address the growing mental health needs of today’s youth.

The occupational therapy-based curriculum for at-risk adolescents has been developed for use in the public school systems by occupational therapists. The curriculum will allow adolescent an opportunity to gain important life skills enabling a smoother transition from juvenile treatment centers into the public school system. The anticipated curriculum goals have been identified in relation to the future implementation of the curriculum. The first goal is to provide the students with the opportunity to gain information regarding important life skills that may provide for a smoother transition for juveniles transitioning between community mental health treatment facilities and the public school system. The second goal is to reduce the revolving cycle of care through increased active involvement of occupational therapists in the mental health treatment continuum. The third and final goal of the curriculum is to aid adolescents in planning for healthy and productive futures through the involvement of a supportive, unified treatment team and environment.
There are several limitations of the proposed occupational therapy-based curriculum. One limitation is that the activities were not written out for the entire curriculum, rather only 3 examples for each chapter were provided. Another limitation is that the curriculum will be held during a regular school semester and the students that are enrolled in the curriculum may feel, different due to being singled out in this particular class. The last limitation of this project is that with the literature review there was little previous research done in school based mental health programs providing us with a limited amount of background information.

Few school-based occupational therapy programs focus on mental health issues within the pediatric population, so research on this topic would be useful in planning and implementing preventative programming early on in the public school system. Future research implications may include several different aspects. The first research implication is to implement the curriculum in both rural and urban areas. Secondly one could implement the curriculum into psychiatric treatment facilities before the students return back to school rather than in the schools. The last future research idea is to implement the curriculum as a partial hospitalization program where the students attend the program for the entire day for a certain period of time on an outpatient basis rather than jumping right back into the public school system.

It is intended that the proposed scholarly project will assist in allowing school professionals to understand the important role occupational therapists play in the identification of adolescent needs. It is also important that helping school professionals understand that occupational therapist work toward implementation of healthy, supportive programming to guide adolescents through this challenging developmental
period of their lives. Occupational therapists strive to improve the quality of life, which will strengthen the market for occupational therapy within the school system and in turn strengthen the entire team approach in providing holistic care to young individuals.
References


Weist, M.D. (2002). Challenges and opportunities in moving toward a public health approach in school and mental health. *Center for School Mental Health Assistance, Dept. of Psychiatry, University of Maryland School of Medicine.* Baltimore, MD, USA.
Appendix A
4
The Adolescent Role Assessment

Maureen Black, Ph.D., O.T.R.

Literature Review

Much of the credit for the concept of adolescence in industrialized societies goes to G. Stanley Hall's Adolescence, published in 1905. Hall was a maturationist who wrote that adolescents' lives are dominated by the inevitable conflicts, which include hyperactivity versus inertia, independence versus dependence, submission versus dominance, and responsibility versus self-absorption, and often result in inconsistent, and sometimes rebellious, behavior. Hall argued that, for successful passage from childhood to adulthood, adolescents be permitted to resolve these conflicts, and their behavioral inconsistencies be tolerated. Hall's work forms a baseline of thinking on adolescence in America and indeed, adolescents are afforded a freedom of expression unavailable either to children or to adults. Society expects adolescents to display occasional bouts of crazy behavior, and they comply.

In spite of the emphasis on the stress and strain of adolescence, most of the time adolescents are not in the throes of turmoil or rebellion, but are busy with school, family, and friends. Most adolescents successfully pass through this stage of development to become competent adults. However, many adults with adjustment problems do have a history of adolescent misbehavior. It is difficult to discriminate between the expected turmoil of adolescence and the early signs of pathology, particularly because the boundaries of acceptable adolescent behavior are so flexible. Thus, very little is known about normal adolescent development or the effect of stress on adolescent adjustment.

Even less is known about the adolescents seen by occupational therapists—those with physical or emotional disabilities. The problems of these adolescents go beyond the expected conflicts of maturation. Not only are they in the midst of a change of roles from childhood to adulthood, but they have been identified either through their physical or behavioral abnormalities and may be denied many of the experiences of adolescence. For example, physically handicapped adolescents may not be permitted the independence and responsibilities periodically demanded by most adolescents, or schizophrenic adolescents may be unable to recognize the changing role playing expected of them. These adolescents may require additional support and guidance in successfully coping with the conflicts of adolescence.

Although the discordance of adolescence has been widely publicized both through professional and popular literature, attention should also focus on the consistencies of development. Such a perspective has emerged from a framework of occupational behavior, and enables questions to be raised about the acquisition and
transfer of skills from one stage to another. In this way it may be possible to earmark the developmental strengths and weaknesses of adolescents seen by occupational therapists, rather than ignoring problems of adjustment, or automatically attributing them either to maturation or to pathology.

**Occupational Choice**

The theory of occupational choice, described by Ginzberg and others, fits well within the framework of occupational therapy, because it outlines a progression of decision making stages from childhood to adulthood. The occupational choice process is conceptualized in three stages, characterized by specific evolutionary tasks. The first stage begins in childhood play and includes fantasy and exploration. Through play, children learn to organize rules for games, to win and to lose, and to receive spontaneous feedback from peers. Feedback enables children to distinguish acceptable social behavior from unacceptable behavior.

Through role models and experience, children build references for their fantasies. The stick becomes a director’s baton, the parked car drives to the store, and the hat transforms the child into a fire fighter. Children daydream and explore make-believe alternatives as they increase the scope of their reality. From their dreams and fantasies, they develop interests and hobbies to guide further exploration.

The second or tentative choice stage emerges when the interests built in childhood are related to personal capabilities, values, and goals. Since adolescents are no longer licensed to actively fantasize by pretending to be fire fighters, they require more subtle outlets for their exploration. Childhood play is replaced by adolescent leisure activities, especially social interaction and interest development.

Adolescents are expected to assume responsibilities within the family, neighborhood, and school. They receive feedback from their performance and become increasingly accountable for their actions. This feedback assists adolescents in judging their own capabilities and forming values and goals. As values and goals are compared with interests, the search for possible occupational role alternatives continues.

By late adolescence, the alternatives narrow and adolescents enter the realistic stage or final phase of occupational choice. This stage is characterized by thoughts crystalizing on one choice and the development of skills and habits within that choice. To achieve satisfaction and competence in an occupational role, the role expectations must be consistent with adolescents’ values, and within their skill level.

This theory, which originated as an explanation of the decision making process leading to the selection and preparation of an occupational role, and the feedback system inherent within the progression, makes it useful for working with adolescents, regardless of their presenting problems. The Adolescent Role Assessment (Appendix B) is an interview tool which is constructed from the stages in the occupational choice process.

**Assessment**

**Administration**

The Adolescent Role Assessment is administered as a semistructured interview through casual dialogue. The questions are phrased in the vernacular, and the therapist must be familiar with the purpose of the questions and the rating criteria. Specific rating criteria are included with each question in the assessment, and are
designed to reduce value judgements and subjectivity as much as possible. For example, a question entitled *Goals* asks about future plans, and is rated by the adolescent's ability to mention goals and preparation, regardless of the actual goals. The ratings are based on normative adolescent behavior, and are summarized on the Scoring Sheet (Appendix C): plus (+) indicates appropriate behavior, zero (0) indicates marginal or borderline behavior, and minus (−) indicates inappropriate behavior. For example, a positive response which addresses the question would receive a plus, a noncommittal response of, "I don't know," would receive a zero, and a negative response such as, "I have no interests or friends," would receive a minus. A predominance of plus scores suggests appropriate role behavior, a predominance of zero scores suggests apathy and an unwillingness to respond, and a predominance of minus scores suggests serious doubt about appropriate role behavior. Intervention should be designed using the content from the interview as a guide for specific treatment planning.

**Behaviors Assessed**

The Adolescent Role Assessment is divided into six sections, representing various stages of development in the choice process. The first section includes questions about childhood play. During that period, children typically learn a variety of play activities and can identify friends, heroes, games with rules, make-believe games, and the development of interests. Adolescents who cannot identify these aspects of their childhood play may need remedial activities to help them to use role models or to fantasize.

By separating adolescents' primary sphere of influence into family, school, and peers, the next three sections of the assessment are used to investigate performance in a variety of concurrent roles. The items in the family section focus on the role as a responsible family member in terms of interactions, chores, and money. Through these items it is possible to determine if adolescents view themselves as passive victims or as active participants within the family.

School occupies a major segment of adolescents' time and energy, particularly in industrialized societies where education often extends into the mid-20s or beyond. The developmental tasks associated with school include an increasing recognition of the adolescent's own abilities and limitations within an institutional setting. In many ways school performance (ability to get along, rather than grades per se), serves as an index to subsequent vocational performance.

The peer group often acts as a shelter in which adolescents try out and practice various behaviors before entering adulthood and the larger society. The questions in the peer section address the variety of experiences available to the adolescent.

The final two sections involve occupational choice and work. The former section looks at work attitudes and concrete plans, while the latter section looks at the adolescent's ability to fantasize about long range ideas and goals.

The Adolescent Role Assessment outlines topics that should be considered in working with adolescents. In problem areas, the therapist should explore further to identify specific situations that could be incorporated into program planning.

**Research**

The Adolescent Role Assessment was administered to 12 inpatients at the Neuropsychiatric Institute of the University of California at Los Angeles. The subjects ranged in age from 13-17 years with diagnoses that included adjustment reaction, anorexia nervosa, school phobia, and depression. Subsequently it was
administered to 28 normal adolescents aged 13-16 from schools in a suburban metropolitan area. Not only were the hospitalized adolescents more likely to give marginal and inappropriate responses, \( t(38)=2.19, p<.05 \), but the range in their responses was wider. The largest difference between the two groups occurred in the sections on family and school socialization. The hospitalized adolescents were less likely to mention themselves as accountable for their own actions, \( X^2=3.92, p<.05 \).

In order to verify the adolescents' responses, a battery of assessments including participatory observation, Rosenberg's Self-Esteem Scale, Bills' Index of Adjustment and Values, Interest Check List, Rotter's Generalized Expectations for Internal Versus External Control, and Buhler's Life Goals was given to the hospitalized group. The analysis suggested that weaknesses identified through the Adolescent Role Assessment also appeared through the other assessments.

Reliability was checked by administering the questionnaire twice to a small subset of the sample. Based on the rating criteria, the adolescents' responses are highly reliable, \( r = .91 \). However, the content obtained during the second interview was more copious and specific than initially obtained, probably reflecting the importance of a positive relationship between the adolescents and the therapist.

**Critique and Suggested Research**

The value of any interview depends on the respondent's willingness to cooperate in a truthful manner. Often this willingness may be influenced by the setting and by the therapist's interviewing skills. Thus, interviews taken by different interviewers may yield slightly different results. Furthermore, there may be discrepancies between what adolescents say and what they actually do. Whenever possible, results should be verified through observing, administering other assessments, or interviewing parents, teachers, or siblings.

The possibilities of future research are endless. Although this discussion has centered on adolescents in a psychiatric setting, the Adolescent Role Assessment could be used with any group of adolescents, regardless of their problem—physically handicapped, learning disabled, juvenile delinquent, etc. The assessment could be administered to various groups of handicapped and nonhandicapped adolescents in order to identify areas of greatest difference where intervention may be effective. For example, in my study, it was found that hospitalized adolescents were less likely than nonhospitalized adolescents to accept responsibility for their actions. This discrepancy could be incorporated into treatment planning, and a follow-up assessment could be administered to determine the adolescents' response pattern after treatment.

Either on an individual or on a group basis, the Adolescent Role Assessment may be used to evaluate behavior changes in response to specific treatment programs. These evaluations yield an index both on the adolescents' progress and on the effectiveness of the treatment.

Theoretically, those adolescents with the least adjustment problems should have the most success in their movement toward adulthood and adaptive occupational roles and, conversely, those with more adolescent adjustment problems should have less adult success. This prediction could be tested by dividing adolescents into groups on the basis of their scores, following them over several years, and then obtaining a measurement of their competence as adults. Outcome could include tabulations of the number of people in each group who live independently, have not had legal problems, work regularly, assume some responsibility for others, and other measures of general competence. The design of such a longitudinal project
could enable researchers to begin to identify and document adaptive paths from adolescence to adulthood that may be available to handicapped individuals.

**Conclusion**

Adolescents seen by occupational therapists frequently have two problems—in addition to a physical or emotional disability, they are experiencing the expected conflicts of adolescence. The Adolescent Role Assessment is based on an occupational behavior model, and enables therapists to focus on past, present, and future role adjustment through the decision-making stages of occupational choice. It serves as a guide for treatment planning and evaluation, rather than as a diagnostic tool. Nevertheless, it does discriminate between normal and hospitalized adolescents in the present sample. Moreover, the casual dialogue seems to facilitate the formation of a relationship in which adolescents are able to respond.

Although some behavioral inconsistencies are expected during the transition from childhood to adulthood, it is too easy to attribute all adolescent adjustment problems to maturational strains, particularly when other disabilities may be present. The Adolescent Role Assessment enables therapists to focus on past, present, and future role adjustment through the decision making stages of occupational choice. By incorporating data from the Adolescent Role Assessment, the occupational therapist can plan an intervention program relevant to specific adolescents, as illustrated in a recent case study. Occupational therapists are in a unique position to provide opportunities for adolescents to explore, to search for alternatives, and to evaluate feedback. With an understanding of the Adolescent Role Assessment and the tools of occupational therapy, therapists may design and implement treatment programs to facilitate the transition through adolescence.

**References**

Appendix B

ADOLESCENT ROLE ASSESSMENT

I. Childhood-Play

1. Activities
   Kids spend a lot of time playing. When you were a child, what was your favorite age and why? What kinds of things did you like to do? Alone or with friends?
   + — Identifies favorite age and names activities
   0 — Hesitant or vague response
   - — Unable to identify favorite age, pessimistic

2. Rules
   What games or physical sports did you do as a child? Did you play team games or other games with rules?
   + — Identifies games with rules
   0 — Vague or only games without rules
   - — No games or sports

3. Interactions
   As a child did you play with kids your own age, other than brothers and sisters?
   + — Able to interact with same age peers
   0 — Vague or marginal interaction
   - — No interaction or inability to interact without fights

4. Fantasy
   When you were a kid did you daydream or have make-believe friends or make-believe games?
   + — Identifies fantasy
   0 — Vague, not sure
   - — Can identify no fantasy

5. Role Models
   When you were a kid how did you learn to do things such as ride a bike, tell time, etc?
   + — Identifies role models
   0 — Vague or difficulty remembering
   - — Unable to do skills or unable to identify role models

6. Interests
   Sometimes, as people grow their interests change. What kinds of interests did you have as a kid? How do those interests compare with current interests?
   + — Identifies childhood interests, able to discriminate from current interests
   0 — Few interests, basically same as now
   - — Lack of childhood interests

II. Adolescence-Socialization

A. Family

7. Interactions
   Teenagers often hassle with their families. How would you describe your relationship with your family? Do you do anything to agitate your family? What are the positive qualities about your family? Negative qualities?
   + — Relatively positive relationship, recognizes strengths and weaknesses
   0 — Moderate relationship with vague recognition of strengths and weaknesses
   - — Negative relationship with no recognition of positive qualities

8. Responsibilities
   What kinds of responsibilities do you have at home? Are these responsibilities reasonable? Do you usually do them on time?
   + — Age-appropriate responsibilities, usually completed on time
   0 — Lack of clarity of responsibilities usually completed on time
   - — No responsibilities, inappropriate responsibilities, or refusal to do responsibilities on time

9. Economics
   How do you obtain spending money? Are you satisfied with the amount and arrangement for obtaining it? Who decides how you will spend it?
   + — Manages own money
   0 — Vague plan for obtaining money with few personal decisions on where spent
   - — No plan for obtaining money or no personal decisions on how it is spent

B. School

10. Consistent Behavior
    What grade are you in? What kinds of marks do you achieve? Throughout your life as a student have your marks been consistent?
    + — Consistent marks of average to high range
    0 — Average to low range of marks, some drop in consistency
    - — All low marks or significant drop in consistency

11. Responsibilities
    Are you usually prepared for class with assignments completed on time? Do you attend your classes? Are you often late? Do you study regularly or only for tests?
    + — Class attendance regular, usually prepared, regular study habits
    0 — Occasionally late for class, occasionally unprepared, studies mainly for tests
    - — Often unprepared, often misses classes, few study habits

12. Feedback
    Are you satisfied with your school performance? What could you do to improve your school experience? Do you ever follow your teachers’ suggestions on improvement?
    + — Identifies ways to improve, uses feedback
    0 — Recognizes improvement potential, but has difficulty using feedback or recognizing ways to improve
    - — Denies improvement potential or does not use feedback

13. Effect of Role Models
    Are you treated fairly by teachers? Are you ever removed from class for your conduct? Do you have any favorite teachers? If so, what qualities make them your favorites?
    + — Usually fair treatment, conforms to norms, identifies positive qualities in a teacher
    0 — Questionable treatment, occasionally removed from class
    - — Unfair treatment, often removed from class, or no positive qualities in teachers

14. Activities
    What activities are you involved in at school? What activities do you do with friends (include clubs)? What activities do you do alone?
    + — Several activities, age appropriate
    0 — Hesitant with few activities or some inappropriate activities (e.g., stealing)
    - — No activities or many inappropriate activities

C. Peers

15. Activities
    After school are you usually alone? With one friend? With a group? Are your friends older? Same age? Younger? What do you like about your social situation? What do you dislike?
    + — Positive relationships
    0 — Mixed feelings about relationships or most friends older or younger
    - — Poor relationships, few friends

16. Time
    How many hours a week do you spend in the following activities? How do you decide upon your time schedule? Do you usually complete activities? Is scheduling a problem?
    School work (outside of school)
    Reading for pleasure
    Watching television
    Doing nothing
    Daydreaming
    Working
    Making yourself or your clothes look good
    Dating
Hanging around talking with friends
Playing tennis, swimming, etc.
Other
+ — Balanced, completed activities with no scheduling problems
0 — Concentrated time spent in a few activities, some incompleted activities, or some scheduling difficulties
- — No activities or multiple disjointed activities without completion, serious scheduling difficulties

17. Community
What do you know about your neighborhood? Where is the nearest food store, park, library? If public transportation is available, do you know how to use it?
+ — Knowledge of community
0 — Vague
- — No knowledge of community

III. Adolescent-Occupational Choice

18. Work Attitudes
Have you ever worked? What kinds of work have you done? What did you like about working? What did you dislike? From your experience, what are your attitudes toward work in general (eg, necessary evil, valuable, etc.)?
+ — Positive attitudes
0 — Mixed attitudes
- — Negative attitudes

19. Stage of Choice
What occupation would you like to enter? How did you make this selection? What are your plans for further education or training? Do you know anyone in this occupation? What occupation do you think you will actually be in ten years from now?
+ — Selection based on interests, capacities, or values, with plans for implementation
0 — Selection based on fantasy or interests with few implementation plans. May be role model and recognition that actual occupation is more realistic than idealized
- — No selection or selection based on fantasy with no role model or no plans for implementation

IV. Adulthood-Work

20. Goals
When you think about your future, what things do you think will be important to you (eg, money, free time, career, family, etc.)? How can you prepare yourself for these goals?
+ — Some ideas on goals with preparation ideas
0 — Vague ideas on goals
- — Not future-oriented, no goals or no preparation ideas

21. Fantasy
If your future could be whatever you wanted, what would you want? If you could change anything in the world, what would you change? When you daydream, what do you dream about?
+ — Able to fantasize about the future
0 — Some fantasizing, but minimal
- — Unable to fantasize, very concrete
## Appendix C

**ADOLESCENT ROLE ASSESSMENT — SCORING SHEET**

### I. Childhood-Play
1. Activities
2. Rules
3. Interactions
4. Fantasy
5. Role Models
6. Interests

### II. Adolescent-Socialization

#### A. Family
7. Interactions
8. Responsibilities
9. Economics

#### B. School
10. Consistency
11. Responsibilities
12. Feedback
13. Role Models
14. Activities

#### C. Peers
15. Activities
16. Time
17. Community
III. Adolescent-Occupational Choice
18. Work
19. Choice Stage

IV. Adulthood—Work
20. Goals
21. Fantasy
Appendix B
**Impacting Occupational Role/Environmental Factors**

(Once primary occupational roles and environments have been established, utilize the following categories to determine influential and underlying factors contributing to performance and success within the roles and environments.)

**Sensorimotor**
Visual/auditory factors:
Physical challenges: muscle tone, strength, endurance
Speech
Tactile sensitivity

**Psychosocial**
Self-control
Regulation of emotions:
Range of emotions:
Motivation: interests and values
Self-image:
Responses to significant events:

**Cognitive**
Attention span: distractibility
Memory: retaining information, following through with responsibilities
Organization: sequencing of tasks, planning,
Time management: punctuality, planning ahead,
Arousal: stimulation, motivation
Problem solving:
Decision making: impulsivity, extended processing

**Summary**

What do you feel you would like to work on during the next semester?

Top 3 Goal Areas:
1.
2.
3.

Therapist Signature ___________________ Date____________

Student Signature____________________
Initial Evaluation Outline

(The following outline is designed to assist the therapist/teacher during the initial interview. The questions are only guides toward gaining pertinent information about each student and deviation from the questions is encouraged.)

Name: __________________________  Date: ________________
Age: ______
Referral source: __________________

Introduction:
Why do you think you have been enrolled in this course?

Occupational Roles
Tell me about who you are?
What do you spend your time doing?
Give me an example of your typical day?
Which role is the most important to you? Why?
Are there any pressures associated with any of these roles? Such as...

Examples of Roles: Son/daughter, Sibling, Student, Employee, Friend, Extracurricular activities, Community involvement, Other

Environments
Where do you spend your time?
Which environment is the most supportive? Unsupportive?
Where do you feel the most comfortable? Uncomfortable?
Are there any pressures associated with any of these environments?

Examples of Environments: Home, School, Work, Friends homes, Community (i.e. mall, park, church)
Appendix C
Self-Esteem

BOOSTERS =
actions/thoughts/ways
that improve self-esteem.

I will climb these necessary "steps" to greater self-appreciation....

&

I will recognize these symptoms of the path to self-defeat....

BUSTERS =
actions/thoughts/ways
that lower self-esteem.

HELP!
### The HIV Infection/AIDS Quiz

Indicate with an X if you believe the statement is TRUE or FALSE.

<table>
<thead>
<tr>
<th></th>
<th>TRUE</th>
<th>FALSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anyone can get HIV.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. A person can get HIV by means of tears, sweat, saliva or urine alone.</td>
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<td></td>
</tr>
<tr>
<td>3. Latex condoms and/or dental dam reduce the possibility of transmitting HIV.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sharing needles and other drug use material increases the risk of HIV.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. AIDS is the final stage of infection with HIV.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. HIV infection/AIDS is preventable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. HIV infection/AIDS is curable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Safer sex means not exchanging blood, semen or vaginal secretions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. A person may be infected and not realize it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Only gay men get AIDS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. People infected with HIV have no rights.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. An HIV infected woman can pass the virus to her unborn baby before or during birth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Breast milk can carry HIV.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. An HIV infected individual must abstain from sexual activity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Today, it is highly unlikely to get HIV infection/AIDS by receiving a blood transfusion.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Are you at risk for becoming infected with HIV?

(Circle any that apply:)

- **Share needles**
- **Many sex partners**
- **Use natural skin or lamb skin condoms**
- **History of blood transfusions** *(particularly before 1986)*
- Thinking that if you ignore HIV/AIDS, it will go away
  - Thinking that if you don’t talk about it, it won’t happen
  - Thinking that it could never happen to you.
1. When I get angry, I usually (explain what you do).

2. Does this reaction work for me? Why or why not?

3. How is anger expressed in my family?

   Mom:

   Dad:

   Siblings:

   Important others:

4. How can I improve the way I deal with angry feelings?
GROUP EXERCISES FOR ADOLESCENCE

FALSE BELIEFS ABOUT ANGER

It's not okay to feel angry.
Anger is a waste of time and energy.
Good, nice people don't feel angry.
We shouldn't feel angry when we do.
We'll lose control and go crazy if we get angry.
People will go away if we get angry at them.
Other people should never feel angry toward us.
If others get angry at us, we must have done something wrong.
If other people are angry at us, we made them feel that way and we're responsible for fixing their feelings.
If we feel angry, someone else made us feel that way and that person is responsible for fixing our feelings.
If we feel angry at someone, the relationship is over and that person has to go away.
If we feel angry at someone, we should punish that person for making us feel angry.
If we feel angry at someone, that person has to change what he or she is doing so that we don't feel angry anymore.
If we feel angry, we have to hit someone or break something.
If we feel angry, we have to shout or scream.
If we feel angry at someone, it means we don't love that person anymore.
If someone feels angry at us, it means that person doesn't love us anymore.
Anger is a sinful emotion.
It's okay to feel angry only when we can justify our feelings.

—Author Unknown
**Changing My Communication**

*Directions:* Describe in writing the things you usually do and say to express these feelings listed below. Then see if you can change your communication by writing a *more positive way* to express yourself in the second column.

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Normal Expression</th>
<th>Positive Expression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sad</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Happy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frustrated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bored</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A more *positive* way to express my anger would be to: __________________________

A more *positive* way to express my sadness would be to: __________________________

A more *positive* way to express my happiness would be to: __________________________

A more *positive* way to express my frustration would be to: __________________________

A more *positive* way to express my boredom would be to: __________________________
**Conversation Skills**

**IS WHERE IT'S AT!**

Sometimes, when we first meet people, it's difficult to start up a good conversation. What to talk about? What not to talk about? How often do you...

<table>
<thead>
<tr>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face and look directly into the eyes of the person you are talking to.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid overusing “I”. (Sometimes people talk a lot about themselves because they're nervous.)</td>
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<td></td>
</tr>
<tr>
<td>Make sure you focus and listen when the person responds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Try bringing up something that's neutral – weather, recent movies or TV shows, current events, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Try to be honest, but not too honest. (Honesty is a good quality in relationships, but it can be overdone.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give sincere compliments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept compliments by saying “Thank You”.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid touchy subjects, like religion, politics or overly personal information from your past.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End a conversation with a pleasant phrase - “Nice meeting you”, “Hope to see you again”, “It's been nice talking to you”, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Looking at the marks above, which do you do best in conversations? ________________________________

Which area do you feel you need to work on the most? ________________________________

Conversation skills, like all skills, take time and practice. GIVE IT A TRY!
Passive - AGGRESSIVE is a category of behavior and communication associated with indirect aggression. It takes the form of a passive, but non-confrontive style.

Meet PATRICIA Passive-AGGRESSIVE

Hi! I'm sarcastic and sly - often feeling one way, but doing something else. I like to be critical of advice and direction of others. Sulking, pouting, dawdling, procrastinating and being chronically late are common characteristics of my behavior. Negative and pessimistic, I often feel like a victim and have difficulty accepting responsibility. Sometimes, I dress inappropriately for social or occupational activities. At work, I sabotage the efforts of others and often have educational and social failures. I often feel envious and resentful and am subtly antagonistic.

Meet PATRICK Passive-AGGRESSIVE

Helpful strategies in dealing with Passive - AGGRESSIVE traits . . .

- encourage ventilation and space for anger
- offer consistency and rules
- model assertive responses
- try humor and openness
- confront behavior directly
1. How well am I taking care of myself?

| poor | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | good |

2. What influences how well I take care of myself?

3. What steps do I need to take to improve my self-care?

- bathing regularly
- eating a balanced diet
- participating in good grooming
- participating in good oral hygiene
- keeping clothes clean & in good condition
- taking medications and/or vitamins regularly
- socializing
- exercising regularly
- avoiding drugs & alcohol
- getting the proper amount of sleep

4. Write 2 goals to ensure follow-through with above identified self-care activities.

I will

I will

5. Who can I share these goals with to achieve success?