Facilitating Occupational Performance in At-Risk Rural Middle School Students

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Facilitating Occupational Performance in
At-Risk Rural Middle School Students

by

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A Scholarly Project
Submitted to the Occupational Therapy Department
of the
University of North Dakota
In partial fulfillment of the requirements

for the degree of
Master in Occupational Therapy

Grand Forks, North Dakota
May
2004
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Chapter 1: Introduction

Adolescents in today's society are making the transition from childhood to adulthood in turbulent times. Adolescents in rural areas face different challenges when compared to their urban peers. Economic conditions in rural areas, such as North Dakota, are deteriorating, causing stress on families. Rural schools are spending less on students and having to consolidate to keep rural schools open and competitive. There are more young rural people that are moving to urban areas. These different influences on rural life affect the adolescent’s occupational performance. The rates of adolescent depression, substance abuse, eating disorders, behavioral problems, antisocial behavior, suicide, and anxiety disorders are rising nationally, and the impact is felt in rural areas.

The prevalence rates of mental disorders among adolescents are rising, and are becoming an obvious concern. The causes of these issues are not well defined, although it is argued that environment as well as genetics plays a role. Adolescents are at a unique developmental stage in their lives, and this may make them more vulnerable to psychological disorders. All the developmental changes combined with the stresses of living in a rural place can be associated with an increased chance of psychological and substance abuse behaviors. Many adolescents do not meet the full criteria for a psychological diagnosis; however, they may have some signs and symptoms that need to be addressed. If these signs are not addressed at an early stage, there is a high probability that the problems will evolve to a level that warrants a diagnosis.

An extensive literature review, in Chapter Two, has been conducted on the topics of rural adolescents, the problems they face, and existing preventative programming. The information gained from the literature review has established the need and foundation for
a new program. This is a preventative program, aimed at grades 6 through 8 (12 to 14 years old), to facilitate occupational success by increasing self-efficacy, healthy lifestyle, and interpersonal skills. The approach incorporates preparatory, purposeful, and occupation-based activities, including the use of occupations and activities related to schoolwork tutoring, music, athletics (basketball, volleyball, and other areas of client interest), healthy lifestyle including diet and exercise, fieldtrips (chosen and planned by clients), groups to develop healthy and effective communication skills using role-play, and community volunteerism. Staff is present to facilitate the positive skills and interactions and assist the adolescents in generalizing the skills to their own lives. The predicted outcome of this program is that participating adolescents are less likely to experience any of the previously mentioned psychiatric and behavioral problems, benefiting themselves, their families, schools, and communities by coping positively with the changes of adolescence.

The literature review, Chapter Two, provides information on adolescents, the problems they face, rural life, and existing preventative programming. Chapter Three describes the methods used to gather information. The Leadership Development Program is contained in Chapter Four and has the complete program description along with a reference list. Chapter Five presents the summary with the limitations and clinical implications. A reference listing concludes the paper.
Chapter 2: Review of Literature

Adolescence is the period in development between the onset of puberty and adulthood (Anderson, 2002). This begins between ages 11 and 13, and continues until roughly 18 to 20 years of age. Adolescent development includes the areas of physical, psychological, emotional, cognitive, and personality. Normal adolescent development can be disrupted in various ways. These disruptions present as psychological disorders, substance abuse behaviors, and suicidal thought and actions. The suicide rate in the Midwest was 12% in youths aged 12 to 17 in 2000 (SAMHSA, 2002). The rate of depression and anxiety disorders among adolescents is rising. The prevalence of substance abuse disorders is also rising, with 24.72% of adolescents reporting alcohol use (SAMHSA, 2002).

Regardless of the specific disorder or issue, the adolescent’s functioning in the roles and activities that are meaningful to them are affected. When occupational therapists consider activities, they are called occupations. Specifically, a human occupation is “the doing of work, play, or activities of daily living within a temporal, physical, and sociocultural context that characterizes much of human life” (Kielhofner, 2002, p. 8). Adolescents have the main occupations of student, play, and social participation. These occupations have specific roles that go with them. Each role has its own behaviors, and learning those behaviors is important in being successful in that role. Behaviors typically include learning social expectations and how to interact with the environment.

Adolescents in rural areas face different challenges when compared to their urban peers. Economic conditions in rural areas, such as North Dakota, are deteriorating,
causing stress on families. Rural schools are spending less on students and having to consolidate to keep rural schools open and competitive. There are more young rural people that are moving to urban areas. These different influences on rural life affect the adolescent’s occupational performance. As stated earlier, the rates of psychological, substance abuse, and suicidal issues are on the rise in rural adolescents. Action has to be taken to address these issues.

In North Dakota, there is a strong effort by community leaders, schools, and parents to provide prevention education for their children to address current concerns. Some of the programs address a specific issue, such as suicide prevention, while others look at improving an adolescent’s personal perspective, such as increasing their self-esteem. A review of these programs will give an idea of what is available to adolescents and what types of programming have not been developed.

Development of Adolescents

Areas of Development

Physical changes include an increase in height and weight. Girls usually begin this growth at age 11, and boys tend to start at age 13. The arms and legs reach their growth potential before the trunk increases in length and width. The onset and termination of this growth is variable between each individual, and the average length of growth for both sexes is 4.5 years. There is an increase in muscle development and a decrease in the rate of fat development throughout the growth spurt (Conger & Galambos, 1997).

Physical changes that occur that are not as visible include development of the brain, and growth in the heart and lungs. Sexual maturation also occurs during this age,
with a predictable sequence of appearance of secondary sex characteristics in both sexes. Not all adolescents follow the same sequence, but most follow it fairly closely. Girls tend to develop breast tissue and pubic hair from the ages of 8 to 14, menarche usually occurs between 10 to 16, and about two years after pubic hair appears, axillary hair, eccrine sweat glands, and sebaceous glands develop (Fox, 1999). Boys experience the growth of testes and pubic hair from ages 10-15, growth of body and penis from ages 11 to 16, the voice lowers at the same time as the penis grows, and about two years after the appearance of pubic hair, facial and axillary hair, eccrine sweat glands, and sebaceous glands all develop (Fox).

Cognitive ability also develops at this time in adolescent life. One way to define the stages of cognitive development is to use Piaget’s stages. These stages are: the sensorimotor stage (0-18 months), preoperational stage (2-7 years), concrete operational stage (7-12 years), and formal operational stage (12 years and on) (Case-Smith, 2001). Most adolescents are beginning the formal operational stage by age 12, but this varies for each person. This stage contains the ability to consider the possible or potential solutions with problem-solving. Abstract reasoning is used more, and the person is capable of hypothetico-deductive reasoning. Hypothetico-deductive reasoning is when logical reasoning and experimental thought are used to deduce the correct solution to problems or to determine a viewpoint. This is an improvement over the previous stage, the concrete operational stage, where the child begins to deal with object properties and the relationships between the properties (Conger & Galambos, 1997).

There are different ways to define developmental stages, and this varies according to the theorist. Erikson’s developmental theory stretches over the lifespan, and considers
the importance of childhood experiences, social interactions, and the influence of one’s culture in development. These stages are identified as conflicts that the person has to resolve before moving on to the next developmental stage. The stage that occurs in adolescence is identity versus role confusion, meaning that the adolescent is attempting to define their identity with their roles, often searching for a personal and vocational identity (Conger & Galambos, 1997). The search for an identity can include changes in social activities, friends, clothes, interests, and attitudes about authority. The adolescent is separating from their parents, and are searching for their independence. They are looking for adult roles and responsibilities, and for other adults to recognize them as such (Conger & Galambos).

*Parental Role*

Parents play a role in an adolescent’s search for identity. Family relationships that encourage children to have independence in thinking and are free to express their opinions, along with encouraging family connectedness and respect for others, are thought to have a positive effect on the development of identity. Families that do not encourage individuality were thought to discourage identity formation (Conger & Galambos, 1997).

A child’s behavior is influenced by parental behavior, which can be categorized into two dimensions, responsiveness and demandingness. Responsiveness is defined as a parent that is “accepting, affectionate, understanding, child-centered, and reassuring” (Conger & Galambos, 1997, p. 124). This can contribute to the development of the child’s self-esteem, healthy relationships, increased perception of perspectives, and confidence. Demandingness can be defined as parents that “involve restrictions and strict
enforcement of rules, including rigid insistence on neatness, orderliness, obedience, and inhibition of aggression” (Conger & Galambos, p. 124). A moderate level of demandingness assists the child in developing expectations for social behavior and responsibilities. Excessive demandingness may inhibit social behavior and may restrict creativity and initiative (Conger & Galambos).

There are four different ways to describe parental behavior. These descriptions involve different combinations of the dimensions of responsiveness and demandingness. Authoritative parents are highly responsive and highly demanding. These parents treat their children with respect, encourage participation in family decision-making, and facilitate independence. Adolescents are more competent and adjust better when they are raised by authoritative parents (Conger & Galambos, 1997). Authoritarian parents are highly demanding and unresponsive in their interactions with their children. This is the type of situation where the child is to accept the parent’s viewpoints and commands without question. Adolescent behaviors linked to authoritarian parenting style are deficits in socializing, initiative, low self-esteem, external locus of control, external orientation, and negative self-perceptions (Conger & Galambos).

Permissive-indifferent parents are unresponsive and undemanding. These types of parents are uninvolved with their children, and these children are known to have deficits socially, academically, and in behavior. These children have higher rates of distress, which can be manifested in psychological disorders (Conger & Galambos, 1997). Permissive-indulgent parents are undemanding and highly responsive. Children are psychologically well-adjusted, but do experience more behavior problems such as substance abuse and deviant behavior at school (Conger & Galambos).
Parental behavior has a large impact on the development of children at all ages, but has a unique impact on adolescents. The cognitive and role identity changes (as described earlier) make conflict between adolescents and adults a developmental tool. Adolescents need to take responsibility for their behavior and develop new roles. The cognitive changes in adolescents lead them to consider different options when dealing with behavior and rules, and parents need to be able to explain their position in a rational and understandable way.

Adolescent development is an intense time, with physical, cognitive, emotional, psychological, and personality. The new roles and expectations placed on an adolescent by other adults and family can add more stress to their life than they can handle. The way the adolescent’s parents delegate responsibility and facilitate independence can be a good indicator of how the adolescent copes with all these changes. When the adolescent has inadequate skills to deal with these changes is when there can be problems with normal development and various disorders are evident.

**Interruptions to Development**

There are a variety of psychological disorders that occur in adolescence. Some of the psychological disorders that commonly occur in adolescents are anxiety and mood disorders. Eating disorders are common in this age group, as well. Suicide rates are rising, and substance abuse is more prevalent than previously in North Dakota, similar to other states. Some of these disorders have been connected to the stress of the physical, cognitive, and social changes of adolescence. Children and adolescents are vulnerable to social stressors such as family conflict, abuse or neglect, and academic difficulties (Kaplan & Sadock, 1996).
Anxiety disorders are characterized by physiological effects (such as sweating, headaches, palpitations) and the feeling of nervousness or fear. Some anxiety is normal, and can help a person if faced with danger. People with anxiety disorders have these symptoms frequently, and are accompanied by distortions of thinking, learning, and perceptions. The combination of the symptoms and the distortions can be disabling to the person. Specific examples of anxiety disorders include separation anxiety, generalized anxiety, panic disorder, phobias, and obsessive-compulsive disorder (Kaplan & Sadock, 1996).

Mood disorders include major depressive disorder (also referred to as depression), bipolar disorder, dysthymic disorder, and cyclothymic disorder. Major depressive disorder has 5% prevalence in adolescents (Kaplan & Sadock, 1996). Diagnostic criteria include depressed or irritable mood, anhedonia, significant weight change, changes in sleep patterns, fatigue, feeling of restlessness or slowness, decreased thinking ability, and thoughts of death (Kaplan & Sadock). These symptoms have to cause impairment in function in order to be diagnosed as major depressive disorder. Less severe, but similar, symptoms may qualify for dysthymic disorder. Hallucinations and delusions may accompany adolescent depressive disorder. The hallucinations are commonly one voice speaking about derogatory or suicidal thoughts. Delusions typically involve themes of “guilt, physical disease, death, nihilism, deserved punishment, personal inadequacy, and sometimes persecution” (Sadock & Sadock, 2004, p. 576). Delusions like this occur in half of all psychotically depressed adolescents (Sadock & Sadock).

Suicide is commonly associated with mood disorders in adolescents. Completed suicide occurs in adolescent boys five times more frequently than in adolescent girls.
The national suicide rate for adolescent ages 15 to 19 years old is 13.6 per 100,000 for boys and 3.6 per 100,000 for girls. In the Midwest, the rate is 12% for adolescents aged 12 to 17 in 2000 (SAMSHA, 2002). Suicide is the third leading cause of death in the U.S. for people in the age range of 15 to 24 years old, preceded by accidents and homicides (Sadock & Sadock, 2004). Adolescents that are considered to be at high-risk for suicide have these characteristics: made previous suicide attempts, have attempted suicide with a lethal weapon, have a diagnosed mood disorder, history of substance abuse, have history of aggressive behavior, and has continuous suicidal ideation (Sadock & Sadock).

Adolescents also at risk of suicide are those that have poor problem-solving skills and inadequate coping skills to deal with immediate stressors. These stressors are often continuous family conflict, rejection, and/or failure. Suicidal behaviors, along with aggressive and self-destructive behaviors, occur in great frequency in people who have continuous stressful family lives (Kaplan & Sadock, 1996).

Eating disorders include anorexia nervosa and bulimia nervosa, and they combined have a prevalence of up to 4% in adolescents (Sadock & Sadock, 2004). The common age of onset for anorexia nervosa 14 to 18 years old and is 10 to 20 times more prevalent in females. Five percent of adolescents have symptoms but don’t meet diagnostic criteria (Sadock & Sadock). Anorexia nervosa is characterized by “a profound disturbance of body image and the relentless pursuit of thinness, often to the point of starvation” (Kaplan & Sadock, 1996, p. 273). Bulimia nervosa is recurrent incidences of eating large amounts of food when feeling out of control, and when the binge eating stops, it is followed by feelings of guilt and self-disgust. Bulimia is more prevalent then
anorexia nervosa. To compensate for the guilt associated feelings, the person may self-induce vomiting, use laxatives or diuretics, cease eating, or exercise excessively to prevent weight gain. One of the main differences in the two disorders is that people with anorexia nervosa are at 85% of expected weight, and people with bulimia nervosa may maintain a normal weight (Kaplan & Sadock).

Substance abuse is not a psychological disorder, but is a common diagnosis that has effects like a psychological disorder. Substance abuse is the “overindulgence in and dependence on a stimulant, depressant, or other chemical substance, leading to effects that are detrimental to the individual’s physical or mental health, or the welfare of others” (Anderson, 2002, p. 1648). A substance is something that is either manufactured or naturally occurring that causes an intoxicated state. Intoxication is associated with behavioral and/or psychological changes in the person. The criteria for substance dependence includes (need three or more criteria in a twelve month period to qualify for diagnosis) substance tolerance, withdrawal, increasing consumption amounts, unsuccessful in quitting, large amounts of time are spent obtaining the substance, social/occupational/recreational activities are stopped to devote time to substance, and use continues despite health problems caused by it (Kaplan & Sadock, 1996).

Substance abuse treatment admissions in North Dakota in 2001 were 2,171 people. Of that, 13.6% were adolescents aged 12 to 17. The two substances that were used more prevalently were alcohol and marijuana. North Dakota has an 8.6% illicit drug use among adolescents aged 12 to 17. Alcohol use among this group is 24.72%. The alcohol statistic puts North Dakota in the top ten states for alcohol use. Binge use of
alcohol in North Dakota is also in the top ten, with 17.88% among those ages 12 to 17 (SAMHSA, 2002).

Often people have more than one psychiatric disorder, termed comorbidity. This dual diagnosis commonly involves substance abuse of one or more chemicals and a mood or anxiety disorder. Adolescent rates of comorbidity are approaching that of adults, with is 76% of men and 65% of women having comorbid disorders (Kaplan & Sadock, 1996).

This section has reviewed the primary disorders and issues that affect adolescents. The prevalence rates in these disorders are rising, and are becoming an obvious concern. The causes of these issues are not well-defined, although it is argued that environment as well as genetics plays a role. Adolescents are at a unique developmental stage in their lives, and this may make them more vulnerable to psychological disorders. The developmental changes combined with the stresses of living in a rural place are likely associated with an increased chance of psychological and substance abuse behaviors. Many adolescents do not meet the full criteria for a psychological diagnosis; however, they may have some signs and symptoms that need to be addressed. If these signs are not addressed at an early stage, there is a high probability that the problems will evolve to a level that warrants a diagnosis and extensive treatment. The next section examines some specific environmental influences to which rural adolescents are exposed.

Influences on Development of Rural Adolescents

Economic Influences

Financial troubles bring added stress to today’s families. The difficulties that families face may include problems in providing adequate food, housing, and healthcare for all the family members. The stress of managing financial concerns with less than
adequate income can cause family relationships to deteriorate. A decrease in the emotional well-being of family members has a negative effect on adolescent development (Conger & Galambos, 1997).

A study by Conger, Conger, Matthews, and Elder (1999) examined how economic pressure on rural families affects the adolescent’s sense of mastery and emotional distress. The hypothesis was that family economic pressure would indirectly influence the adolescent’s sense of mastery and distress levels. Economic pressure was measured through three indicators as reported by parents: degree to which families cannot afford basic necessities of life (food, clothing, and housing), whether families can pay their monthly bills, and how many cutbacks parents have had to make in monthly expenditures. This type of pressure and failure to provide basic materials for living was assumed to lead to a decline in the psychological health of a family and can cause problems in relationships.

The study demonstrated that adolescents had a decrease in sense of mastery and increase in distress when they perceived the family was under economic stress, not when they experienced financial hardship as an individual. The adolescents also reported decreased sense of mastery when the economic strains on the family were high enough to have a negative influence on family relationships. Since the study lasted three years, it was also indicated that sense of mastery could predict a change in distress level over time (an increase in mastery can lead to a decrease in distress, and vice versa) (Conger et al., 1999).

Rural adolescents experience economic hardship in both their families and their schools, causing them more stress than the average adolescent. Rural students have
lower achievement levels in education and are more likely to drop out of high school when compared to urban students of the same age. This has been connected to lack of educational resources in both the family and school. A study by Roseigno and Crowley (2001) compared rural family and school educational resources. It was determined that rural students had significant deficits in family and school resources, and this has an effect on the achievement of the students. Generally speaking, rural school systems have less money to invest into resources, and rural students receive roughly $700 less in educational spending when compared to urban students. This can be contributed to lower revenue from local taxes and cuts in state or federal funding. Without the financial resources, schools have difficulty in investing in areas that are linked to higher student achievement, such as small class size, new and more challenging curriculum, and highly qualified teachers (Roseigno & Crowley).

Influence of Family Processes

Stewart, McKenry, Rudd, and Gavazzi (1994) examined family processes contributing to depressive symptomatology of rural adolescents. The sample was obtained by recruitment through 4-H clubs, high school clubs, and a school-affiliated parent group. The adolescents and parents were evaluated on depressive symptoms, family life events, quality of communication in the family, family levels of cohesion, and family’s adaptability (Stewart et al.). The parents and adolescents were administered the instruments separately. The adolescents had higher scores in the number of life events when compared to the norms for that age range. Fifty-three percent of the adolescents from the sample could be classified as clinically depressed according to their scores on the Center for Epidemiologic Studies Depression Scale (CES-D). The mean
communication scores from the mothers, fathers, and adolescents were lower than the norms. The scores for family levels of cohesion were lower than the norms, but the adaptability scores were higher than the norms (Stewart et al.).

The original hypothesis of this study was that family processes (cohesion and adaptability) would mediate between family life events and adolescent depression, and this was not proven by the results in this study. It was found that an increased level of depression was associated with greater number of life events, poor communication between adolescents and parents, and low levels of family cohesion. The strongest association was between the depression levels and number of life events (Stewart et al., 1994).

The recruitment methods for this study are interesting in the fact that they used clubs, specifically 4-H, from which to draw their sample. 4-H clubs are designed to facilitate the growth of the child/adolescent with goals related to “making decisions, learning to communicate, learning the characteristics of leadership, and learning how to cope with change” (Fazio, 2001, p. 240). These clubs also have a high commitment to serving the community they are in. Participation in a club like 4-H would lead one to expect a decrease in rates of depression symptoms in adolescents, due to the increased emphasis on leadership and personal improvement. Although the high school clubs were not described in the study, generally speaking, clubs can provide an environment where education is provided, an opportunity to learn and enhance skills, and supportive adults and peers to help facilitate the process. This type of environment can increase the adolescent’s sense of self-efficacy (Fazio). Parent groups are a supportive system that people utilize to share and get ideas, and to problem-solve. All three of these clubs
address issues that may be of concern when examining adolescent mental and physical health, and are commonly used to facilitate personal growth. Despite the potential benefits from these types of clubs, 53% of the sample still qualified as clinically depressed (Stewart et al., 1994).

Adolescent Perceptions

A phenomenological study by Hedlund (1993), called the Program in Rural Youth Development, was designed to follow its participants for four years, asking about the context of their lives and also for the students to reflect from year to year in the interviews. The purpose of this study was to analyze the interviews of rural adolescents about their perceptions on their community, family, school, social interactions, and self-identity. These topics were fit into one of two frameworks: living in a rural community and the importance of adult-adolescent interactions.

The first framework was perceptions of living in a rural community. The feeling of connectedness was evident in the participants’ responses of how safe they feel and how they feel they can get help with any problems they may have. A negative feeling about the connectedness was shown in how the participants don’t feel they have much privacy. Prejudice was another theme, shown by how the students were acutely aware of social divisions and biases based on socioeconomic status and family history. Family history played a large part in these perceptions of prejudice, possibly due to the extension of family and the tendency for families to stay in the community. The theme of isolation was in relation to transportation problems, few social opportunities, and lack of cultural experience. Relating to the isolation, most participants said that they felt that they would
get into more trouble in a larger city, and that their own rural community is a good place to raise children (Hedlund, 1993).

The second framework was adult interactions. Attitudes about the community were evident in the importance of perceived community support for them and their school. Participants were also aware of the community politics, although they said little about their personal influence in the politics. Family involvement was important to students. Of special importance were the family members that listened to the adolescent, and would confide in them also. Teachers that treated the student as important were also highly valued. Students that reported positive interactions with teachers were also high academic achievers (Hedlund, 1993).

These preliminary results indicate that the adolescents in the study can identify advantages and disadvantages of their communities. It is of interest that although there were many disadvantages listed about their community, such as lack of privacy, prejudice, and isolation, many subjects think that their own rural community is a good place to raise children. This may show that the adolescents in this study have analyzed their living situation and compared it to other, more urban settings. The importance of adult involvement in the adolescent’s personal lives, as well as involvement in the community, indicate the worth that adolescents place on the adults in their lives (Hedlund, 1993).

Reed and Rossi (2000) identified the hopes, aspiration, and concerns of a group of middle school students from Virginia from urban, suburban, and rural areas. The question that all the students were asked was, “if you could have three wishes, what would they
be?” The answers were broken down into the categories of each grade, along with the geographic location.

Generally speaking, all sixth graders in the sample wished for wealth, fame, material goods, and academic success. Rural sixth graders also wished for changes in their family life. Seventh graders wished for wealth, possessions, academic success, and social issues such as world peace. Rural seventh graders, like the sixth graders, emphasized the want for changes at home. Eighth graders had a pronounced emphasis for social change, along with wealth, material possessions, and good careers. The family emphasis that the rural student expressed through the previous two grades was now evident through urban and suburban students as well (Reed & Rossi, 2000).

The constant presence of concerns from rural participants about family and wanting to help them is an important factor when analyzing this study. The main theme among rural students in all grades in this study is family oriented concerns. This indicates there is a unique factor influencing rural students that influences their goals and viewpoints. The rural children had similar aspirations when compared to their urban and suburban counterparts, showing that these similarities may be due to the common developmental level of the students. The urban and suburban students had family concerns also, but they did not become apparent until the eighth grade sample. This could lead to the thought that rural children matured faster in regards to family concern and orientation, possibly due to the stress of living in a rural community (Reed & Rossi, 2000).

Family is a large influence on any developing child, and plays a key role in adolescent development. As indicated, family stress levels appear to have a negative
impact on adolescents. This impact may show as psychological symptoms in some cases, or can increase the adolescent’s perceptions of family concern. When psychological symptoms occur, the adolescent and their family face a new challenge: mental health treatment.

Mental Health Treatment

*Stigma*

Had those students in the previous studies been clinically diagnosed with a mental illness, they would have to deal with another type of problem in addition to the symptoms they are dealing with. When an adolescent has been diagnosed with a mental health condition, they are faced with social bias attached to mental illness. This type of stigma prevents many people from seeking professional help. The rural population, including adolescents, has to overcome the stigma of mental illness.

One way to combat the stigma with mental illness is to educate people. Ester, Cooker, and Ittenbach (1998) completed a quasi-experimental study to determine if classroom instruction on changing conceptions of mental illness and attitudes about using professional help was effective when used with rural adolescents. It has been established in past research that Americans, particularly rural Americans, do not use available mental health services. A control and a treatment group were assessed pre-intervention, post-intervention, and 12 weeks post-intervention on their attitudes and feelings about mental illness. Both groups were involved in a health class, and this is where the intervention took place. The treatment group received a unit of instruction about mental illness, what different types of agencies and mental health professionals are qualified to assist with mental health issues, available resources in that specific community, and the stigma
associated with mental illness. The control group did not receive any of the above information, and the topics covered did not relate to mental health (Ester et al.).

The treatment group showed significant improvement from the pretest scores to the posttest scores. The 12 weeks posttest scores did not change significantly from the previous posttest, showing that the students retained the information for a length of time. The control group did not show any improvement across the tests (Ester et al., 1998).

This study shows that education is beneficial in changing perceptions, and may contribute to decreased stigma about mental illness. This is relevant by showing that education is effective, and that adolescents may be a good group to target when working with mental illness prevention.

It is unknown how many rural American adolescents do not seek help, but there is information on those that do. Services available to treat mental illness in rural areas are very scarce, and many people would have to travel long distances by car to gain access to these services. The mental health services available in North Dakota are concentrated in the largest cities, and little is available in smaller communities. The high prevalence of co-morbid disorders indicates that the adolescent will need treatment for more than one issue.

*Co-morbid Treatment*

A phenomenological study by Anderson (2003) examines the treatment needs of rural adolescents for mental health and substance abuse issues, and the available services for those adolescent. Results show that roughly two-thirds of the adolescents with dual diagnoses did not receive treatment for both their mental health disorder and their substance abuse problem. The improvements between the adolescents that received dual
treatment and those that had single-focused treatment were not significantly different at discharge. The single focus treatment improved that particular area, but did not affect the other issue. The results from this study point to the need to address and develop treatment methods for adolescents with mental health disorders and substance abuse problems.

Prevention

Many of the above mentioned adolescent mental health problems and other issues can be and are being addressed with preventative programs. Prevention is a large area of community practice. There are three different categories for prevention interventions: primary, secondary, and tertiary. This section will describe the different categories for prevention, with examples of existing adolescent programming.

Primary Prevention

Primary prevention is directed at the population as a whole. This is an attempt to prevent illness and disease by maintaining the population or person’s health and reduce risk factors (Scaffa, 2001). A common example of primary prevention is spraying wetlands for mosquitoes to reduce the incidence of diseases carried by them (Fazio, 2001). Other examples are wearing a seatbelt, removing general access barriers in community business, and healthy people that continue to eat a healthy diet.

An example of a primary prevention program is the Problem Solving for Life Program (PSFL). A quasi-experimental design was used to study this program by Spence, Sheffield, and Donovan (2003), in Brisbane, Australia. The PSFL program was taught in eight sessions, once a week, for 45 to 50 minutes. The curriculum provided to the teachers covered life problem-solving skills, positive problem-solving orientation,
and optimistic-thinking styles. In general, the PSFL program integrates cognitive restructuring and problem-solving skills training (Spence et al., 2003).

The students in both the control and treatment groups were assessed pre-intervention, post-intervention, and at 12-months post-intervention to evaluate depressive symptoms, risk factors, social and cognitive functioning, and problem-solving skills. The students were determined to be high or low risk for depression in the pre-intervention assessments. If the child was referred to guidance counselor for further attention, that child would still participate in the intervention, but there was no further data analysis on that child (Spence et al., 2003).

At post-intervention, the intervention group students that were identified as high risk showed a significant decrease in depressive symptoms and increase in life problem-solving scores when compared with the high risk control group. Low risk intervention group students showed a small decrease in depressive symptoms and a great increase in problem-solving scores when compared to low risk controls. The low risk control group had an increase in depressive symptoms over the intervention period. All reported results were not maintained at the 12-month follow-up assessment (Spence et al., 2003).

Secondary Prevention

Secondary prevention is directed to people in the community who are at risk for certain illness and disability. The goal of this type of prevention is to “slow the disease process, attempt to cure or control it as soon as possible, and prevent complications and disability” (Scaffa, 2001, p. 38). Examples of secondary prevention are teenage parenting classes, back injury prevention classes, and smoking cessation classes.
Reed (1994) used Structured Learning Theory (SLT) to treat adolescents with depression in a quasi-experimental study. Structured Learning Therapy (SLT) is designed to treat adolescent depression by focusing on behavior modification, cognitive restructuring, and social interactions. Although this study was done in the inner-city, its structure is relevant to all adolescent populations. The SLT uses education, skill training, social interaction, and use of constructive feedback to enhance the adolescent’s skill base (Reed, 1994).

Results of this study revealed that treatment subjects were rated as having received moderately successful treatment, whereas the control subjects were rated as having received unsuccessful treatment. The gender of the treatment subjects proved to be more interesting, as the males were rated as more successful than females when comparing pre-intervention, post-intervention, and follow-up assessments (Reed, 1994). None of the control participants were rated as improved when evaluating the gender hypothesis. Females in the treatment group actually exhibited higher depression scores between the pre- and post-intervention. These differences in scores when categorized by gender may be explained by the differences in the maturation process of males and females (Reed).

A study by King, Vidourek, Davis and McClellan (2002) evaluated levels of self-esteem and school, peer, and family connectedness. This study has a good example of how to determine what students are at risk. This study, on the Healthy Kids Mentoring Program, was completed with fourth grade students at a Midwestern school. The Healthy Kids Mentoring Program was designed to increase self-esteem, relationship building skills, goal setting, and academic skills in its participants.
All fourth grade students completed a standardized assessment and a 55-item survey that measured students’ school, peer, and family connectedness and involvement in unhealthy behavior. Students had to meet at least one of five conditions listed: “had self-esteem scores at least one standard deviation below the group mean; had engaged in two or more risky health behaviors; had been sad or depressed for two consecutive weeks in the past month; had abused alcohol, tobacco, or other drugs in the past 30 days; had failed two or more classes in the first academic quarter of 1999” (King et al., p. 296). The wide-ranging criteria for qualification are needed due to the various indicators of disorders in development. Students that met these criteria were interviewed by the school counselor to verify their survey answers, and their parents were contacted for permission to participate in the program (King et al.).

The results of participation in the Healthy Kids Mentoring Program included increased scores in the participants’ self-esteem, school, peer, and family connectedness from pre-test to post-test. Participants were also less likely to bully or fight with peers, or to have felt depressed at post-test. Seventy-one percent of students improved academically when comparing test scores (King et al., 2002).

_Tertiary Prevention_

Tertiary prevention is focused on maximizing function, increasing independence, and decreasing the effects of illness or disability after it occurs. This is an area that occupational therapy practitioners are already familiar with, as this is where many occupational therapists practice (Scaffa, 2001). An example of this would be adolescents that are actively treating their depression by utilizing psychiatric services.
A meta-analysis by King (2001) outlines primary, secondary, and tertiary prevention components in a comprehensive school suicide prevention program. Tertiary prevention occurs after a student has threatened, attempted, or completed suicide. The main focus is to “minimize trauma to students and reduce the likelihood of copycat or further suicides” (King, p. 136). Strategies for this included staff meetings to inform and discuss action steps, provide counseling options for students, handling media, and monitoring the emotional levels of the school.

The existing programming for adolescents, as described above, is varied in its structure, target population, and goals. Primary programs, like the Problem Solving For Life program (Spence et al., 2003), are a good example of what can be done for all adolescents. Many times, due to funding and staffing, universal approaches are not always practical when addressing mental health and other issues with adolescents.

The examples of secondary prevention, the Structured Learning Theory for depression (Reed, 1994), and the Healthy Kids Mentoring Program for increasing self-esteem (King et al., 2002) are strong examples for both their results and their structure. These are common types of prevention programming and occur in schools, healthcare and community settings. Many of these programs target one diagnosis or problem area for intervention. Interventions can be similar, for example, some of the studies described use cognitive restructuring and behavior modification. The goals of these programs are specific to the problem area. Targeting only one area may not be as effective long-term, as shown by the inability to maintain the positive results for an extended amount of time after the completion of the intervention. There is a lack of programming that addresses adolescent occupations and their interactions with peers, adults, and family. This type of
occupation-based programming will address the problem areas and skills similar to the existing programs, but will be more holistic and comprehensive.

**Occupation-based Programming**

There is a lack of programming that addresses adolescent occupations. Some of the programs described, such as the Healthy Kids Mentoring Program, address the occupation of student. This is a good example, but is specific to that occupation and does not address others. A more comprehensive program that deals with a variety of occupations is needed. A program not only needs to use occupations as an intervention, but also as outcomes. A program will have to enhance occupational functioning by addressing various underlying performance skills, patterns, and client factors, and how these affect occupations.

*Occupational Therapy*

Occupational therapy is a qualified profession to develop and implement an occupation-based program. Occupation is defined as “all the activities that occupy people’s time and give meaning to their lives” (Neistadt, & Crepeau, 1998). Occupations have specific meanings to the person, and are important in how a person defines themselves, giving them identity and competence. Occupations also influence how a person spends their time, sets their goals, and what activities they may be interested (AOTA, 2002). A large part of the meaning of an occupation is derived from a sense of accomplishment and satisfaction from participating in it.

A program with improved occupational performance as a goal needs to have a model to follow. A model is a body of knowledge that created to, “generate and test theory about some phenomena of concern to the profession. . . and to develop and test
related strategies, tools, techniques for use in therapy” (Kielhofner, 2002, p. 3). A model that will fit well with the proposed programming is the model of human occupation, developed by Gary Kielhofner.

*The Model of Human Occupation*

The model of human occupation (MOHO) is a way to explain occupation and the effects of illness and disability on occupation. These are four main concepts addressed in this model. Three of them are human components: motivation for occupation (volition), routine of occupational behavior (habituation), and performance capacity. The fourth concept is the influence of environment on occupation (Kielhofner, 2002).

Volitional thoughts and feelings are what motivate a person to do an activity. These thoughts, such as enjoyment or success, are formed from past experiences. Past experience, combined with the person’s interpretation of that experience and thoughts of future experiences, can affect the motivation to participate again. Activity choices are influenced by this volitional system of experience, interpretation, and future motivation (Forsyth & Kielhofner, 2003).

Volitional thoughts can be described as a reflection of a person’s sense of value, enjoyment, and sense of competency in their activities. These concepts are termed values, interests, and personal causation. Values are beliefs and thoughts of what is good, just, and a priority. Interests are formed from enjoyable and satisfying occupations. Personal causation is how effective a person feels in their abilities and how responsive the environment is to these efforts (Forsyth & Kielhofner, 2003).

Habituation is the way a person organizes occupational behavior. It also assists in integrating occupation into the environment. Habituation consists of habits and roles,
which gives people a pattern of occupational behavior. These patterns are established by repeated actions, and are difficult to change. Habits are ways of completing occupations in the same manner every time, and interact with the environment the same way. This is the way that habits become automatic. Roles give people an identity, a perspective on situations, and a set of behaviors. Role depicts the person’s behavior, by the internal and external expectations for that role.

Performance capacity is the abilities of one’s physical, cognitive, emotional, psychological, and social skills and systems when performing occupations. The model of human occupation does not address these capacities directly, as other models already have accomplished that. MOHO looks at how the person subjectively views their capacities and their effect on performance.

Environment has an effect on occupations because it has an influence on how the person performs. Each environment is different, with various opportunities, resources, demands, and disadvantages. The three human components discussed earlier determine how the person deals with the environment. Environment can be broken down into seven categories according to the Occupational Therapy Practice Framework Domain and Process (AOTA, 2002): cultural, physical, social, personal, spiritual, temporal, and virtual.

Occupational performance is a result of volition, habituation, personal causation, and the environment. Occupational participation involves that person’s occupations, and those activities are termed occupational forms. Skills are purposeful actions that a person uses while performing occupational forms or occupations.
Adolescent Occupation

It has been identified that the main occupations of an adolescent are play, student, and socialization (Neistadt & Crepeau, 1998). Play is apparent in organized and unorganized sports activities, and often includes a social component. The occupation of student is where the adolescent integrates academic achievement and social expectations, and this occupation takes a majority of their time. The requirements for academics are formally defined, in contrast to the social learning, which is taught informally. The people that surround adolescents during their school hours are other children, adolescents, and adults that aren’t family, leading to a variety of influences on thought and behavior (Neistadt, & Crepeau). The occupation of socialization can be defined alone, but also is integral to participation in other occupations.

The school system is a natural community where interventions can take place for adolescents, since this is where their primary occupation takes place. Interventions should use “education, information, skill building, and supportive coaching/mentoring are needed to encourage self-efficacy and a smooth transition toward positive choices” (Fazio, 2001, p. 236). The changes in adolescent thought, as described in the beginning of this paper, can lead to internal conflicts of past methods of problem-solving and new abstract thought processes. Many adolescents are developing value systems of their own, as opposed to adopting the ones of their parents or peers (Fazio, 2001). To add to the stress of transitioning, adolescents are expected to take on more responsibilities and adult roles. These changes can lead to changes in performance of occupations, and a deficit in occupational performance can lead to psychological problems, such as depression, suicide, eating disorders, substance abuse, and anxiety disorders.
Occupational therapy’s role in the community is not a new one, as some therapists have been practicing in the community already. Community settings include schools, community mental health centers, and outpatient rehabilitation centers. Performing occupational therapy in the community is, “accepting the challenge of responding to that community’s need with what must be new and innovative ways of being” (Fazio, 2001, p.5). Occupational therapy is a holistic profession, evaluating areas of occupation, client performance skills, client performance patterns, context, activity demands, and client factors (AOTA, 2002). A community setting allows the practitioner to assess these areas and determine how to treat that particular client.

The Leadership Development Program

The literature points to an identified need for occupation based programming for adolescents that will utilize the school community atmosphere. The proposed program is the Leadership Development program, a preventative program for rural grades 6 through 8 (12 to 14 years old). Adolescents in rural areas have the unique experience of transitioning during a fast-changing rural landscape, with the weakening economic structure and weakening of the traditional family structure. The program is designed to facilitate occupational success by increasing self-efficacy, healthy lifestyle, and interpersonal skills.

Occupational performance is influenced by factors defined by the model of human occupation. Time needs to be spent in developing the three human components: volition, habituation, and performance capacity to facilitate success in these areas. The programs previously discussed contained interventions that addressed the person’s performance capacity, including problem-solving skills or academic skills. None of the
Programs focused on the volition and habituation components. The Leadership Development Program proposes to focus on all three components.

The volitional subsystem will be addressed through a module titled “Self-efficacy,” and will focus on the adolescent’s perception of self-control and their ability to achieve their goals. This part of volition is being addressed because the confidence to believe one has control over one’s life is a powerful motivator.

The habituation subsystem will be addressed through the module “Healthy Lifestyle,” that focuses on habits and roles. Habits, healthy or otherwise, provide a regular way to deal with the environment. They also organize the physical, temporal, and social environments. Healthy lifestyle habits include proper meals, regular exercise, and adequate balance of activities. Establishment of these habits will promote health and well-being in the adolescents. Roles are important to address because when a person internalizes a role, he/she identifies with it. He/she internalizes the societal attributes of that role and he/she’s own personal interpretation of it. Roles influence occupation by determining the content of actions and the daily or weekly times people perform those actions.

Performance capacity will be addressed through “Interpersonal Skills.” This skill was chosen due to the impact it has on the main areas of occupation. Interpersonal skills are the skills and knowledge needed to interact and communicate with other people in a positive and productive way. This area is important to address because these skills are often the first to decrease when there is a mental illness or other health issue present, so strengthening these skills is a preventative measure. The objective experience will be addressed by skill evaluation and skill acquisition through education and practice.
The subjective experience will look at the feelings associated with using the skills in the structured practice provided and when the students use the skills in their relationships and occupations.
Chapter 3: Activities/Methodology

Various resources were used to develop the Leadership Development Program. Interviews with several people in different programs, to be described in more detail below, took place to establish what resources needed to be accessed for Chapter Two. The occupational therapy faculty advisor was consulted in the writing and editing process throughout the scholarly project.

Brad Gibbens, Ph.D., associate director for the Center for Rural Health, UND School of Medicine and Health Sciences, suggested various useful resources. He recommended the Rural Assistance Center (RAC), a national resource center located on the UND campus specializing in health and human services information for rural America. RAC shared an Internet web address to assist with literature searches, and RAC personnel performed a customized search of databases on the specific topic of rural adolescent programming. The holdings of the Chester Fritz Library and the Harley E. French Medical Library were accessed to gather the remainder of information used in the literature review, mainly professional journals and books.

The Leadership Development Program was developed after careful review of the existing literature on adolescents, rural life, and existing examples of adolescent programming. The research on adolescent development, the influence of parents, and typical interruptions in adolescent development was reviewed to better understand adolescents and potential problems faced. The literature on the stress of living in a rural area was also reviewed, and rural living was associated with higher stress levels on families, including adolescents. Adolescent programming was researched to discover
what problems programs are addressing, and what type of structure and setting these programs use.

Chapter Four is the product of the information gathered in the literature review. The Leadership Development Program is described, including the purpose, participants, staff, and the modules for implementation. It is designed for the at-risk rural adolescent population, and is implemented through a school-based setting. The model of human occupation is used in the modules, and directs the choice of activity examples. The following chapter, Chapter Five, summarizes the Leadership Development Program and future considerations.
The Leadership Development Program

What is it?

The Leadership Development Program is designed as a preventative program aimed at rural grades 6 through 8 (12 to 14 years old). Adolescents in rural areas have the unique experience of transitioning during a fast-changing rural landscape, with the weakening economic structure and weakening of the traditional family structure. This can be connected to the rise in psychiatric diagnoses in this population, and the rise of behaviors such as eating disorders and substance abuse.

What is the function/purpose of the Leadership Development Program?

The Leadership Development Program focuses on increasing self-efficacy, healthy lifestyle, and interpersonal skills as a way to facilitate occupational success. The expected outcomes of participation in the Leadership Development Program are a decreased likelihood of psychiatric and behavioral problems experienced in adolescence. A decrease in the occurrence of these problems will not only benefit the adolescent, but also their friends, families, schools, and communities.

The Leadership Development Program will attempt to accomplish these outcomes by using preparatory, purposeful, and occupation-based activities. Preparatory activities are used to prepare a person for purposeful and occupation-based activities. Their goal is usually to provide information or to prepare the person physically. Purposeful activities are used to engage the client in goal-directed behaviors that are therapeutically designed to lead to occupational performance. Occupation-based activities are designed to engage the client in occupations that are context-specific and are congruent with their goals.

For each of the modules described, there is an example of a preparatory, purposeful, and occupation-based activity intervention. These fit with the modules, and are examples of how to further structure activities. They are also designed to fit in one session, or they can be completed over several sessions.

Who does it involve?

Adolescents

Adolescents that qualify for admittance to this program are those with risk factors in their families, are struggling in school, or have difficulty with peer interactions. Family risk factors include history of mental illness and/or substance abuse, strained family relationships, recent financial hardship or parents’ employment change, or other life events that have negatively affected the adolescent’s coping skills. School struggles can include academic, behavioral, and accepting authority problems. Difficulty in making and maintaining relationships with peers, social interactions, and isolation behaviors all would be considered problems in peer interactions.

Staff

The Leadership Development Program was created with focus on occupational performance and success and designed to be directed by an occupational therapist. The director of the program will need to be an occupational therapist prepared to train other staff regarding the objectives of the program and presentation of the program activities. The rest of the staff can have various qualifications such as teachers, social workers,
counselors, and nurses; however, they should not be parents of the adolescents. This allows the adolescents to have a safe place to discuss their lives and practice their skills without the threat of being judged or having the program activities ‘go home’ with them. Teachers, paraprofessionals, and other community leaders have potential to be involved with the program. Volunteer high school students are also a strong area for assistance in running the program, and can be of great help as mentors to the adolescents.

How do the students get involved?

Students can be referred to the program by school staff, community health workers such as social work, parents, coaches, and other community leaders. Referred students will need their parent’s permission to participate in the Leadership Development program. The maximum amount of students the program can support is twenty, and consideration will be made to balance the participants from the three grades but no set quota from each grade is needed. Students do not have to attend every session, but must attend at least twice per week. Students that are involved in sports or other extra-curricular activities are exempt from the twice per week rule, but will resume attendance when possible. The students will be divided into multi-grade groups of 4-5 participants with one leader.

An in-service will be conducted for all school staff on the purposes and modules covered in the program. The school staff needs to be informed so they can refer adolescents to the program. A community in-service can be planned if there is interest from parents and community members.

What kind of space and equipment are needed?

The space required for this program is a large room with tables that will seat 5-6 people. Availability of audiovisual media will be needed, along with access to a kitchen. A gym area may be needed for activities depending on client interests. Other equipment, such as board games and sports equipment will need to be available, although this will vary according to the participants.

When will the Leadership Development Program take place?

The Leadership Development program will run after school from 3:30 to 5:30 p.m. on Monday, Tuesday, and Thursday from September to May. The program will have the same vacation days and cancellations as the school does.

Why the name, “Leadership Development”?

The program is named Leadership Development for several reasons. One, the program is constructed to develop skills and qualities needed to develop leadership in adolescents. The second reason is that this title is positively worded, and eliminates any negative connotation associated with the program. Adolescents are focused on what others perceive them as, and would be sensitive to any perceptions that they are not ‘normal,’ or need extra help to function as a normal teenager. A program name such as Leadership Development implies the participants are learning to be leaders, and that they are fine as average adolescents.
Module: Self-efficacy

Objectives:

- Increase participants’ feelings of self-control.
- Increase participants’ beliefs that they can achieve set goals.
- Provide experiences that increase the belief that the participant can have an impact in their world.
- Increase participant’s ability to adapt to change in their roles and habits.
- Instruct and provide practice in how to accurately evaluate the participant’s efforts in activities and occupations.

Personal causation is a human subsystem, as defined by Gary Kielhofner (2003), is “one’s sense of competence and effectiveness” (Kielhofner, p. 59). Two dimensions can further explain this definition, sense of personal capacity and self-efficacy. A healthy level and connection between these two dimensions indicate that the person will search for opportunities, use people and environmental feedback to adjust performance, and will work to achieve their goals.

Sense of personal capacity refers to the physical, intellectual, and social capabilities that one possesses, as determined by that individual. Self-efficacy is the perception of self-control and the ability to achieve desired goals. These two areas of self-efficacy strongly influence a person’s belief in their abilities and competencies in relation to the world. When a person believes strongly in themselves in these areas, it can be a powerful motivator to participate in occupation.

Self-control refers to control over one’s actions, as well as their emotions and thoughts. This leads to a perception of control over their environment and the outcomes of their actions. An established sense of self-control can assist with adapting to change. A key aspect of this area is the ability to realize what that person can and cannot control. Realistic expectations for performance aids in controlling the emotions related to that experience.

Adolescence is a time of great change, and involves development in the physical, emotional, and cognitive areas. Additional changes, often in relationships or environment, can also occur at this time. For some adolescents, these changes are overwhelming and can lead to psychological disorders or destructive coping behaviors.

Efforts to develop the adolescent’s self-efficacy are instrumental in the prevention of the common disorders that occur in this group. An increased level of self-efficacy can enable the individual in adapting to change, in both themselves and the environment. Self-efficacy lies in the perception of each individual. Those who believe they have many limitations or deficits will decrease their performance opportunities because they have a low feeling of self-control. An individual who exaggerates their abilities will increase their opportunities too much, and will experience disappointment and feelings of failure when the outcomes are not what they anticipated. A balance between these two extremes is the optimal situation for a developing adolescent.
Preparatory Self-Efficacy Activity: Self-Determination

**Purpose:** To practice self-determination through discussion of choices in behavior in real-life situations.

**Materials:** Marker board and markers, index cards with situations (see list below)

**Activity:** Discuss the meanings of helpless and self-help, and how people can react either in helpless or self-help ways to different situations.

Example: You got a ‘D’ on a test.
Helpless: You blame the teacher and the test, and do nothing to help raise your grade.
Self-Help: You plan a meeting with your teacher to discuss the test content, questions, and how you could have prepared better. You also talk about future strategies and ways to raise your grade.

Example list:
Someone is physically/sexually/emotionally abusing you
You lost your sports jersey
You have physical symptoms of illness
You have very little education
You will run out of medicine in 2 days and need more
You received a speeding ticket
You need to go to the dentist
You cannot afford your car payment
You don’t know how to complete an assignment
Your relationship with your boyfriend/girlfriend is failing
You didn’t score well on your ACT test
You get disciplined at work for tardiness
Your vehicle is not running as usual, and does not start reliably
Your sports skills are below the level of your teammates
You can’t make a scheduled appointment because you are sick

**Follow-up:** Have students discuss ways they dealt with situations in their lives recently, and have the group give feedback.

Activity adapted from ‘Self-Help vs. Learned Helplessness’ in:
Purposeful Self-Efficacy Activity: Acting Into Good Thinking

**Purpose:** Practice controlling one’s actions in a positive way, acting one’s way into good thinking. Acting confident despite fears, calm despite agitation and excitement, kind despite dislike, controlled despite anxiety.

**Materials:** Marker board and markers

**Activity:** Discuss with group that it is effective and positive to act as though they are confident and calm when faced with difficult and uncertain situations. Bring into discussion that always hiding true feelings, called masking, is not desired, and people should feel safe to talk to counselors, clergy, trusted friends/family about their true feelings. Acting confident and calm allows the person to practice these positive behaviors, and eventually may have these feelings automatically.

Have group members’ brainstorm and list real-life situations that have happened to them or have potential to happen (see example list below). These situations can be stressful, embarrassing, annoying, and tense. Have each group member role-play a situation that they feel is most relevant to their life, either in pairs or with the facilitator. Other group members can provide feedback, or if there are particular situations that gather interest from a majority of the group, the facilitator can have discussion and/or different role-play scenarios.

Example list:
- First date
- Do poorly at a job interview
- Ridiculed by classmates
- Yelled at by boss for mistake at work
- Can’t answer a question asked by a teacher in class
- You don’t have a date for the school dance
- You can’t control your acne
- You have to deal with cramps during phys ed
- You are embarrassed to change in the locker room for gym
- You are trying out for a sports team
- You have to give a speech in class

**Follow-up:** Reiterate the important parts of the previous discussion, especially on the importance of not hiding your feelings all the time and the difference in ‘acting’ and ‘masking.’

Activity adapted from ‘Self-Help vs. Learned Helplessness’ in:
Occupation-based Self-Efficacy Activity: Kickball

**Purpose:** To allow participants to evaluate their performance in an activity with their peers.

**Materials:** Gym or outdoors field, bases, kickball

**Activity:** Discuss with participants the rules of kickball and divide into teams. Each team will have a facilitator/coach. Allow the participants to play the game with little input from the facilitator on their behavior or on game strategy. The teams decide any conflicts or arguments.

After the game, each team meets with their facilitator to discuss the game. The facilitator is responsible to direct the discussion through the areas of the participants’ satisfaction with their skill performance, their team performance, and their overall feelings about the experience. Discussion will also focus on the team’s interactions with each other and the other team. The facilitator will have situations and examples that occurred during the game for the participants to discuss. Feelings of competency and control will be discussed, with emphasis on the impact each individual player had on the team.

**Follow-up:** Have participants reflect on how their feelings of control and competency in the kickball game are similar to the feelings they have when completing assignments, or working at their job, etc. Discuss why there may be similarities and differences, and how the activity often affects the feelings of self-efficacy.
Module: Healthy Lifestyle

Objectives:
- Provide students with a structured schedule during the Leadership Development program to allow them to experience habit formation.
- Facilitate students in learning what a healthy lifestyle implies.
- Students will be able to identify a plan of action for them to take to change to healthy habits.
- Provide learning experiences in the areas of diet, exercise, work/productive activities, leisure, and rest.

Habits and internalized roles are part of what Gary Kielhofner (2002) describes as the habituation subsystem. Habituation is the patterns of a person’s behavior that is determined by their habits and roles that are matched to the environment. People have routine ways of acting in similar environments. For example, people have the same routine when ordering food from a drive-thru sign, regardless of the specific food chain. Habituation provides the person with a strategy of action, and is closely related to environment and context.

An internalized role is “the incorporation of a socially and/or personally defined status and a related cluster of attitudes and actions” (Kielhofner, 2002, p. 72). It is a sense of what the person is expected to perform, and generally how others will perceive them in that role. A person identifies with a role due to the positions and status they have, and they have the self-perceptions of someone who holds that role. These self-perceptions are personal, and even though people have common roles, they might not have the same understanding of what that role means. Most roles are socially defined, with some universal expectations. Other roles do not have established social expectations, and these are often more difficult to internalize because the expectations are vague. For example, a role that is not well defined is being the spouse of an alcoholic. Support groups like Al-Anon assist these people because they provide a way to meet other people in the same situation as themselves. This allows them to help each other determine what the role expectations are, and it validates the existence of that role.

Habits are defined as “acquired tendencies to automatically respond and perform in certain, consistent ways in familiar environments or situations” (Kielhofner, 2002, p. 64). Habits can vary in their cycles. Daily routines are a combination of habits, and can vary according to the time of day. There is a routine to the occupations performed during the week, such as working Monday through Friday, participating in leisure activities on Saturday, and spending time with family on Sunday. Habits are also demonstrated with the actions taken during different seasons, holidays, and vacations.

Habits can be called a set of game rules for a specific environment. These rules help evaluate the environment, what actions are needed, and what outcomes are expected. Habits include actions that are effective and efficient. Actions with these qualities are integrated into the habit, and those that aren’t as effective or efficient will be discarded or replaced. An example that illustrates this is that people generally drive the same route to their job, and is typically the route that takes the least amount of time. This route has variations that could be taken, but those variations have been discarded because they weren’t the most time efficient. Habits also provide a way for the person to decrease the concentration needed to perform the tasks. This allows the person to think about or even
perform other tasks. Many people, for instance, can mentally form a grocery list while they are driving to the local store. This can happen because driving to a familiar location becomes a habit and doesn’t require much cognitive effort.

Habits that are common to a group of people become social customs and/or a part of the larger culture. This allows people to use habits as a way to fit in and share common interests. Habits are also developed from the influence of others, such as proper etiquette, efficiency, or traditional ways of performing occupations. People tend to seed environments that fit our habits.

Habits are present in interpersonal behavior, or the person’s style. This refers to the attitude, personality, and perspective that a person has throughout occupational performance.

A person through their environment can learn unhealthy or dysfunctional habits. These habits are hard to change; because habits are based on the way a person interprets their world. Habits bring order to the actions required in similar environments. When the habit has to be changed, the person has difficulty because those actions are routine. Performing the new actions in the same environment requires more cognitive effort to develop it as part of the routine. The actions, when first performed, may cause the person to feel awkward and unconfident. The continuations of the new actions will eventually decrease those feelings.

The relationship between roles and habits make the two areas reliant on each other. Adolescents are at a point in their lives where they are expected to take on more adult roles. This involves changes in their responsibilities in these roles, and will change their habits and routines. Role changes will also alter the adolescent’s perception of himself or herself, and may also lead to changes in the relationship with peers and adults. Given that all these changes are occurring as the adolescent is developing physically and mentally, it can be a stressful time. This stress may lead the adolescent to using unhealthy coping behaviors, such as drinking alcohol or using drugs. Substance abuse can start as a way to cope with occasional stress and from there develops into a dangerous habit. It is these types of habits that need to be addressed through programming.
Preparatory Healthy Lifestyle Activity: Activity Wheel

**Purpose:** To have participants examine their activities during the day, and to understand what areas need to be modified to have a more balanced lifestyle.

**Materials:** Activity wheel for each participant (pie graph with hourly divisions) with categories listed below (work, school, leisure/relaxation, sleep/rest, self care, other), pencils/pens, marker board and markers

**Activity:** Each participant fills out their pie graph according to his or her typical day, filling out the graph with the names of the activities that usually occur at that particular time period. For example, many of the graphs will have 11 pm to 7 am blocked off for sleep, and the hour of 5 to 6 pm will have the activity of eating. The facilitator can assist those who may need it. The participants can list off their various activities for a master list on the board. Discussion of the various activities and the categories will follow.

**Transition to Purposeful Activity:** Each participant will then be asked to categorize their activities by the given categories and add the number of hours spent in each. Group discussion of the balance between all the categories will follow, with emphasis on what common category to the group gets more time, and why participants feel that is. The facilitator will educate the participants on what it means to have a balanced lifestyle, and will assist the participants in identifying any areas that have too much or too little time. Participants will then be asked to alter their time spent in one or more of the categories to facilitate a healthier lifestyle.

**Follow-up:** At a later session (approximately one week), discussion on how effective the participant’s changes were in their life, and what can be done further to balance their lifestyle.

Activity adapted from ‘Activities Wheel’ in:
Purposeful Healthy Lifestyle Activity: Yoga

**Purpose:** Allow participants to experience a new form of exercise and relaxation.

**Materials:** Large space in a classroom or gym, mats, TV with VHS or DVD, yoga instructional VHS or DVD

**Activity:** Set up area with TV and mats so there is ample space for all participants. The facilitator will also participate, and will be familiar with the format of the instructional program. A beginners program will be used (usually 30 minutes with a warm-up and cool-down), and can be purchased from any store, such as Wal-Mart or Target. The group will go through the program together.

A VHS or DVD program is used because it is a form that is accessible to the participants in their community. A professional yoga instructor could be contacted and s/he could give a demonstration, but realistically, a yoga instructor may not be available and the participants may not be able to afford the fees if there was one available.

**Follow-up:** Discuss with participants their feelings about performing yoga and about trying a new activity. Also discuss how their feelings of trying a new activity or trying it in a group format relate to other activities in their life. Example: Performing yoga in a group may bring feelings of anxiety to some participants, and they may be able to relate it to similar feelings when speaking in class or working on group projects.
Occupation-based Healthy Lifestyle Activity: Snacks

Purpose: Participants will learn what makes a healthy snack and will learn how to prepare these snacks for the whole group.

Materials: Kitchen, nutritional education (Health class instructor may be able to complete the education portion), supplies for snacks for that session
Note: The education will take place before the participants make the snacks, so the kitchen will not have to be available for all sessions devoted to this topic.

Activity: The educational portion will include information on food groups, and what are healthy snack options. The teacher that has the Health class may be able to assist in the instruction.

The participants will then choose several snacks to prepare as a group. Each group will take a turn at preparing snacks for all the participants in the program. This portion will require instruction and practice in safe food handling in preparing for the whole group. Safe food handling includes hand washing, cross-contamination practice, proper food temperature, etc.

Potential snack ideas are fruit and vegetable combos, pretzels and salsa, vegetables and low-fat dip, cheese and crackers, etc.

Follow-up: Discuss the preparation methods and how these methods are used for food preparation in restaurants, and how to use the knowledge of safe food handling to evaluate restaurants. Have group members rate their performance in preparation and in knowledge amounts. Discuss the likelihood of group members choosing these snacks at home and in other areas.
Module: Interpersonal Skills

Objectives:

- Increase participants understanding of the importance of the subjective experience in self-evaluating.
- Expand the participants’ knowledge of positive communication skills.
- Increase the participants’ awareness of positive and negative relationships.
- Educate the participants’ in how the subjective experience of a relationship has a large impact on how the people communicate and interact with each other.

Performance capacity is the “ability for doing things provided by the status of underlying objective physical and mental components and corresponding subjective experience” (Kielhofner, 2002, p. 81). The objective components are often evaluated when someone is learning a new skill, or after some type of injury or illness has given them a deficit in performance. The popular theories and evaluations used in occupational therapy practice today also tend to focus on the objective. Deficits or inabilities in performance are explained by the components that are not working properly. The whole objective piece of performance capacity can be described as the outsider’s view.

The subjective component is often overlooked when discussing performance, in both healthy individuals and in those with deficits. Each individual has their own unique subjective perspective on their performance, and this subjective experience can reveal information about the objective components. When people learn a complex skill, such as ice skating, they will first focus on the objective components such as length of stride, how much force to use when pushing on the skates, and how to use the skates to stop. After these components are practiced, the subjective experience takes over, and the person concentrates on how it feels to skate. When it doesn’t feel ‘right,’ the person adjusts their objective components until it returns to being comfortable. This example, along with other skills like riding a bike and skiing, shows why once a skill or activity is well learned, it is not forgotten. The concept of the lived body, which is how subjective experience is the foundation to understanding the objective components of a person, explains why people rarely forget what it takes to ride a bike even after years of not performing it.

Interpersonal skills are the performance capacity area that the Leadership Development program will address. The objective piece will be client education and practice on successful interpersonal skills. Interpersonal skills are the skills and knowledge needed to interact and communicate with other people in a positive and productive way. The subjective experience will also be focused on, in the structured practice provided and when the students use the skills in their relationships and occupations.

This skill area was selected because it is used in interactions with people throughout all occupations. These skills are also ones that are decreased if an adolescent has a mental illness or other health issues. Strengthening these skills can be seen as a way to prevent such issues from happening.
Preparatory Interpersonal Skills Activity: Body Language

**Purpose:** Educate participants on open and positive v. closed and negative body language.

**Materials:** Video clips from TV shows, interviews, or any type of media that portrays physical body language

**Activity:** Educate participants on open and positive body language, such as nodding, open stance, eye contact, good posture, and neutral hand/arm positioning. Also educate negative body language such as slouching, arm crossing, avoidant or hostile eye contact, and closed stance. Add any other body language behaviors that the participants may use to the above lists.

Discuss the effect that body language can have on conversations with people. Use role-play to demonstrate the physical appearance of the different body language presentations. Have the participants use different positive and negative body languages in the same situation to allow them to experience the effect body language has on their interactions.

**Follow-up:** Discuss personal examples from participants and facilitator on the effect of body language, either from themselves or from others. Encourage participants to be aware of their body language when interacting with others, and especially during times of conflict or stress. Follow-up with another session focused the importance of body language in portraying an image and/or message.
**Purposeful Interpersonal Skills Activity: Passive, Aggressive, and Assertive Behaviors**

**Purpose:** Discuss aggressive, passive, assertive, and passive-aggressive behaviors and their outcomes. Practice assertive behaviors.

**Materials:** Marker board and markers, cards with situations

**Activity:** Discuss the meanings using comparisons to assist in illustration (aggressive = explode, passive = doormat, assertive = nice but firm, passive aggressive = sneaky). Emphasize that assertive behaviors are the most effective and the rest are not effective.

Put situations (see list below) in a bucket and have each participant choose one card. Have them give one of each of the responses to the situation, and facilitate group discussion on what they have done in similar situations.

Situation list:
- Someone doesn’t return a borrowed item
- Baby-sitting kids that get on your nerves
- You are cut off in line
- You pursue a relationship with someone that doesn’t feel the same way
- You are facing large amounts of peer pressure to drink and/or do drugs
- Someone copies your test and you didn’t want them to
- You do not understand class materials/assignments
- Your mom/dad is going through your personal things
- Classmates call you nasty names
- Someone says mean things about your family
- You are being emotionally, physically, or sexually abused
- Your parents have a substance abuse problem
- Your grades are dropping
- A telemarketer calls you during your supper
- Someone cuts you off while you are driving
- Someone is treating your friend with disrespect and is mean to them

**Follow-up:** Do role-play to practice using assertive behaviors in the given situations or in real-life situations the participants suggest.

Activity adapted from ‘Passive, Aggressive, Assertive’ in:
Occupation-based Interpersonal Skills Activity: Planning a Group Outing

**Purpose:** Participants will collaborate with each other to plan an outing for the group, including planning dates, transportation, and any expenses.

**Materials:** Marker board and markers, phone, phonebook

**Activity:** The groups will plan on going on an outing together. Possible outing sites include historical places in the community/county, library, and volunteering for an event (such as clean-up after a basketball game, cleaning the park, etc). Participants will choose a site/event, and will organize the details with minimal assistance from the facilitator. It is suggested that the group elect a team captain to assure everyone is in agreement and a recorder to write down the plans. The phone and phonebook may be needed to call facilities to ask questions and set up times.

The facilitator’s role is to prompt the participants to make responsible choices and to include everyone in the decision. The facilitator will have more input in the beginning of the planning process, particularly with choosing the day, time, and site/event. The facilitator should have some well-researched options in mind as the participants are brainstorming, so they will have some reliable choices to add to the list.

**Follow-up:** Discuss how the participants feel about their planning experiences, and trouble-shoot any issues as they appear. Assist the participants in determining what they want to get accomplished from the outing. After the outing, discuss what happened, how it could have been different, and the participants overall satisfaction with the experience.

Future Considerations

More activities can definitely be added to the modules, and should be added to reflect the interests and needs of the adolescent group. These activities are outlined in detail because they are good examples of the type of activity that would fit into that category description. Many activities could be added to the modules to complement and expand on the current activities. The books referenced in the activity descriptions are sources to find more activity ideas to adapt for use.

The program modules can also be expanded to other areas of the Model of Human Occupation that are briefly described in the module descriptions. Personal capacity can be addressed in relation to the ‘Self-efficacy’ module, and would be more skill based. The participants’ internalized roles can be further addressed in the ‘Healthy Lifestyle’ module by adding more activities that focus on that area. The objective and subjective personal capacity components addressed in the ‘Interpersonal Skills’ module can be expanded to other performance capacity areas, such as anger management and goal-setting.

Another consideration would be to involve more community agencies in conducting the program, allowing the adolescents to learn more about what’s available in the community for them and their families. The county public health department can be asked to speak about safe food handling practice as part of the education piece in the occupation-based activity for the ‘Healthy Lifestyle’ module. A fitness instructor from the region can come to do the yoga instruction for the purposeful activity for the ‘Healthy Lifestyle’ module. These are just two examples where community resources can be incorporated into the current activities.

An academic tutoring section can be added to the program using high school students as tutors. Being a student is a main occupation and role of adolescents. High school students that have above average grades, willingness to be a tutor, and exhibit positive behaviors such as helpfulness to peers, positive communication skills, and goal-setting could benefit this portion of the program by providing the academic assistance and serving as a role model for the participants. A successful high school student is a role model that the participants can look up to and set their goals to have similar success.
References


Chapter 5: Summary

In conclusion, the Leadership Development Program is designed as a preventative measure addressing psychological and behavioral interruptions in development. It is targeted at early adolescents, and takes place in a school-based setting. By following the model of human occupation, the Leadership Development Program has a theoretical foundation to follow in future developments.

Program Expansion

On implementation, more activities can and should be added to the modules to reflect the interests and needs of the adolescent group. The reference list for Chapter Four will be useful in developing additional activities for each module. The examples provided are solid in their structure, and future activities should follow the structure provided.

The program modules can also be expanded to other areas of the model of human occupation as described in the module descriptions. For example, personal capacity can be addressed in relation to the ‘Self-efficacy’ module, and would be more skill-based. The participants’ internalized roles can be further addressed in the ‘Healthy Lifestyle’ module by adding more activities that focus on that area. The objective and subjective personal capacity components addressed in the ‘Interpersonal Skills’ module can be expanded to other performance capacity areas, such as anger management and goal-setting.

Another consideration would be to involve more community agencies in conducting the program, allowing the adolescents to learn more about what is available in the community for them and their families. Community agencies such as the county
public health department and social services, Toastmasters, local fitness centers, and youth organizations such as 4-H can be accessed to expand the Leadership Development Program.

One area that would likely be a benefit to the participants would be a daily academic tutoring session. This portion could use high school students as tutors. Given that one of the primary occupations of adolescents is being a student, it is an important area to address.

Limitations

A major limitation of the Leadership Development Program is that it has not been tested with a group of adolescents, and therefore has no outcome research on success or failure. This would be the first limitation to address, and could be remedied by implementing the Leadership Development Program at a rural school and collecting necessary data to study implementation and outcomes of the program. The research would better inform program implementation and development.

Another limitation is the requirement that an occupational therapist direct the program. Nevertheless, it is strongly recommended the director position be filled with a person from this background to retain the theoretical foundation. The model of human occupation is an occupational therapy specific model, and is best applied in community practice by an occupational therapist that understands the background and intent of the information. This is considered a limitation from the standpoint of the difficulty in locating occupational therapists in rural settings. It can be considered a strength in many other ways, but the practicality of staffing with an occupational therapist is a concern.
Future action

Recommended future action is implementation and research on the Leadership Development Program. When this is completed, changes and expansions can be made to the program, and then it can be repeated and researched further. With fine-tuning, the Leadership Development Program will be ready to be marketed to other schools and the N.D. Department of Public Instruction. An ideal situation is for the N.D. Department of Public Instruction to adopt and fund the Leadership Development Program in selected schools around the state. Schools that implement the program will be able to use each other as support systems and will be able to collaborate as needed toward further refinement of the Program.
Appendix A:
References


