Promotion of Positive Mental Health in Children and Youth With Developmental Disabilities

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ABSTRACT
Although there is a higher prevalence of mental health conditions among children and youth with developmental disabilities (Schwartz, Garland, Waddell, & Harrison, 2006), there is also a critical need to promote positive mental health in this population. Through the use of meaningful occupations, occupational therapy practitioners have ample opportunities to facilitate the development of strengths within supportive environments in order to promote positive mental health. An overview of occupational therapy strategies at the universal (promotion), selected (prevention), and intensive (intervention) levels is provided.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Recognize the differences between the mental health continuum, a public health approach to mental health, positive psychology, and positive youth development.
2. Identify the three pillars of positive psychology as described by Seligman (2002).
3. Recognize the mental health challenges and strengths of children and youth with developmental disabilities.
4. Recognize the relationship between positive emotions, participation in occupations, and mental health.
5. Select examples of how occupational therapy practitioners can promote mental health within a three-tiered model.

“Raising children...is vastly more than fixing what is wrong with them. It is about identifying and nurturing their strongest qualities, what they own and are best at, and helping them find niches in which they can best live out these strengths.” (Seligman & Csikszentmihalyi, 2000, p. 6)

INTRODUCTION
This article provides a foundation for conceptualizing occupational therapy’s role in mental health promotion, prevention, and intervention in children and youth with developmental disabilities. In addition to addressing the needs of youth with identified psychiatric conditions, there is a critical need to promote positive mental health among all children with developmental disabilities—building on positive qualities and personal strengths in addition to remediating problems. While the emphasis of occupational therapy varies depending on context, all efforts share a common belief in the positive relationship between participation in a balance of meaningful occupations and health.

POSITIVE MENTAL HEALTH
Over the past decade, there has been growing attention to the promotion of positive mental health among leaders in psychology and sociology, leading to a paradigm shift reflected in new areas of study and terminology: mental health continuum, public health approach to mental health, positive psychology, and positive youth development (Barry & Jenkins, 2007; Keyes, 2007; Larson, 2000; Seligman & Csikszentmihalyi, 2000). In 1999, mental health was defined by David Satcher, then U.S. surgeon general, as “a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with people, and the ability to adapt to change and cope with adversity” (U.S. Department of Health and Human Services, 1999, p. 4). This definition affirms the view that mental health is not merely the absence of mental illness but also the presence of something positive.

Based on a large survey of U.S. adults between the ages of 25 and 74 living in the 48 contiguous states, findings support this continuum model of mental health and mental illness (Keyes, 2005). The mental health continuum as described by Keyes (2007) can be viewed as a range of functioning from mental illness or “languishing in life” at one end to “moderately mentally healthy” to “complete mental health and flourishing” at the other end. Increased impairment and disability were found in adults without complete mental health and flourishing—even those without a mental illness. Completely mentally healthy adults had the fewest missed workdays, fewest chronic physical conditions, lowest health care utilization, and highest levels of psychosocial functioning.

Mental health promotion, then, focuses on achieving positive mental health and quality of life in the whole population (Barry & Jenkins, 2007). As such, mental health promotion is best envisioned using a public health approach that emphasizes improving the social, physical, and economic environments that determine the mental health of individuals and
populations. Whereas prevention frameworks focus on reducing the incidence and seriousness of mental health disorders, promotion frameworks emphasize building psychological strengths and competence (Barry & Jenkins, 2007).

Information derived from positive psychology is useful in thinking about how to promote positive mental health. “The aim of positive psychology is to begin to catalyze a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities” (Seligman & Csikszentmihalyi, 2000, p. 5). As such, positive psychology is the study of processes and conditions that promote optimal functioning, such as character strengths and positive experiences.

Seligman (2002) proposed three pillars of positive psychology as a framework for promoting mental health and happiness. The first pillar, positive emotions, emphasizes subjective experiences (joy, happiness, pleasure, contentment). Positive emotion experienced during participation in an activity is thought to be a central factor in promoting further exploration and eventual mastery (Fredrickson, 2004).

The second pillar, positive traits, emphasizes the importance of developing individual character strengths and virtues such as persistence, optimism, self-control, and social skills. Six core virtues have been identified: wisdom and knowledge, courage, love and humanity, justice, temperance, and spirituality and transcendence (Seligman, 2002). Strengths and virtues serve people during both good times and challenges. A person’s signature strengths are deeply characteristic of him or her, and one’s highest success in living and deepest emotional satisfaction are derived from building and using these signature strengths (Seligman, 2002).

The third pillar, positive institutions, focuses on environmental factors such as families, caring adults, and programs that foster character strengths and positive emotions (Seligman, 2002). In a related area of study, positive youth development emphasizes building and improving assets that enable youth to grow and flourish throughout life. Larson (2000) emphasized developing initiative as a core quality of positive youth development and made a case for participating in structured leisure activities (e.g., sports, arts, organized clubs) as an important context for such development.

Occupational therapy practitioners have ample opportunities to promote alignment of the three pillars of positive psychology and foster positive youth development given that our services, through the use of meaningful occupations, emphasize the development of needed and desired occupations within supportive environments (Bayzyk, in press-b).

MENTAL HEALTH OF CHILDREN AND YOUTH WITH DEVELOPMENTAL DISABILITIES

Mental Health Challenges

The federal definition of developmental disabilities is broad and includes a large number of conditions (e.g., intellectual impairment, cerebral palsy, autism) resulting in severe, lifelong mental and/or physical impairments that occur before the age of 22 and are likely to continue indefinitely (Administration on Developmental Disabilities, 2010). Although children and youth with developmental disabilities are 2.5 to 5 times more likely to experience mental health challenges than their typical peers, attention to this area of functioning tends to be overshadowed by an emphasis on the remediation of physical and functional limitations (Petrenchik, King, & Batoriwicz, in press). According to the National Health Interview Survey on Disability, approximately one third of children with developmental disabilities have co-occurring mental health conditions (Schwartz et al., 2006).

The reasons for a higher prevalence of mental health conditions in children and youth with developmental disabilities are not clear, but may be related to genetic predisposition combined with additional daily living stressors associated with disability (Crabtree & Delaney, in press). Children with disabilities are more likely than their typical peers to encounter negative social environments and experiences well into their adulthood (Petrenchik et al., in press).

The co-occurrence of mental health disorders with specific developmental disabilities has also been reported. For example, increased rates of depression, anxiety, bipolar disorder, obsessive-compulsive disorder, and attention deficit hyperactivity disorder (ADHD) have been identified in children with autism spectrum disorder (Crabtree & Delaney, in press). Co-occurrence often exists between ADHD, learning disabilities, and developmental coordination disorders, which may also co-exist with other conditions, such as Tourette syndrome; sleep, depression, and anxiety disorders; and being overweight or obese (Poulsen, in press). In a retrospective review of 30 individuals with cerebral palsy, 63% experienced anxiety and 10% reported depression (Krakovsky, Huth, Lin, & Levin, 2007). Lastly, in an extensive literature review of psychopathology and intellectual impairment, 25% reported self-injury; 21% reported depression; 19% reported anxiety; and 28% reported aggression (Dykens, 2006). “Understanding the co-occurrence of mental health challenges is important for designing effective prevention, early intervening, and individualized intensive intervention programs” (Crabtree & Delaney, in press).

Character Strengths

Most developmental disabilities are diagnosed based on negatives or limitations (Dykens, 2006). For example, persons with intellectual impairment have low IQ and adaptive behavior scores, those with cerebral palsy have motor impairments, and those with autism demonstrate social and communication challenges. The tendency to focus on pathology can also be noted in the literature. Dykens (2006) found 1,825 publications on psychopathology and intellectual impairment over the past 25 years and 19 articles that explored happiness in
persons with intellectual impairments. There have been good reasons for practitioners and researchers alike to focus on alleviating problems and meeting external needs; however, Dykens (2006) argues that it may be time to consider inner states, character strengths, and factors associated with the experience of happiness.

Recent studies of the behavioral features of persons with genetic causes of intellectual impairment primarily examine the cognitive, maladaptive behavior, and psychopathology associated with specific conditions. “Just as people with these or other syndromes are prone to specific problems, however, so too are they prone to unusual areas of strength” (Dykens, 2006, p. 189). Such syndromic strengths may present themselves as special talents, positive affective states, or intense interests. For example, persons with Down syndrome have been observed to smile more often than their typical peers or their peers with other disabilities (Kasari & Freeman, 2001), and parents typically use upbeat, happy descriptors of their children (Hornby, 1995) suggesting a natural tendency to demonstrate positive affect. Individuals with Prader-Willie have been found to demonstrate a strong desire to nurture babies, children, and animals, with some putting this core strength to use by working in daycare centers, nursing homes, or animal shelters (Dykens & Rosner, 1999). Additionally, those with one of the genetic subtypes of Prader-Willi syndrome (the paternal deletion of 15q11-q13), tend to be strong in visual-spatial tasks, demonstrating outstanding abilities in completing jigsaw and word-search puzzles (Dykens, 2002). Such innate strengths may lead to puzzle making as an intense and enjoyable interest. Finally, individuals with Williams syndrome are typically friendly and outgoing (Gosch & Pankau, 1997) with noted strengths in expressive language and the ability to read affect from faces, making them empathetic (Tager-Flusberg, Boshart, & Baron-Cohen, 1998). In addition, many persons with Williams syndrome have a high interest in music, which has spurred the development of special camps and programs designed to nurture playing an instrument or singing.

Although the strengths noted in individuals with three different conditions were addressed in Dyken’s work, positive emotions, intense interests, and positive attributes likely exist in all persons with developmental disabilities. In an effort to prevent an over-focus on pathology or limitations, it is important for occupational therapy practitioners to make note of and foster such personal attributes.

**POSITIVE EMOTIONS, OCCUPATIONAL ENGAGEMENT, AND MENTAL HEALTH**

*In general, happy and optimistic people are healthier; live longer; and use their positive states to facilitate and expand their problem-solving abilities and learning* (Fredrickson, 2001).

As one of the three pillars of positive psychology, experiencing positive emotions is thought to contribute to mental health (Seligman, 2002). Persons can have positive emotions about the past, such as contentment, or about the future, such as anticipation. Such experiences can be enhanced and prolonged through reflection, discussion, and daydreaming. Positive emotions in the present can be brought about in a number of ways. Sensory pleasures such as eating a favorite meal bring about positive emotions in a momentary fashion. However, Seligman (2002) recommends other routes to happiness that are more enduring—all of which involve engagement in meaningful and enjoyable occupations. In particular, participation in occupations that enlist character strengths (e.g., love of learning, curiosity, humor) and talents (e.g., painting, puzzle making) is associated with positive emotions and feelings of joy.

In a similar way, Csikszentmihalyi’s (1990) years of researching thousands of people around the world to identify when they experience the most enjoyment in their lives, led to the conclusion that optimal experience occurs when people are actively versus passively engaged in meaningful activity. Specifically, enjoyment or fun occurs with engagement in occupations involving several major characteristics: when activities have clear goals (e.g., making greeting cards), involve concentration (e.g., thinking about how to design the card), are doable (e.g., children have a clear chance of completing the cards), allow for choice, and provide immediate feedback (e.g., seeing the end product and giving the card to family or friends). Challenge is another important element of enjoyment, where “the opportunities or action perceived by the individual are equal to his or her capabilities” (Csikszentmihalyi, 1990, p. 53). Occupational therapy practitioners have traditionally valued the use of occupations that provide the “just-right” challenge—a concept inspired by A. Jean Ayres (1998).

One might wonder exactly how positive emotions influence mental health. Major theorists’ models focus on the idea that emotions are associated with specific action tendencies (Levenson, 1994). Anger, for example, is linked with the urge to attack, fear with the urge to escape, and disgust with the urge to repel. However, traditional approaches to the study of emotion have tended to ignore those that are positive. Recently, Fredrickson (2004) proposed a new model of positive emotions—the *broaden-and-build theory*—“because positive emotions appear to *broaden* peoples’ momentary thought-action repertoires and *build* their enduring personal resources” (p. 1369). Joy, for example, creates an urge to play and be creative; interest creates an urge to explore and take in new information; contentment creates the urge to relax and savor life circumstances; and love creates recurring urges to play with, explore, or savor our loved ones. These thought-action tendencies, then, have the potential to broaden habitual modes of thinking or acting. For example, play can lead to shared moments of social interaction, enjoyment, and attachment. Based on a phenomenological study...
by Bazyk and Bazyk (2009), occupation-based groups involving creativity and choice were described by children as “fun,” resulting in positive emotions and a desire to engage in more of the same activities.

Fredrickson (2004) presented foundational evidence supporting the many mental health benefits of positive emotions. Research suggests that positive emotions: (a) broaden attention and thinking; (b) reduce negative emotions; (c) promote emotional resilience; (d) fuel psychological and physical well-being; and (e) foster human flourishing. In sum, when positive emotions are in ample supply, people become “generative, creative, resilient, ripe with possibility, and beautifully complex” (Fredrickson, 2004, p. 1375).

Implications for occupational therapy: Occupational therapists can apply this knowledge in everyday practice by: (1) recognizing features of activities associated with positive emotions (e.g., those that utilize personal strengths, offer a just-right challenge, and allow choice); (2) consciously designing occupations for children and youth that lead to enjoyment and positive emotions; and (3) observing and articulating the mental health outcomes of such participation to children, families, and other health care providers. For individuals with severe and persistent mental illness or developmental disabilities, it is important to guard against focusing solely on the reduction of problem behaviors. Attention to participation in meaningful occupations that foster positive emotions and signature strengths will enhance a sense of emotional well-being, happiness, and quality of life.

The concept of occupational enrichment can be used to foster participation in occupations that promote positive emotions and build strengths. Occupational enrichment involves the deliberate manipulation of the environment to support engagement in a meaningful array of occupations and is especially critical in situations involving occupational deprivation (Molineux & Whiteford, 1999). For youth experiencing significant mental health issues or developmental disabilities, ensuring access to a range of community-based leisure occupations (e.g., arts, theater, dance, sports, etc.) and supporting successful participation is recommended. Individuals with a variety of developmental disabilities are recognizing and developing their artistic talents. For examples, view art developed by young adults with autism (www.sethwastart.com) and various developmental disabilities (Pure Vision Arts at www.purevisionart.org).

OCCUPATIONAL THERAPY STRATEGIES FOR MENTAL HEALTH PROMOTION, PREVENTION, AND INTERVENTION
An understanding of positive psychology, positive youth development, and mental health promotion is applied to an ecological model of occupational performance to inform occupational therapy services in the promotion of mental health in children and youth with developmental disabilities. The proposed occupational therapy process involves:

(1) awareness (gaining knowledge and skills); (2) appraisal (observation, gathering information, or evaluation); and (3) action (indirect and direct intervention strategies) related to each domain (Bayzk, in press-a).

For example, in terms of the person, occupational therapists need to become aware of the mental health continuum, including symptoms associated with various mental illnesses and factors associated with mental health at multiple levels (individual, community). Appraisal involves using a number of strategies to evaluate the mental health of the person or groups of individuals and qualities of the physical and social environments. At the most basic level, occupational therapy practitioners should pay attention to every child's mental health (including those with developmental disabilities) by specifically observing emotions (does the child demonstrate periods of happiness, joy, satisfaction throughout the day?); patterns of occupational participation (does the child have special interests and/or hobbies that foster a sense of joy and personal well-being?); and quality of the settings (do the settings involve caring adults who promote character strengths and positive emotions?). Actions are based on the appraisal process and refer to interventions and conditions that promote optimal mental health. Because mental health is perceived as a dynamic state of functioning that can vary throughout a person's life based on a number of biological (e.g., genetics), environmental (e.g., poverty), or situational (e.g., death of a parent) factors, the occupational therapy practitioner must remain vigilant about discerning the impact of such factors on the person's mental health.

Three-Tiered Public Health Framework To Guide Occupational Therapy
A three-tiered public health framework is used to envision and guide occupational therapy in mental health promotion, prevention, and intervention in children and youth with developmental disabilities. Although the incidence of co-occurring mental health conditions is greater, not all children and youth with developmental disabilities have or will develop mental health problems. The aim of occupational therapy, then, is to promote mental health and flourishing at all tiers—in those with and without identified mental illness. A brief discussion of the occupational therapy process at each tier in school and community settings follows.

Tier 1: Universal Services Emphasize Promotion and Prevention
Services at this level reflect a dual commitment to promotion (development of competencies) and prevention (reduction of risks) and are geared toward the entire population. At the universal level, the occupational therapy process focuses less on direct, individualized care and more on indirect services geared toward large groups of children and youth. Awareness of school-wide and community-based promotion and prevention initiatives is critical (e.g., social
and emotional learning, positive behavioral intervention and supports [see Resources on p. TK]. It is also critical to become familiar with reputable technical assistance centers in order to develop and maintain information related to mental health promotion (e.g., Center for School Mental Health [see Resources on p. CE-7]).

Based on a sound awareness of best practice related to mental health promotion and prevention, occupational therapy practitioners should appraise school and community settings for the presence and quality of such efforts. It is important to identify what educational policies and established programs exist so that systematic efforts (action) can be made to ensure that occupational therapy becomes an active and recognized profession within these systems of care.

When integrating services in the classroom, for example, an in-service on the Alert Program (Williams & Shellenberger, 1996) could help teachers adapt classroom practices based on students’ varying sensory needs.

Because attention to mental health tends to be overshadowed by an emphasis on remediating physical and functional limitations, children with disabilities can benefit from promotion efforts focusing on competence enhancement. Mental health literacy education, for example, focuses on providing a working knowledge of mental health as an integral part of overall health (Barry & Jenkins, 2007). Children gain knowledge and beliefs about mental health and mental disorders, which assists in knowing how to foster mental health and seek treatment for mental illness (Griffiths, Christensen, & Jorn, 2009). A school-based occupational therapy practitioner might collaborate with health educators or school nurses in co-teaching a unit on the mental health continuum, including mental illness and positive mental health (Keyes, 2007). Programs that help children learn and talk about mental health, mental illness, and interventions may help reduce the negative stigma associated with mental illness by framing mental health as a positive state of functioning. Such information may need to be provided in a graded manner, depending on each child’s cognitive processing.

**Tier 2: Targeted Interventions**

Tier 2 services are geared toward students at risk of behavioral and mental health problems, which includes children with and without physical or developmental disabilities. Selective interventions are designed to support children and youth who have learning, emotional, or life experiences that place them at risk of engaging in problematic behavior and/or developing mental health challenges. For example, children with physical or developmental disabilities might struggle with low self-esteem, issues related to feeling different, or the stress associated with frequent hospitalizations.

At this level, children are generally not identified as having a mental or emotional disorder but often begin to display subtle changes in performance. Services emphasize both prevention of the development of a mental illness and promotion of competencies to offset early symptoms (e.g., time management, relaxation strategies, etc.). Occupational therapy practitioners might focus on adapting activities and the environment to foster successful participation as well as applying strategies to minimize early symptoms and promote positive psychological functioning (e.g., giving one segment of school assignments at a time to minimize anxiety; teaching relaxation strategies).

To address the needs of youth at risk of developing mental illness, occupational therapy practitioners need to understand the specific needs of this population. Although strategies to prevent problem behaviors have received significant attention in school settings, the prevention of mental illness through early identification and intervention has not. Forness (2003) suggested that applying the concept of developmental psychopathology supports a public health framework of children’s mental health, and, as such, can assist families and professionals in being more proactive in the early detection of emotional or behavioral disorders. Parents, teachers, and related service providers who interact with youth on a daily basis may become aware of and concerned about early symptoms and/or mild functional impairments, but may not recognize them as prodromal, or early symptoms of a psychiatric disorder. Such symptoms are often misidentified as learning disabilities. Tier 1 and 2 services ought to include systematic attention to interdisciplinary screening and referral for mental health disorders. Occupational therapists, with our background in psychopathology and behavior, can play an important role in such early detection, screening, and intervention. Educating teachers about the early signs of mental illness and proactive strength-based prevention strategies may help them identify problems early and develop appropriate classroom accommodations.

Following a screening process, a range of early intervention activities can be implemented. For many students with mild mental disorders, accommodations that are provided under Section 504 are sufficient for enhancing school functioning. For the child with anxiety, the occupational therapist might consult with the teacher and child to discuss realistic expectations and strategies for reducing stress (e.g., break down assignments into manageable pieces). Small group interventions may also be developed jointly by occupational therapists and other team members to serve students with similar needs (Freeman et al., 2006).

All children, at some point in their lives, will struggle with situational stressors such as parental divorce, the death of a family member, living in poverty, friendship issues, bullying, or academic challenges. While interacting with and observing children, occupational therapy practitioners can make a habit of tuning in to possible stressors and advocating for and developing services to counteract stressors and build competencies (e.g., bereavement support groups, participation in
after-school clubs). Children with developmental disabilities are at heightened risk of being bullied and becoming overweight or obese (see Resources on p. CE-7).

**Tier 3: Interventions for Those With Identified Mental Health Problems**

Tier 3 services are provided for children and youth with developmental disabilities and comorbid mental, emotional, or behavioral disorders that limit participation in needed and desired areas of occupational performance. At this level, the person-occupation-environment transaction requires an in-depth knowledge of a range of mental health and behavioral disorders, how the disorders influence the person’s functioning in a variety of occupational areas (education, leisure, activities of daily living, social participation), current medical and psychosocial interventions, and school and community services. Accessing information from reliable technical assistance centers, government reports, and current literature is essential for developing a solid knowledge base (see Resources on p. TK).

Although services at Tier 3 are designed to meet the specific needs of the individual, it is critical that a systems perspective be adopted because children and youth often benefit from supports and services that are intensive and provided by multiple systems in the community. Systems of care approaches provide a framework for youth, families, schools, and community partners to provide individualized services and supports that help children and youth with serious emotional disturbances and their families achieve their desired goals (Sebian et al., 2007). Philosophies guiding systems of care approaches emphasize a comprehensive, integrated continuum of mental health and related services and supports that are community based, family driven, youth guided, and culturally and linguistically competent. Such approaches are necessary because youth with serious mental health disorders typically receive services from two or more public agencies such as juvenile justice, child welfare, special education, and state and local mental health departments. To assist in providing comprehensive, integrated services, occupational therapy practitioners need to embrace systems of care approaches and work collaboratively with youth, families, and multiple service providers.

**CONCLUSION**

In addition to addressing the needs of children and youth with comorbid psychiatric conditions, there is a critical need to promote positive mental health in all children with disabilities. Occupational therapists have ample opportunities to promote alignment of the three pillars of positive psychology given that our services, through the use of meaningful and enjoyable occupations, emphasize the development of needed and desired occupations within supportive environments. In an effort to prevent an over-focus on pathology, it is important for occupational therapists to foster character strengths and positive emotions to enhance a sense of emotional well-being, happiness, and quality of life.

**REFERENCES**


Two Ways To Apply for Continuing Education Credit

A. After reading the article Promotion of Positive Mental Health in Children and Youth With Developmental Disabilities, answer the questions to the final exam that begins below by September 30, 2012. There are two ways to take the exam:

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Final Exam CEA0910

Promotion of Positive Mental Health in Children and Youth with Developmental Disabilities • September 27, 2010

Learning Level: Intermediate

Target Audience: Occupational therapists and occupational therapy assistants

Content Focus:

Category 1: Domain of Occupational Therapy, Areas of Occupation

Category 2: Occupational Therapy Process, Intervention

1. The three pillars of positive psychology (Seligman, 2002) foster engagement in occupations that emphasize all of the following except:

A. Positive emotions
B. Individual strengths and core virtues (humor, optimism, self-control)
C. Reduction of problem behaviors
D. Supportive environments

RESOURCES

Centers for School Mental Health—Technical Assistance Centers
These Web sites include information and resources on school-based mental health programs: UCLA (www.snhp.psych.ucla.edu); University of Maryland, Baltimore (www.csmaa.umaryland.edu)

Minnesota Association for Children’s Mental Health (MACMH): www.macmh.org
This site offers practical school mental health resources based on current research and effective programming. Refer to mental health fact sheets.


Positive Behavioral Interventions and Supports (PBS): www.pbis.org
PBS interventions are designed to prevent problem behaviors by proactively altering a situation before problems escalate, and by concurrently teaching appropriate alternatives. Refer to the bully prevention manuals.

SchoolMentalHealth.org: www.schoolmentalhealth.org
These resources emphasize practical information and skills based on current research, including prominent evidence-based practices, as well as lessons learned from local, state, and national initiatives.

Social and Emotional Learning (SEL) programs help children recognize and manage emotions, think about their feelings and how one should act, and regulate behavior based on thoughtful decision making. The Collaborative for Academic, Social, and Emotional Learning (www.casel.org) focuses on the development of high-quality, evidence-based SEL as a necessary part of preschool through high school education.

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Earn .1 AOTA CEU (one NBCOT PDU/one contact hour). See below for details.
2. A public health approach to mental health can be used to envision the following shift in occupational therapy:
   A. Services for all children and youth, not just those with identified disabilities or limitations
   B. An emphasis on engagement in health-promoting occupations
   C. Services in the community as well as schools, hospitals, and clinics
   D. All of the above

3. When working with children and youth, positive psychology recognizes the importance of acknowledging and developing:
   A. Personal strengths and virtues (persistence, love, courage, etc.)
   B. Social skills
   C. Cognitive behavioral strategies
   D. Emotional intelligence

4. An area of study that focuses on helping young people build assets and initiative through participation in structured leisure activities is referred to as _____.
   A. Mental health literacy
   B. Positive youth development
   C. Prevention efforts
   D. Tiered system of support

5. Children with autism spectrum disorder demonstrate increased rates of all of the following mental health disorders except:
   A. Anxiety
   B. Depression
   C. Schizophrenia
   D. Obsessive-compulsive disorders

6. Children and youth with Williams syndrome generally demonstrate the following strengths:
   A. Musical interest and talent
   B. Ability to be empathetic
   C. Strong social skills
   D. All of the above

7. The best way to foster positive emotions that will likely endure in a person's life is through:
   A. Having pleasurable sensory experiences
   B. Participating in enjoyable occupations that enlist character strengths
   C. Thinking about happy times
   D. Avoiding challenge

8. Occupational therapy practitioners need to consciously design occupations that are fun because positive emotions:
   A. Reduce negative emotions
   B. Can build personal resources such as resilience
   C. Promote attention and thinking
   D. All of the above

9. Whole-school strategies to provide all students with a working understanding of mental health and mental disorders and how to seek services is referred to as _____:
   A. Social and emotional learning
   B. Mental health literacy education
   C. Developmental psychopathology
   D. Person-environment-occupation interaction

10. A three-tiered public health framework:
    A. Promotes mental health and flourishing at all tiers
    B. Represents a shift in thinking from a traditional individually focused deficit-driven model of mental health intervention, to a whole population strength-based approach
    C. Suggests that all occupational therapy practitioners should provide direct and indirect services to promote mental health in all individuals and settings
    D. All of the above

11. At Tier 2 awareness, it is important to tune into subtle early symptoms of mental illness (prodromal) that may be overlooked misidentified as learning disabilities.
    A. True
    B. False

12. A comprehensive coordinated network of interagency school and community services for youth with severe emotional disturbance is referred to as _____:
    A. Systems of care
    B. Mental health literacy
    C. Prevention services
    D. Early intervening services