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The Effectiveness of Teaching Life Skills through Sport-Based Interventions for At-Risk Youth

Melinda Katheran Scott

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THE EFFECTIVENESS OF TEACHING LIFE SKILLS THROUGH SPORT-BASED INTERVENTIONS FOR AT-RISK YOUTH

by

MINDY SCOTT

(Under the Direction of Brandon Harris)

At-risk youth are children and adolescents who live in a negative environment and/or do not possess the skills they need in becoming responsible members of society (Collingwood, 1997). Many of these youth experience adjustment difficulties, behavioral problems, academic failure and dropout, or mental health difficulties (Moreau et al., 2012). One of the current resources for these youth has been sport-based interventions or physical activity to measure the benefits of psychosocial wellbeing among the adolescents. However, these have typically been outreach projects rather than research based. The current study analyzed the effectiveness of a life skills program called SUPER that used sport in a population of at-risk youth (Danish, 2002). There were also two additional mental skill modules implemented. A single subject ABA design was used. The researcher worked with three male participants using basketball to teach life skills to these youth. The life skills included managing emotions, goal setting, relaxation, confidence, mental preparation, and seeking help from others. The participants responded to a portion of the Life Skills Transfer Survey (Weiss, Bolter, & Kipp, 2014) as well as a portion of the Ottawa Mental Skills Assessment Tool (Durand-Bush, Salmela, & Green-Demers, 2001) to evaluate the effectiveness of the intervention. Results indicated that the intervention was effective at enhancing the ability for two of the three participants to use life skills they learned in the intervention. This study supports the use of sport-based interventions with at-risk youth as well as the use of individualized interventions to enhance the results.

INDEX WORDS: At-risk youth, Sport-based intervention, Life skills
“THE EFFECTIVENESS OF TEACHING LIFE SKILLS THROUGH SPORT-BASED INTERVENTIONS FOR AT-RISK YOUTH”

by

MINDY SCOTT

B.S., Appalachian State University, 2012

A Thesis Submitted to the Graduate Faculty of Georgia Southern University in Partial Fulfillment of the Requirements for the Degree

MASTER OF SCIENCE

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THE EFFECTIVENESS OF TEACHING LIFE SKILLS THROUGH SPORT-BASED INTERVENTIONS FOR AT-RISK YOUTH

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DEDICATION

I hereby dedicate this thesis to my wonderful parents, Harold and Kay Scott. These two beautiful people have always been there for me and believed in me even when I did not believe in myself. They are always willing to bend over backwards to help me with whatever I may need, and without their support I would not be nearly as successful as I have been thus far. To my parents: your little angel will always appreciate everything you have done for me.
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“At-risk” or “disaffected” youth are children and adolescents who live in a negative environment and/or do not possess the skills that assist them in becoming responsible members of society (Collingwood, 1997). While the circumstances and events influencing youth who have been placed in this category are sometimes uncontrollable, their reactions and emotional responses to the situations are within their control. Many of these young people face adjustment difficulties, behavioral problems, academic failure, and dropout or mental health difficulties (Moreau et al., 2012). Programs such as after-school care, alternative high schools, and residential treatment facilities have all been used to provide structure, academic support, recreational activities, and sometimes therapy in an attempt to foster responsible young adults for our future societies.

In addition to categorizing students as being “at-risk”, researchers have also identified health-risk behaviors among this special population of adolescents. For example, Johnson, Eisenberg, Bearinger, Fulkerson, and Sieving (2014) determined that health-risk behaviors included substance use, sexual risk-taking, and violence involvement. Dunn (2014) further detailed these behaviors by also measuring dietary behaviors, physical activity, and unintentional injury. Several studies have included the use of the Youth Risk Behavior Survey to measure the abovementioned categories (Dunn, 2014; Taliaferro et al., 2008; Taliaferro, Rienzo, & Donovan, 2010). This survey is administered among representative samples of students in grades 9 to 12 in the United States every odd year by the Centers for Disease Control and Prevention and has provided researchers knowledge about risk factors as well as protective factors for at-risk youth.
Using this survey, some researchers have analyzed various relationships between sport and physical activity and preventing at-risk youth from participating in unhealthy behaviors such as substance abuse and gang affiliation. Research in this area has yielded mixed results (Dunn, 2014; Johnson et al., 2014). Dunn (2014) specifically examined the relationship between physical activity, enrollment in a physical education class, and sports participation on the substance use practices of high school students. While cigarette usage decreased as physical activity increased, an inverse relationship was observed with smokeless tobacco; the percentage of students using smokeless tobacco increased as the number of sports teams played on increased. Dunn suggested that individuals who value athletic performance are more likely to use smokeless tobacco compared to cigarettes in order to protect their cardiovascular endurance. Another result of this study was that sport participation and physical activity appeared to be a risk factor for alcohol use for males but not females. The researcher suggested that increased alcohol use in athletes may be a result of “socialization, modeling, and the macho persona that accompanies physical activity” (Dunn, 2014, p. 683). Johnson and colleagues (2014) expanded these correlations while looking at health-risk behaviors that also included sexual risk-taking and violence involvement in alternative high school students. The researchers observed a positive correlation between condom use and sports team participation for males and an inverse relationship between the number of sexual partners and sport participation for females. However, these authors suggested that sport team participation may be a risk factor for violent outcomes as there was a positive association between sport team participation and gun carrying for both genders.

While the previous researchers have focused on health-risk behaviors that may contribute to someone being labeled “at-risk,” Lubans, Plotnikoff, and Lubans (2012) described the
effectiveness of interventions that used physical activity to improve social and emotional well-being in at-risk youth. They analyzed different types of physical activity programs including outdoor adventure programs, sport and skill-based programs, and physical fitness programs. One specific program they analyzed was the Singapore Sports Challenge where they emphasized using sport as a medium due to the life skills they also learned. These included realistic goal setting, strategies to address conflict resolution with peers and family, strategies to ask for adult support, stress management, and promoting positive social behaviors in the outdoor setting and in the classroom (Lubans, et al., 2012). However, the researchers recommended caution in interpreting results due to the high risk of bias they found in the program because it lacked a control group. In addition, the researchers stated that the results may not have been dependent on the level of physical activity. There may be something else the program could have implemented in order to benefit the youth even more than simply increasing fitness. Past research has not been strong due to confounding variables that may have influenced the findings. Also, the methodology may have inhibited the results without a control group to use for comparison. While the students may have benefited from this program, additional research is warranted due to the limitations of previous results.

Sport-based interventions among at-risk youth have been of interest to other researchers as well (Kelly, 2012; Moreau et al., 2012). Kelly (2012) conducted a qualitative study on Positive Futures which is a government-funded sport-based intervention in England and is regarded as “Britain’s largest national youth crime prevention programme” (Kelly, 2012, p. 7). Participants in the program were interviewed about their views of the program’s effectiveness which included promoting self-esteem, achievement, positive relationships, and new opportunities. Kelly (2012) identified additional ways that sport-based interventions can impact
crime reduction including changing people, changing environments, and changing responses. These principles may be adopted to assist youth in developing certain life skills that will help them with decision-making as they endure certain unhealthy environments that are not in their control. Moreau and colleagues (2012) conducted a similar study interviewing participants of a program that targeted troubled youth using a cooperative model of sports intervention. They developed six principles that they believed should be adopted for similar programs including (a) cooperation amongst peers, (b) personality of staff, (c) continually pushing youth outside their social habits, (d) the interplay of enjoyment and effort, (e) constant innovation and novelty of training sessions, and (f) risk associated with taking new chances as well as overcoming failure.

To further understand what principles and program designs could benefit at-risk youth, Barnert and colleagues (2015) conducted interviews with incarcerated youth on protective and risk factors for juvenile offending. Youth were asked to describe the different environments they encounter during their lives such as home, school, neighborhood, and jail. Within each environment, the incarcerated youth detailed what they felt would be an ideal living situation. For example, many youth expressed that their ideal home should be the most protective environment; however, their reported home environment was described by these youth as consisting of fighting and a lack of family cohesion. For school, the youth said they would see an ideal environment as a safe place that taught them practical skills to be successful. However, many stated that it did not feel safe due to gang violence and bullying. The youths’ ideal neighborhood was described as peaceful and quiet with abundant nature and parks as well as friendly neighbors. In reality, their neighborhoods were affiliated with gangs, shootings, and murders. When the youth discussed being incarcerated, some felt that it was an extension of their neighborhood and was ultimately inevitable. The youth expressed mixed feelings about the
jail environment, though. Some stated that they did not like missing their families and the restrictions on their freedom while others stated that they felt safe in jail because of the structured environment.

Barnert and colleagues (2015) also inquired about the youths’ internal needs. Some responses included love and attention, discipline and control, and role models and perspective. These are all examples that the youth may not be able to control themselves, so there needs to be more resources for them to use in their communities to provide them with the tools they will need to be successful.

Some studies have examined the associations between risk taking behaviors and sport and physical activity (Dunn, 2014; Johnson et al., 2014), but the results regarding their effectiveness have been inconclusive; thus, additional components may need to be implemented in these programs to further show positive results. One of these components could include mental skills training. Mental skills or psychological skills are personal qualities or characteristics that children attain through participation in sport (Weiss, 1991). While mental skills have been used in a wide variety of applied settings, it has not specifically been used with an at-risk youth population. The use of mental skills such as goal setting, relaxation, imagery, and cognitive restructuring can be beneficial to at-risk youth because of the following findings.

Brewer and Shillinglaw (1992) implemented psychological skills workshops while working with a male lacrosse team and found that the workshop produced significant gains in self-reported knowledge of, importance placed on, and use of goal setting, relaxation, imagery, and cognitive restructuring. Although an ideal situation for these researchers would be to have provided psychological skills training on a one-to-one basis, various constraints such as monetary and consultant availability often require consultants to provide this training in a group
setting; therefore, a workshop was the best method to be measured. Some researchers have suggested other benefits for the different techniques associated with mental skills training programs. For goal setting, Filby, Maynard, and Graydon (1999) suggested the technique enhances feelings and perceptions of control. Relaxation strategies have been shown to allow people to have appropriate resources available for decision-making (Landers & Boutcher, 1998). Thelwell and Greenlees (2003) implemented imagery into their design in order to enhance motivation. Lastly, Hardy and colleagues (2001) suggested that mastery self-talk can influence focus, self-confidence, and coping with difficult situations. All of these benefits for mental skills can be applied to various settings that are encountered by at-risk youth.

For the present study, the additional mental skills that will be implemented include concentration and mental preparation. Concentration is important for youth to become better students while attending school. Larson and Kleiber (1993) observed youth experiencing enhanced concentration during leisure activities such as sport when compared to their concentration levels during class. However, youth were not taught how to transfer their concentration skills from leisure activity to the classroom or other environments they encounter. Mental preparation can help prepare youth for a situation that may be in their near future. Moody, Childs, and Sepples (2003) included cognitive preparation in the social skills training component of the Youth Empowerment and Support Program (YES-P). The researchers observed an 82% increase in social skills attainment among the participants. Although the study recruited the participants from an inner-city neighborhood, there was no physical activity component to it. To the current researchers’ knowledge, there has not been a study completed that includes the importance of mental preparation in sport and how that can be transferred to other environments for at-risk youth.
In addition to mental skills, life skills interventions have been used to assist youth in becoming responsible members of society. Danish and Donohue (1995) defined life skills as the skills and attitudes learned during sport participation and their application to daily life. Life skills enhance the development of the psychological skills that are required to deal with the challenges of everyday life (Papacharisis, Goudas, Danish, & Theodorakis, 2005). These can be physical, behavioral, or cognitive (Danish & Donohue, 1995). Life skills are similar to physical skills in that they can be learned through demonstration and practice. Many skills learned in sports can be transferred to daily life such as the ability to perform under pressure, solve problems, meet deadlines, set goals, communicate, handle success and failure, work with a team, and receive feedback (Papacharisis et al., 2005).

Danish (2002) developed one such formal life-skills program. Before beginning his own program, he was asked to work with sports teams through the NCAA YES program which stood for Youth Education through Sport. This program utilized student-athletes to serve as role models and teach life skills within the communities of their schools. He also worked with soccer teams implementing the GOAL program where the primary focus was on setting goals and making a plan for how to achieve them (Danish & Nellen, 1997). Danish then created his program called SUPER, which stands for Sports United to Promote Education and Recreation (Danish, 2002). SUPER was designed to show the relationship between the skills that are taught while playing sports and their applicability to other settings such as home or school. The original program consisted of 18 modules with three areas in each: learning the physical skills related to the sport, learning life skills related to sports in general, and playing the sport. The SUPER program has been used in a number of sport and/or physical activity contexts, including basketball, soccer, golf, rugby, and volleyball (Danish, Forneris, & Wallace, 2005). Papacharisis
and colleagues (2005) also implemented the SUPER program in an abbreviated format only using eight modules rather than the full 18. While the SUPER program has been used to work with youth already involved in sport teams, it has not been applied to working with at-risk youth. This population would benefit from a program that implements sport as well as life skills

While some of the abovementioned studies have demonstrated benefits for using physical activity or sport-based interventions for at-risk youth, they have suggested mixed results in regards to the lessons actually learned by the youth and their applicability to the struggles experienced by this population. Therefore, the purpose of this study is to examine the effectiveness of an abbreviated sport-based intervention that teaches mental skills and life skills to at-risk youth. It is hypothesized that the ability for at-risk youth to transfer life skills will increase after participating in this study. Also, it is hypothesized that the ability for at-risk youth to use mental skills will increase after participating in this study.
At-Risk Youth

Before beginning to explain different types of interventions that can be used, we must understand the meaning of the term “at-risk.” “At-risk” has been synonymous in the past with “disadvantaged youth,” “alienated youth,” “problem youth,” or “troubled youth” (Collingwood, 1997). Although the terms may have changed, there has been a consistent pattern of needs from these youth that are not being met. There may be situations in their environment that create personal hazards for them where they do not know a beneficial way to cope with these. For these reasons, at-risk youth has been defined as youth who live in a negative environment and/or lack the skills and values that help them become responsible members of society (Collingwood, 1997). Although some may believe at-risk youth are inner-city or minority youth, this definition includes a broader range of adolescents. Their environments usually lead them to developing serious problem behaviors such as substance abuse, delinquency, violence, emotional disturbances, poor health and fitness, and educational difficulties.

Before one can understand the needs of at-risk youth, it is important to understand the prevalence in the United States. The National Center on Addiction and Substance Abuse at Columbia University conducted a national study and found that substance abuse in adolescence was America’s number one public health problem (2011). The findings from June, 2011 suggested that 75% of high school students had drunk alcohol, used another drug, and smoked cigarettes. This finding seems to be associated with another result that 46% of children under the age of 18 usually lived with a risky substance abuser. Although high school students can experience peer pressure from their friends, the home and family were the most common source
of substances that are addictive. In addition to substance use, the National Survey on Drug Use and Health in 2010 found that the top three reasons for youths aged 12 to 17 to receive mental health services were feeling depressed, having problems at home, and breaking rules or “acting out” (Substance Abuse and Mental Health Services Administration, 2012). The Surgeon General also reported on the mental health conditions of children and adolescents saying that one in every ten children and adolescents in the United States experience severe mental illness that causes some level of impairment; however, less than one in five of those children have received appropriate treatment (U.S. Public Health Service). Sexual risk taking has also been measured. A fact sheet from the Guttmacher Institute states that one in every five teen girls is at risk for an unplanned pregnancy (2014). Also, about 17% of youth in the United States between the ages of 13 and 24 were diagnosed with HIV/AIDS (Guttmacher Institute, 2014).

While these may appear to be a series of problems, some researchers believe these are actually symptoms of a general underlying problem known as developmental deficit (Collingwood, 1997). In other words, the problems may be due to youth not developing a responsible and health-enhancing lifestyle. Some developmental themes that influence youths’ lifestyle choice include: (a) search for identity; (b) development of a sense of autonomy; (c) development of a sense of self-control; (d) development of a sense of accomplishment; and (e) development of strategies to reduce physical and psychological pain, peer pressure, and stress (Collingwood, 1997). Some institutional programs have attempted to focus on these needs from youth based on verbal expression, such as counseling, psychotherapy, and psychosocial interventions (Moreau et al., 2012) where the aim is primarily to encourage problem verbalization and explore solutions in a welcoming and confidential environment (Clark, 2007). While several different therapeutic approaches have been beneficial to youth, participation rates
and commitment from troubled youth remains a challenge (Binder, Holgersen, & Nielsen, 2008). Youth may experience distrust of counseling due to attitudes of resistance and greater instability (Kline, 2009). While working with an at-risk youth population, these difficulties should be taken into consideration when trying to find the best plan of action to benefit their lives.

At-Risk Youths’ Perspectives on their Environments

For some at-risk youth, juvenile correctional facilities become an environment to which they must adjust. Juvenile offenders represent a vulnerable population with disproportionately high rates of unmet physical, developmental, social, and mental health needs, and higher mortality (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). It is important to work with adolescents who are offenders due to the increase in likelihood that they become adult offenders or other adverse outcomes such as poor health, substance use, and increased mortality (Coffey, Veit, Wolfe, Cini, & Patton, 2003). Previous studies have found that low school achievement, poor mental health, substance use, parental incarceration, large family size, single-parent families, poor parental supervision, delinquent peer groups, and residing in high-crime neighborhoods are risk factors for juvenile offending (Farrington, 2002). Barnert and colleagues (2015) wanted to discuss with incarcerated adolescents about what they believed should occur within their different environments to prevent incarceration and compare that to what is reality for these youth. The researchers believed that hearing the opinions of the youth would help in understanding the protective factors that may help youth avoid becoming incarcerated or the risk factors associated with juvenile offending. Youth were asked to describe the different environments they encounter during their lives such as home, school, neighborhood, and jail. Within each environment, the incarcerated youth detailed what they felt would be an ideal living situation. For example, many youth expressed that their ideal home should be the most
protective environment; however, their reported home environment was described by these youth as consisting of fighting and a lack of family cohesion. For school, the youth said they would see an ideal environment as a safe place that taught them practical skills to be successful. However, many stated that it did not feel safe due to gang violence and bullying. The youths’ ideal neighborhood was described as peaceful and quiet with abundant nature and parks as well as friendly neighbors. In reality, their neighborhoods were affiliated with gangs, shootings, and murders. When the youth discussed being incarcerated, some felt that it was an extension of their neighborhood and was ultimately inevitable. The youth expressed mixed feelings about the jail environment, though. Some stated that they did not like missing their families and the restrictions on their freedom while others stated that they felt safe in jail because of the structured environment. Despite the various results, participants indicated that ending up in jail was the easiest choice given the environments in which the youth live.

Barnert and colleagues (2015) also inquired about the youths’ internal needs. Some responses included love and attention, discipline and control, and role models and perspective. The youth stated that receiving love from parents motivates them to please their parents and be successful. By contrast, adolescents who did not feel loved but felt neglected see no reason to spend time with their families or perform well in school leading them to try to thrive on the streets. In order to promote discipline and control, the youth discussed how they felt their parents should regulate their activities and try to keep them at home due to the unsafe environments in their neighborhoods. This would show the youth that their parents care for them and want them to be successful. The most important role models for youth according to the participants were their older family members. The adolescents felt that parents should influence their children to take a positive, future-oriented perspective. These are all examples that the
youth may not be able to control themselves, so there needs to be more resources for them to use in their communities to provide them with the tools they will need to be successful.

**Risk Behaviors’ Association with Physical Activity**

Some researchers have examined the relationship between risk behaviors associated with at-risk youth and physical activity. Johnson, Eisenberg, Bearinger, Fulkerson, and Sieving (2014) examined the relationship between health risk behaviors, such as substance use, sexual risk-taking, and violence involvement, in alternative high school students and sports team participation. The researchers were able to obtain this data using the Minnesota Student Surveys that is administered every three years to students in alternative schools, traditional schools, and juvenile correctional facilities. The researchers found mixed results. For males, sports team participation protected against most substance use outcomes and was associated with higher condom use. These findings are promising due to the high prevalence of substance use for students in alternative schools. Females who participated on sport teams were more likely to practice abstinence than females who were nonparticipants. However, sports team participation was positively associated with gun carrying for both genders. It should be noted that students in alternative high schools have consistently shown a low engagement in sports teams (Johnson et al., 2014). One of the limitations to this study was the use of a survey only administered in Minnesota. Also, the researchers did not have access to specific sports team participation information such as which sports were being played. Johnson and colleagues (2014) were interested in the relationships between sports team participation and health risk behaviors because youth participate in sports willingly and may benefit from the health promoting atmosphere.
Because sports are not the only method of physical activity, Dunn (2014) expanded the activity variable to include sports participation, physical activity, and enrollment in physical education class when looking at their relationship with substance use in high school students. Physical activity and sports participation have traditionally been considered as ways to encourage healthy habits and decrease health risks in adolescents (Leaver-Dunn, Turner, & Newman, 2007). However, researchers continue to find mixed results regarding the possibility of physical activity being a protective factor against health risk behaviors. Dunn (2014) found a decrease in percentage of students who smoked regularly as physical activity increased. However, the use of smokeless tobacco increased as the number of sports teams played on increased. Dunn and Wang (2003) suggested that this result may be due to athletes protecting their cardiovascular endurance by using smokeless tobacco rather than cigarettes. Also, recreational physical activity and sports participation appeared to be a risk factor for alcohol use behaviors among males (Dunn, 2014). Recreational physical activity and sports participation appeared to be negatively associated with marijuana use among females but not males. These results suggest that further research should be completed in order to better understand the relationship between different forms of physical activity and substance use. It should be noted that Dunn (2014) used self-report surveys to obtain his data on the level of physical activity and substance use behaviors. Some high school students would not be willing to volunteer information about substance use, especially being minors where they could receive punishment from the law as well as their parents. Also, high school students responded to questions about how often they were physically active for at least 60 minutes, but they did not specify what the physical activity was. Physical activity can have different intensity levels that may play a factor into its relationship with substance use.
Interventions for At-Risk Youth

**Physical Activity Interventions.** While some researchers have analyzed the relationships between health risk behaviors and physical activity, others have focused on the effectiveness of interventions that use physical activity as a medium. Lubans, Plotnikoff, and Lubans (2012) specifically described the effectiveness of such programs on social and emotional well-being in at-risk youth. The researchers included three different categories for analysis: outdoor adventure programs, sport and skill-based programs, and physical fitness programs. The outdoor adventure programs included a range of activities such as rock climbing, rope courses, horse riding, orienteering, sailing, and canoeing. The duration also varied ranging from four hours to three months. The researchers observed significant improvements in self-worth, self-concept, resilience, perceptions of alienation and self-control. However, two programs did not improve social and emotional well-being. Some benefits observed in the sport and skill-based programs included: improvements in perceived physical competence, self-esteem, and temperament. These findings should be taken with caution due to the lack of control group for most of these studies. One study that included a control group as well as a skill-mastery intervention and a fitness program found that neither of the experimental groups improved self-concept in children with behavioral disorders. One physical fitness program entitled First Choice Fitness leaders showed significant improvement in a large sample of at-risk adolescents, but there was not a control group for comparison (Collingwood, Sunderlin, & Kohl, 1994). The mixed results of physical activity programs suggest that clinicians who work with this population should be aware of what conditions the programs were most successful at enhancing and which kind of youth such as juvenile offenders or those with mental health diagnoses like depression benefitted the most.
Moreau and colleagues (2012) also examined the effects of a physical activity program. The researchers interviewed the participants in order to understand the youths’ perceptions of the program’s most important dimensions as well as its effects on the physical, psychological, and social spheres of their lives. The program included a nocturnal hike, cycling route, and relay run. The program seemed to enhance four different categories: self-confidence, a want to pursue regular sports practice after the program, surpassing one’s own limitations, and values of determination and perseverance. The researchers’ findings suggest that practicing sports in an environment that encourages positive reinforcement strategies, civic engagement, and group mobilization can be an effective tool in fostering psychosocial development. Also, the structure that the program put in place for the youth could benefit them by allowing them to participate in something that would promote health and psychological wellbeing rather than unhealthy alternatives such as substance use or becoming involved in gangs. The program was implemented in a group setting that allowed youth to develop socialization and collaboration skills. Moreau (2012) developed six principles that seem significant when using sports as an intervention for psychosocial development. These include (a) cooperation amongst youth; (b) personality of staff; (c) moving the youths beyond their physical, psychological, and social comfort zones; (d) the interplay between employment and effort; (e) constant innovation and novelty in training content; (f) risk associated with taking new chances as well as overcoming failure. These principles should be adopted by future researchers when attempting to use sport as an intervention for at-risk youth.

Kelly (2012) was interested in the use of sport-based interventions (SBIs) to reduce crime because such programs are included in the United States, Canada, Australia, the Netherlands, and the United Kingdom. While location can play a role due to the significance placed on these
programs by the national, regional, and local criminal justice and social policies, Kelly examined the role of SBIs within the English policy context. In England, SBI’s target neighborhoods and individuals and have been widely promoted by government departments, sporting bodies, and nongovernmental organizations. Despite the association between sport and crime reduction, finding empirical evidence that suggests sport does in fact play an impact has been difficult to do (Coakley, 2011). Coakley (2011) suggested that sport in itself is unlikely to secure positive outcomes but the effect is contingent on the presence of a variety of enabling factors. These factors include diversionary activities where the youth are engaged in activities that prevent criminal and antisocial behavior and developmental programs where youth can learn how to use sport as a tool to address health, welfare, and educational issues. Kelly (2012) interviewed participants of three “Positive Futures” projects as well as the project managers, operational staff, and representatives from partner agencies in order to explore how stakeholders understood its objectives, strengths, and limitations. Positive Futures is a national sport and activity based social inclusion program that has been in operation for over ten years. The overall aim of the project is to have a positive influence on individual’s substance misuse, physical activity, and offending behavior by giving access to lifestyle, educational, and employment opportunities. According to the stakeholders, the program was effective at promoting self-esteem, achievement, positive relationships, and new opportunities. The researcher further identified ways SBIs could impact crime reduction including changing people, changing environments, and changing responses. Although sports and physical activity have been used as a medium for at-risk youth, there may be other principles or aspects of the programs that should be implemented to further fulfill the youths’ needs.
**Life Skills Interventions.** Life skills interventions have been used to assist youth in becoming responsible members of society. Danish and Donohue (1995) defined life skills as the skills and attitudes learned during sport participation and their application to daily life. Life skills enhance the development of the psychological skills that are required to deal with the challenges of everyday life (Papacharisis, Goudas, Danish, & Theodorakis, 2005). These skills can be physical, behavioral, or cognitive (Danish & Donohue, 1995). Life skills are similar to physical skills in that they can be learned through demonstration and practice. Many skills learned in sports can be transferred to daily life such as the ability to perform under pressure, solve problems, meet deadlines, set goals, communicate, handle success and failure, work with a team, and receive feedback (Papacharisis et al., 2005). However, while some athletes benefit from playing sports, some studies have found mixed results in regards to the benefits of the physical activity (Johnson et al., 2014; Dunn, 2014).

In order to better understand the aspects of sport on the ability to use appropriate life skills, a positive youth development program may need to be implemented. The National Research Council and Institute of Medicine identified 28 personal and social assets that facilitate positive youth development (2002). They further categorized these assets into four domains including: physical development, intellectual development, psychological and emotional development, and social development. Bloom (2000) initially described these assets as: to work well, play well, love well, think well, serve well and be well. An obvious example of how sport could benefit a positive youth development program would be our society’s growing concern for the health of our youth. In order for youth to obtain the recommended amount of physical activity, it is recommended that youth find an activity that they find enjoyable. These activities usually revolve around sports. However, those who work with youth should also teach them the
skills, values, attitudes, and knowledge necessary to succeed with the same intensity as trying to prevent health-compromising behaviors and attitudes (Danish, Forneris, & Wallace, 2005).

In an attempt to benefit all youth, Danish (2002) developed a formal life skills program that used sport as a medium for each lesson. Danish, Forneris, & Wallace (2005) attempted to help school counselors understand that simply having the students participate in sport would not be enough of a benefit for these students. The researchers stated having that mentality could make the students believe that they could change their world if they became better athletes when that is not true for the overwhelming majority. Instead, Danish and colleagues (2005) wanted to emphasize the skills already learned in sport and translate them to general life skills. Also, the major premise of what the researchers wanted to suggest was that the skills needed to enhance sport performance and to succeed in life are basically the same. Danish then created his program called SUPER, which stands for Sports United to Promote Education and Recreation. SUPER was designed to show the relationship between the skills that are taught while playing sports and their applicability to other settings such as home or school. The original program consisted of 18 modules with three different aspects to each: learning the physical skills related to the sport, learning life skills related to sports in general, and playing the sport (Danish, 2002). The SUPER program has been used in number of sport and/or physical activity contexts, including basketball, soccer, golf, rugby, and volleyball (Danish, Forneris, & Wallace, 2005). The SUPER program has also been implemented in an abbreviated format only using eight modules rather than the full 18 (Papacharisis et al., 2005). While this program has been used in a variety of settings, it has not been implemented with an at-risk youth population.

**Mental Skills Interventions.** In addition to life skills, mental skills training has been used by various sport psychology professionals to enhance sport performance. However, some
of the mental skills used can be transferred to other areas of a youth’s life such as concentration and mental preparation. These mental skills are not currently a part of a sport-based intervention program such as SUPER (Danish, 2002). Concentration is important for youth to become better students while attending school. During leisure activities such as sport, Larson and Kleiber (1993) observed youth experiencing enhanced concentration when compared to their concentration levels during class. In order for youth to understand how to transfer the concentration skills they used in sport to the classroom, a positive youth development program should implement it into the curriculum. In addition to concentration, mental preparation can be used for at-risk youth, so they can better prepare themselves for a situation that may be in their near future. Moody, Childs, and Sepples (2003) included cognitive preparation in the social skills training component of the Youth Empowerment and Support Program (YES-P). The researchers saw an 82% increase in social skills attainment among the participants. This study was able to recruit participants from an inner-city neighborhood, but the program had no physical activity component to it. To the current researchers’ knowledge, there has not been a study completed that includes the importance of mental preparation in sport and how that can be transferred to other environments for at-risk youth.
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CHAPTER 3

METHODS

Participants

The participants were recruited from a charter school located in the southeast United States. While charter schools accept all students, this charter school is a year-round program that is designed to support students who may have had challenges in traditional public school settings but cannot afford to attend a private school. The primary researcher recruited three male participants ranging in age from 12 to 14 (See Appendix F). While Kazdin (2011) recommends obtaining a sample size of at least six participants for single subject designs, the researcher was unable to recruit more students from the same school. There were originally seven total participants who were provided consent to participate, but two participants withdrew before the study began, one participant was 18 and could not be included, and Participant 3 withdrew himself after the second day of baseline testing stating that he no longer wanted to take the assessments. After receiving approval from the school to recruit youth for the study, the researcher used a demographic questionnaire to assess the following at-risk criteria for which the participants had to meet at least one: (a) coming from a low income family, (b) coming from a single parent home, (c) being a teen parent, (d) having previously dropped out or been removed from another school, (d) having a history of substance abuse behavior, (d) having been exposed to an emotionally or physically abusive environment, (e) having currently or previously received mental health services, and/or (f) having a grade point average below 1.5 (see Appendix A). These different characteristics have been commonly associated with at-risk youth (Collingwood, 1997; Moreau et al., 2012). Exclusion criteria included youth that may be prone to violent outbreaks or had a low attendance rate according to the school and therefore would not have
been present for enough of the interventions. The participants in the current study included two participants coming from a low income family, two participants coming from a single parent home, and one participant who had received previous mental health treatments. None of the parents or guardians stated the participant’s grade point average, and each of the students participated in extra-curricular activities including sports and religious groups. Two of the participants were currently on a basketball team. The parents or guardians of each student provided consent, and each youth provided assent before participating in the study. The parents or guardians and participants also completed the 2014 Physical Activity Readiness Questionnaire+ (PAR-Q+) (Warburton, Jamnik, Bredin, & Gledhill, 2014) to assure the participant was healthy and able to engage in the physical activity components of this project (see Appendix B).

**Instrumentation**

**Ottawa Mental Skills Assessment Tool-3.** Some of these skills can be included in both life skills and mental skills, but for the purpose of this study the mental skills were assessed using the Ottawa Mental Skills Assessment Tool (OMSAT-3) (see Appendix C). The OMSAT-3 is an 85-item questionnaire with 12 mental skill scales (Durand-Bush, Salmela, & Green-Demers, 2001). However, for the present study, the participants only responded to four of the different subscales that measured the interventions provided including: belief/confidence, relaxation, focusing, and mental practice. The participants responded to each question on a 7-point Likert-type scale ranging from strongly disagree to strongly agree. The four subscales that were used in this study received good Cronbach’s alpha levels (.76-.84). Confirmatory factor analysis suggested the model fit well with the data (Durand-Bush, Salmela, & Green-Demers, 2001).
**Life Skills Transfer Survey.** In order to examine the effectiveness of the intervention in teaching the participants how to transfer life skills to other settings, they completed the Life Skills Transfer Survey before, during, and after the intervention as well (Weiss, Bolter, & Kipp, 2014; see Appendix D). The LSTS is a 50-item self-report measure that reflects youths’ perceptions on their ability to use life skills learned in one context and transfer it to another domain. The measure includes eight subscales, but for this study the participants only responded to questions from the goal setting, managing emotions, and getting help from others subscales that corresponded to the specific interventions. Responses were given on a 5-point Likert-type scale including “really not true for me, not true for me, sort of true for me, true for me, and really true for me.” As a part of the measure’s development, authors also demonstrated validity for its use with youth as young as the age of 10. All eight subscales achieved good Cronbach’s alpha values (α=.80-.92). Structural validity was assessed for all eight subscales and revealed reasonable-to-good fit to the observed data (Weiss et al., 2014).

**Procedures**

Because the participants were not legal adults, their parents or guardians were asked to provide written consent for their child’s participation in this study. After consent was obtained, the students were asked to participate and also provided written assent stating they understood what they will be asked to do during the study as well as the purposes for the study. This study was a single-subject design where the participants served as their own control groups and participated in the interventions individually.

Because the participants were corresponding with the researcher individually, it is important to note the credentials of the primary researcher. The researcher has played basketball for almost 15 years in various recreational leagues, high school teams, and a collegiate club.
team. Having this skill set allowed the researcher to implement the interventions by showing the participants examples of what they are being asked to do. Also, the researcher has previous experience working with at-risk youth at a residential treatment facility and understands the importance of building rapport with these youth as well as the struggle some of these youth may have with trusting another adult that is asking to be a part of their lives. With these experiences the researcher was able to work well with the youth during these interventions on an individual basis.

The single subject design took place in three different phases: baseline, intervention, and return to baseline phases (See Appendix F). The baseline phase took place over the course of at least three days including three testing sessions or until stability of their data on the study’s measures occurred. Participant 1 did not reach stability until after five testing sessions occurred while Participant 2 achieved stability after four testing sessions. Participant 4 was able to reach stability after the first three testing sessions which is the minimum recommended by researchers (Kazdin, 2011). The participants completed the LSTS and OMSAT during the baseline phase in order to obtain the participant’s knowledge of life skills and mental skills prior to the intervention beginning. Having this phase at the beginning of the study allowed the researcher to develop rapport with the participants. While working with each one individually, the researcher was able to explain the study, assist the participants with any words or confusing questions from the surveys, and get to know the participants and some of their hobbies. Following this baseline phase, the twelve-day intervention phase began. The students participated in three sessions a week that included the intervention of either a SUPER module or mental skills training as well as participated in certain skills associated with basketball. The participants continued to be assessed four to five times a week.
The SUPER program is designed around implementing life skills into a sport setting for youth to understand the benefits of playing sports as well as how they can transfer those skills to other settings such as home or school (Danish, 2002). While the program is not being implemented with an existing sport team, the structure provided by the program’s module allows it to be applied to other areas while working with youth such as physical education classes. While there are a total of 18 modules in the original SUPER program, the present project only used six of them. The SUPER program has been used in an abbreviated timeline previously (Papacharisis et al., 2005). The six that were included involve skills that are malleable by at-risk youth such as goal setting, managing emotions, relaxation, confidence, and asking for help from others when needed. In addition to those six modules, this project included mental training interventions (i.e., concentration and mental preparation) that are not included in a SUPER module but could benefit at-risk youth in academic or professional settings or prepare them for a difficult situation that may be approaching such as a confrontation with a guardian (Moody, Childs, & Sepples, 2003). After the twelve-day intervention, the participants again responded to the LSTS and OMSAT at least three times on the final days of the project in order to obtain return to baseline information. Participant 4 was only available for two days for return to baseline testing due to the school’s holiday schedule. The following subsections describe each day’s intervention schedule in detail (see Appendix E for specific modules).

**Day 1.** The SUPER module “Setting Goals-Part 1” was used. The module begins by describing goals as dreams that the children may have. Then, the researcher led the participants in discussions about how to make their goals reachable and the importance of stating goals positively. Goal setting was taught using conditioning drills commonly used in basketball. The experimenter asked them to relate that to running 40-yard sprints. The participants were able to
set short-term goals for this particular session regarding the sprints as well as what they would like their times to be at the next intervention. Aside from specific basketball goals, they set goals pertaining to their school work or extra-curricular activities.

**Day 3.** The SUPER module “Setting Goals-Part 2” was used. For the second intervention, the students again discussed goal setting. However, they learned the difference between goals that are in their control as opposed to the ones that are not in their control. Also, they planned for any obstacles they may experience while trying to achieve their goals, whether they are related to the basketball skills they learn or to the different environments they are in. They again practiced the conditioning drills and discussed if they had made any progress in the goals they set during the previous intervention.

**Day 4.** The SUPER module “Confidence and Courage” was used. Having confidence and courage was taught using dribbling skills. Participants seemed to understand the importance of believing in themselves and how to develop more self-confidence as well as identify the strengths they already possess. The experimenter then applied this to dribbling skills where they dribbled with one hand for 50 feet then came back dribbling with the other hand. After doing this drill several times, the participants re-evaluated their confidence levels and if they believed they possess more skills than they had previously believed. Then, they were asked to begin dribbling between their legs. The experimenter emphasized the importance of believing in oneself in order to complete this skill and to continue using the strengths that they possess. After completing these drills, the experimenter led a discussion about the importance of having confidence in everything the students do in their daily lives. They also evaluated the strengths they believe they have that they use everyday while interacting with others or trying to achieve a goal that they set the previous week.
**Day 5.** The SUPER module “Seeking Help from Others” was used. The participants learned passing drills while focusing on how to seek help from others. Participants learned the importance of seeking help from others while working on goals, and they identified people in their lives that could assist them in achieving the goals they set in the first week of the study. The passing drills included each participant learning how to do bounce passes, chest passes, and overhead passes. While working on the passes, the participants were also asked to focus on recognizing signs that the person is ready to receive the pass. Participants then discussed how they had to rely on someone else to make a successful pass instead of trying to do everything on their own. The discussion then turned to how seeking help from others can help them to be successful rather than the youth feeling alone trying to pursue their goals.

**Day 7.** The SUPER module “Managing Emotions” was used. Managing emotions was implemented into a session that included basketball shooting drills while receiving negative feedback. To begin this session, the experimenter discussed how to manage their emotions using the 4 R’s (replay, relax, redo, ready). The participants were taught the importance of controlling their perception of events that happen to them rather than focusing on the event itself that may not be controlled by the individual youth. The participants then began various shooting drills. Once the participants had warmed up, they began decreasing the time between each shot as well as listened to the experimenter criticizing their shot. This was designed to create a stressful environment in which the youth may want to respond angrily or in a sad manner. The experimenter assisted the participants in managing their emotions and how to accept feedback from others. After completing the basketball segment of the session, the participants discussed how they will be able to apply their emotion management skills to their daily lives while dealing with people they may not be fond of. At the conclusion of this session, the participants were
debriefed as to why they received negative feedback and told that the feedback was not truthful. The participants did not leave the session until they told the experimenter that they understood why the criticism was included in the session and that it did not include true statements.

**Day 8.** The SUPER module “Relaxation” was used. The participants learned how to relax while shooting free throws. The participants learned the importance of reducing tension. This session began with the participants shooting free throws. Then, they participated in some deep breathing, so they could focus on being in the present rather than other things they may have been experiencing. After deep breathing, the experimenter led them through a brief Progressive Muscle Relaxation exercise where they learned how to tense then relax different muscle groups. Then, they were asked to shoot free throws again using the relaxation techniques they just learned and take note of the difference in their shooting ability. Lastly, they discussed the importance of relaxation in their daily lives and provided some examples where they can use these techniques to benefit them.

**Day 10.** During this session, the participants learned how to concentrate and focus on personal performance using basketball stations. The different stations included dribbling, shooting, jumping rope, and doing defensive slides. The participants did each station for 30 seconds before transitioning to the next. The students were told to concentrate on each station and what they were doing. Once the cycle of stations had been completed, the experimenter discussed with the participants their personal performances at each station and how they were able to concentrate on their physical abilities at each one.

**Day 12.** The last session focused on mental preparation. The experimenter began the session by explaining to the participants what mental imagery was. Then, the experimenter led the participants through a brief mental imagery script that detailed the students making the
winning shot in a basketball game. After the students completed the script, the students were then asked to act as if they are going to live what the imagery script detailed including shooting the basketball while the experimenter counted down the time. The experimenter led them in a discussion about how visualization can help them be successful in achieving their goals. The participants then related these mental skills to the goals they set during the first week of the interventions. During this discussion, the experimenter assisted them in understanding how these mental skills can be used to achieve different goals they had set for themselves that do not have to relate specifically to sports.

The participants were also assessed on days when there was not an intervention. On days 2, 6, 9, and 11, the participants were only given the assessments and did not perform any basketball skills or learn a new mental skill or life skill.

**Data Analysis**

To assess the effectiveness of the intervention, data was graphically represented for each individual across the baseline, intervention, and return-to-baseline phases. Visual inspection was used to review graphs by a group of trained researchers to determine actual changes in mental skills abilities as well as knowledge of transferable life skills. Researchers observed changes in magnitude that included changes in mean and changes in level. Rate of change was also analyzed including changes in trend and latency in change. Changes in mean refer to the shifts in mean rate of performance while changes in level refer to the shift in performance from the end of one phase to the beginning of the next. The tendency for data to show increases or decreases over time was represented by changes in trend. Latency of change refers to how quickly a change occurs after the end of a phase.
In addition to visual inspection, the researchers of the present study also used the $d$ index as suggested by Glass, McGaw, and Smith (1981) and was also useful in single subject designs when the data did not show trends. The $d$ index was used to describe the magnitude of treatment effects. Also, single subject designs may not change the trend or level of behavior but rather an increase or decrease in the stability of the behavior. An effect size to indicate the magnitude of such a treatment effect was computed (Kromrey & Foster-Johnson, 1996).
Managing Emotions

Participants 1 and 2 demonstrated an increasing trend on the managing emotions subscale throughout the study. For Participant 1, the mean increased from baseline to intervention and was maintained in the return to baseline phase ($M_{Base}=3.24; M_{INT}=3.70; M_{RtoB}=4.07$). The mean shift demonstrated a medium effect size between the baseline and intervention phases ($d=.50$). Participant 1 experienced greater variance during the baseline phase when compared to the intervention phase with a large effect size ($f^2=.45$). In regards to latency, there was a small delay after one session in the intervention phase. For Participant 2, the mean also increased from baseline to intervention and was maintained in the return to baseline phase ($M_{Base}=4.42; M_{INT}=4.97; M_{RtoB}=5.00$). There was a large mean shift observed between the baseline and intervention phases ($d=.92$). Additionally, Participant 2 experienced a large change in variability with the greater variance occurring during the baseline phase when compared to the intervention phase ($f^2=34.69$). Participant 2 showed no latency with an immediate slight increase at the beginning of the intervention phase. Participant 4 experienced a decreasing trend throughout the study. The mean decreased from the baseline to intervention phase and maintained in the return to baseline phase ($M_{Base}=3.33; M_{INT}=3.07; M_{RtoB}=2.83$) with a concurrent large mean shift ($d=-.90$). However, Participant 4 experienced a large change in variability with the greater variance being observed during the baseline phase when compared to the intervention phase ($f^2=.40$). The latency of change was relatively short with an immediate decrease on the first session of the intervention phase (See Figure 1).

Goal Setting
Participants 1 and 2 evidenced an increasing trend on the goal setting subscale throughout the study. For Participant 1, the mean again increased from baseline to intervention and was maintained in the return to baseline phase ($M_{Base}=3.83; M_{INT}=4.28; M_{RtoB}=4.61$). The mean shift between the baseline and intervention phases was small in regards to effect size ($d=.44$). Participant 1 experienced a large change in variability with the greater variance occurring during the baseline phase when compared to the intervention phase ($f^2=8.31$). It should be noted that Participant 1 scored a significantly lower score on day two of baseline testing decreasing his mean of the baseline phase as well as showing greater instability during that phase when compared to the intervention phase. Visual inspection suggests that days 3, 4, and 5 of baseline testing were associated with stability that is also seen throughout the intervention phase. There was no latency evident. Participant 2 also experienced an increase in mean between the baseline and intervention phase and again in the return to baseline phase ($M_{Base}=4.88; M_{INT}=4.99; M_{RtoB}=5.00$). These changes were associated with a medium mean shift between the baseline and intervention phases ($d=.69$). Participant 2 experienced a large change in variability with the greater variance being observed in the baseline phase when compared to the intervention phase ($f^2=2.81$). There was no latency evident. Participant 4 experienced an increase in level between the baseline and intervention phases with the greatest mean occurring in the intervention phase when compared to the baseline and return to baseline phases ($M_{Base}=2.94; M_{INT}=3.04; M_{RtoB}=2.92$). However, there was only a small mean shift between the baseline and intervention phases ($d=.40$). Additionally, there was a large change in variance, but the greater variance occurred during the intervention phase when compared to the baseline phase ($f^2=1.59$). In regards to latency, there was an immediate increase in score on the goal setting subscale at the beginning of the intervention phase (See Figure 2).
Seeking Help from Others

Participants 1 and 2 demonstrated an increasing trend on the seeking help from others subscale throughout the study. For Participant 1, the means increased from baseline to intervention and was maintained in the return to baseline phase \(M_{\text{Base}}=4.12; M_{\text{INT}}=4.42; M_{\text{RtoB}}=4.64\). There was a large mean shift observed between the baseline and intervention phases \((d=.83)\). Participant 1 experienced a large change in variability with the greater variance occurring in the baseline phase when compared to the intervention phase \((f^2 = .61)\). There was a slight delay in latency with an increase on the fourth day of the intervention. Participant 2 also experienced a mean increase from baseline to intervention that was maintained in the return to baseline phase \(M_{\text{Base}}=4.70; M_{\text{INT}}=4.97; M_{\text{RtoB}}=5.00\). There was a large mean shift observed between the baseline and intervention phases \((d=1.04)\). Participant 2 observed a large change in variability with the greater variance occurring in the baseline phase when compared to the intervention phase \((f^2 = 4.40)\). There was no evident latency of change. Participant 4 experienced a decreasing trend throughout the study with the means decreasing between the baseline and intervention phases and then again in the return to baseline phase \(M_{\text{Base}}=3.33; M_{\text{INT}}=3.08; M_{\text{RtoB}}=2.50\). There was a large mean shift between the baseline and intervention phases \((d=-2.08)\). Participant 4 experienced a large change in variability, but the greater variance occurred during the intervention phase when compared to the baseline phase \((f^2 = 4.40)\). Regarding latency, there was an immediate decrease at the beginning of the intervention phase (See Figure 3).

Confidence

Participants 1 and 2 evidenced an increasing trend on the confidence subscale throughout the study. Participant 1 experienced an increase in mean from baseline to intervention and then
again in the return to baseline phase \((M_{\text{Base}}=5.91; M_{\text{INT}}=6.40; M_{\text{RtoB}}=6.49)\). There was a large mean shift between the baseline and intervention phases \((d=1.17)\). It should be noted that visual inspection of the participant’s scores revealed similar scores on the last two days of baseline testing to the intervention assessments suggesting stability was maintained throughout, and there was no latency of change. Participant 1 demonstrated a large change in variability with the greater variance occurring during the baseline phase when compared to the intervention phase \((f^2 =2.12)\). For Participant 2, the means also increased from baseline to intervention and again in the return to baseline phase \((M_{\text{Base}}=6.00; M_{\text{INT}}=6.13; M_{\text{RtoB}}=6.14)\). The mean shift between the baseline and intervention phases was small \((d=.45)\). It should be noted that the last three testing sessions during the baseline phase were similar to that of the assessments recorded during the intervention phase; as such, there was no latency of change appreciated between the baseline and intervention phase. Participant 2 observed a large change in variability with the greater variance occurring during the baseline phase \((f^2 =7.50)\). Participant 4 experienced a decreasing trend with the means decreasing between the baseline and intervention phase and then again in the return to baseline phase \((M_{\text{Base}}=4.36; M_{\text{INT}}=4.08; M_{\text{RtoB}}=3.93)\). There was a large mean shift between the baseline and intervention phases with this decline \((d=-1.47)\). Visual inspection of the participant’s scores suggested an increasing trend starting at the end of the baseline phase and occurring at the beginning of the intervention, but then a decline beginning occurring after the second day of the intervention. Participant 4 experienced a large change in variability, but the greater variance was observed during the intervention phase when compared to the baseline phase \((f^2 =1.10)\) (See Figure 4).

**Relaxation**
Participant 1 experienced a decrease in level between the baseline and intervention phases and then an increase in level during the return to baseline phase ($M_{\text{Base}}=3.10; M_{\text{INT}}=2.42; M_{\text{RtoB}}=2.94$). The mean shift observed between the baseline and intervention phases was small ($d=-.31$). It should be noted that visual inspection of the participant’s scores revealed that the mean during the baseline phase may have been larger due to the second testing session having a much higher score than any other testing session throughout the entirety of the study representing a possible outlier. Participant 1 experienced a large change in variability with the greater variance occurring in the baseline phase when compared to the intervention phase ($f^2 =1.22$). In regards to latency of change, there was an immediate increase in scores at the beginning of the intervention phase, but this increase was not maintained. Participant 2 experienced an increasing trend throughout the study with the mean increasing between the intervention and baseline phases and was maintained in the return to baseline phase ($M_{\text{Base}}=6.38; M_{\text{INT}}=6.99; M_{\text{RtoB}}=7.00$). There was a moderate mean shift between the baseline and intervention phases ($d=.74$). The baseline phase appeared to reach stability despite what was likely an outlier on the first day of testing. There was a large change in variability with the greater variance occurring during the baseline phase when compared to the intervention phase ($f^2 =62.81$). Participant 2 experienced a consistent score of 7 during the return to baseline phase which was the highest that one could score on the relaxation subscale. This also lead to the participant experiencing a higher mean during the return to baseline phase when compared to the intervention phase ($M_{\text{INT}}=6.99; M_{\text{RtoB}}=7.00$). There was no latency of change. Participant 4 experienced a decreasing trend throughout the study with the mean decreasing between the baseline and intervention phases and again in the return to baseline phase ($M_{\text{Base}}=4.39; M_{\text{INT}}=4.03; M_{\text{RtoB}}=3.67$). There was a large mean shift between the baseline and intervention phases ($d=-1.03$). There was a medium change
in variability observed with the greater variance occurring in the baseline phase when compared to the intervention phase ($f^2 = .15$). In regards to the latency of change, there was an immediate decrease at the beginning of the intervention phase (See Figure 5).

**Focusing**

The focusing subscale was reverse-scored. Visual inspection revealed that Participant 1 experienced unstable scores throughout the study on the focusing subscale. However, there was an increasing trend throughout the study. The mean increased between the baseline and intervention phases and was maintained in the return to baseline phase ($M_{Base}=2.91; M_{INT}=5.06; M_{RtoB}=6.38$). There was a large mean shift between the baseline and intervention phases ($d=1.63$), but the variance was greater during the intervention phase when compared to the baseline phase ($f^2 = .88$). Visual inspection of the subscale graph for Participant 1 suggests there may have been other factors that were associated with his ability to focus due to the large variance across the entirety of the study. There was an immediate increase in score at the beginning of the intervention regarding latency of change; however, the change was not maintained in the intervention phase. Participant 2 experienced a change in level with a decrease in mean during the intervention phase and then an increase during the return to baseline phase ($M_{Base}=2.89; M_{INT}=1.93; M_{RtoB}=2.43$). The mean shift observed a medium effect size between the baseline and intervention phases ($d=-.51$). The participant also experienced larger variance during the baseline phase when compared to the intervention phase ($f^2 =11.12$). There was no latency of change. Participant 4 experienced a decreasing trend throughout the study. The mean decreased between the baseline and intervention phases and was maintained in the return to baseline phase ($M_{Base}=4.05; M_{INT}=3.93; M_{RtoB}=3.73$). However, the mean shift demonstrated a small effect size between the baseline and intervention phases ($d=-.22$). The variance was larger
during the baseline phase when compared to the intervention phase with a small effect size ($f^2 = .30$). There was a short latency of change observed with the first decrease in scores being on the third day of the intervention (See Figure 6).

**Mental Practice**

Participants 1 and 2 demonstrated an increasing trend on the mental practice subscale throughout the study. For Participant 1, the mean increased from baseline to intervention and was maintained in the return to baseline phase ($M_{\text{Base}}=4.82$; $M_{\text{INT}}=5.63$; $M_{\text{RtoB}}=5.81$). The mean shift observed had a medium effect size ($d=.60$). There was greater variance observed in the baseline phase when compared to the intervention phase ($f^2=1.56$), and visual inspection revealed even greater stability at the end of the intervention phase and into the return to baseline phase. In regards to latency of change, an increase did not occur until the third day of the intervention phase. For Participant 2, the mean also increased from baseline to intervention and was maintained in the return to baseline phase ($M_{\text{Base}}=6.53$; $M_{\text{INT}}=7.00$; $M_{\text{RtoB}}=7.00$). The mean shift observed between the baseline and intervention phases was medium in effect ($d=.59$). While there was a larger variance observed in the baseline phase when compared to the intervention phase, the effect size could not be calculated due to being unable to divide by zero which was the variance observed in the intervention phase. There was no evident latency of change. Participant 4 experienced a decreasing trend. There was a decrease in mean between the baseline and intervention phases and then an increase in the return to baseline phase ($M_{\text{Base}}=4.19$; $M_{\text{INT}}=3.90$; $M_{\text{RtoB}}=4.00$). There was a large effect size associated with the mean shift between the baseline and intervention phases ($d=-1.71$) indicating this decline as well. Participant 4 experienced the greatest variance in scores during the intervention phase when
compared to the baseline phase with a large effect size ($f^2 = 3.91$). In regards to latency, there was an immediate decrease in score at the beginning of the intervention phase (See Figure 7).
CHAPTER 5
DISCUSSION

The purpose of the present study was to examine the effectiveness of an abbreviated sport-based intervention that teaches mental skills and life skills to at-risk youth. The hypotheses in this investigation were twofold: (a) It was expected that the ability for at-risk youth to transfer life skills would increase after participating in this study; and (b) it was expected that the ability for at-risk youth to use mental skills would increase after participating in this study. According to the assessments used, the life skills in the present study included managing emotions, goal setting, and seeking help from others; mental skills included confidence, relaxation, focusing, and mental practice. Overall, results from the current study supported the effectiveness of this abbreviated sport-based intervention for at-risk youth. Participants 1 and 2 in particular supported both of the hypotheses on almost all of the subscales. Participant 4 evidenced some improvements within some of the life skills and mental skills.

In regards to the life skills targeted in the present study, two of the three participants increased in mean scores on the managing emotions subscale throughout the study, supporting hypothesis \( a \). With single subject ABA designs, researchers typically expect to observe a decrease in scores after the intervention has been removed. However, that was not the case for Participants 1 and 2 as their scores continued to increase into the return to baseline phase that may suggest the participants were able to retain the information about transferable life skills and mental skills. According to Byiers, Reichle, and Symons (2012), not all behaviors are reversible and therefore may not exhibit decreases after the intervention phase. On the goal setting subscale, all three of the participants demonstrated increases also supporting hypothesis \( a \). There may have been greater support for the goal setting subscale due to the researcher doing two
different intervention days with goal setting while every other skill was only placed into one intervention session. On the seeking help from others subscale, two of the three participants showed a similar pattern of increasing throughout the study further supporting hypothesis $a$.

Mental skills demonstrated similar trends for each of the participants as they had shown for the life skills subscales. Confidence increased throughout the study for Participants 1 and 2, supporting hypothesis $b$. For the relaxation subscale, one of the three participants experienced an increase which partially supports hypothesis $b$. Participant 1 had the lowest mean during the intervention phase; however, the mean for the baseline phase may have been the greatest due to the second testing session having a much higher score than any other testing session throughout the entirety of the study. While single subject designs do not suggest removing outliers, researchers suggest making a note about the changes the outliers can make in regards to the results of the study (Richards, Taylor, & Ramasamy, 2013). Two of the three participants experienced decreases on the focusing subscale providing support for hypothesis $b$ as well. On the mental practice subscale, two of the three participants experienced increases supporting hypothesis $b$.

According to Byiers, Reichle, and Symons (2012), studies that utilize single subject designs are said to provide moderate evidence if there is evidence of an effect, but the results include at least one demonstration of no effect. In considering the observed changes in behavior across participants in the various life and mental skills subscales in the present study, the ability for sports to teach valuable skills outside of the physical components of playing the sport is evident. However, Papacharisis and colleagues (3005) noted the limitations that sports alone have for teaching these skills and emphasized the importance of teaching life skills using sports rather than expecting them to be learned from simply participating in sports. The current study
added to the literature regarding these interventions. While the current study used a portion of an existing program, it further enhanced the program’s ability to be used in individual settings.

Some sport or physical activity-based interventions that have been implemented in group settings have experienced mixed results (Kelly, 2012; Lubans et al., 2012; Moreau et al., 2012). Group settings may have variable responses due to the settings of the interventions or other pressures such as ones from peers. The program being exposed to the participants individually was effective in teaching them necessary skills to become responsible members in society and may eliminate the uncontrollable factors of group settings.

While some studies have used surveys to analyze the relationship between health-risk behaviors of youth and physical activity (Dunn, 2014; Johnson et al., 2014), others have analyzed the effectiveness of specific interventions that use sport or physical activity (Kelly, 2012; Lubans, Plotnikoff, & Lubans, 2012; Moreau et al., 2012). However, these interventions were implemented in group settings. The current study utilized a single subject design to examine the effectiveness of teaching life skills through sport-based interventions within a service provision format for individuals. Working individually with the participants allowed the researcher to develop rapport with them. Brendto and Brokenleg (2012) suggest that at-risk youth struggle to develop new relationships due to their inability to trust others; however, researchers who are able to work individually with them are able to create a closer relationship to each individual when compared to an instructor leading a group of youth. The participants worked with the same researcher throughout the study and were able to discuss various topics with the researcher regarding how they were doing and how they were enjoying the study. Also, this allowed the researchers to analyze the scores by comparing them to previous scores by the same individual rather than comparing groups or individuals. While at-risk youth may be in the
same category, they have very different characteristics amongst them. Single subject designs allow these youth to progress at their own speed rather than be compared to someone else.

The current study utilized the SUPER program individually with the participants despite the program being originally designed to work with groups (Danish, 2002). The flexibility of the program allowed this to occur effectively because the researcher still had the ability to choose which activities would be beneficial for each lesson. For example, one of the goal setting modules stated that a student should aim at a target that relates to the sport and repeat the statement, “I will make it” to highlight the importance of stating a positive goal. The researcher had the ability to say the goal would be to make a shot and see how the student performs while saying the positive statement. The participants were still asked the same questions that groups have been asked previously using the SUPER program (Danish, 2002). The results of this study suggest that this particular program can be effective when used with individuals in addition to the studies that have previously shown its effectiveness in group settings (Danish, 2002; Papacharisis et al., 2005).

Another adaptation made for the current study was using the SUPER program in an abbreviated format. Papacharisis and colleagues (2005) have previously used SUPER in an eight week program, but the current study only worked with the participants for five weeks. While the participants in this study were accessible for the entirety of the five weeks at their school, other populations of at-risk youth may not be as accessible as the current study’s population. For example, Barth (1990) found that the population of foster children in his study had been to an average of three different foster homes not including group homes, residential facilities, and shelters. At-risk youth who are in the foster care system may not be in the same location for an extended amount of time emphasizing the importance of developing an abbreviated life skills
program for them. The current study was particularly successful in implementing an abbreviated life skills program for two of the participants.

**Limitations**

One of the limitations observed within the current study was the amount of assessments given to the participants. The participants were assessed at least four times a week during the study that may have led to burnout for the participants. The participants did speak with the researcher about the frustrating aspect of the study being that they had to respond to the questionnaires almost every day. While the researcher sat with each participant while he responded to the assessments, the participant could have simply been skimming the questions and responding based on memory rather than truthful answers. This may have been the case for Participant 2 who responded in a similar manner to each of the questionnaires during the intervention phase even though the current study assumed each participant responded to the questionnaires honestly every time they were taken. Another limitation of the current study is the lack of generalizable data. The current study only includes three participants who met the criteria but were still in school. It should be noted that while these results may not be able to generalize to a larger population, they may be transferable to other students and settings in order to provide a sport-based intervention for various populations. The characteristics of these three participants may not be the same as other at-risk youth. Lastly, a limitation to this intervention was the inability to adapt each module to the individual. While working with at-risk youth, each individual had his own individual needs that differ from another student. Participants 1 and 2 demonstrated more increases in the various subscales when compared to Participant 4. This may have been due to Participant 4’s lack of interest in basketball. An intervention that included an
activity that he enjoyed could further enhance the life skills and mental skills ability for Participant 4.

One of the other challenges with single subject designs is the inability to remove outliers from the data. It should be noted that Participants 1 and 2 experienced days of assessments where their scores were not within a consistent range as observed on other sessions of the study. For Participant 1, the second day of testing in the baseline phase appeared to show drastically different scores than any of the other assessments taken throughout the study. It is unknown what was occurring on day two for the participant that may have altered the scores on the assessments. Participant 2 experienced lower scores on most of the subscales on the first day of testing in the baseline phase. Visual inspection of the participant’s data suggested the participant’s scores may have been regressing to the mean and revealing the true scores that represent the mental skills and life skills abilities. These possible outliers were the reasoning behind more baseline testing days rather than the recommended three (Kazdin, 2011). Utilizing more testing sessions during the baseline phase allowed the participants’ scores to reach stability before beginning the intervention phase. These outliers influenced mean scores of the baseline phases for the participants which were also associated with changes in mean shift. Additionally, the outliers affected visual inspection when discussing possible trends that may have occurred during the course of the study. Outliers also influenced the variances in the baseline phases that were used to measure the effect sizes.

Future Directions

Future studies should continue examining the effectiveness of an abbreviated life skills program using single subject design. However, future studies should utilize fewer assessments per week to measure the success of the intervention. Additionally, future studies can begin
working with at-risk youth in other environments. Not all at-risk youth are able to remain in school. Additional research can examine ways to work with at-risk youth in group homes or residential treatment facilities and the effectiveness an intervention like this would have in those environments. Further, research should examine the effectiveness of sport-based interventions over longer periods of time. While the abbreviated intervention was effective, a study that utilizes a longer period of time and includes post-testing assessments in order to assess the youth’s abilities to retain the life skills and mental skills learned in the intervention may further describe the effectiveness of sport-based interventions. Life skills interventions need to be designed to have lasting impact on the youth who participate in them rather than the students being able to retain the information only for a short period of time. These sessions and interventions could be implemented into physical education classes or sport team practices to reach more youth beyond the at-risk youth population. Life skills and mental skills included in the current study can be related to many aspects of a person’s life to help them become a successful and responsible member of society. Lastly, future studies could implement a mood questionnaire that may help assess the outliers observed in the study. The mood questionnaire could be a simple assessment that could determine how the day is going for that individual. If the participant was not having a good day, the researcher may be able to explain some of the outliers observed.
REFERENCES


Danish, S. & Nellen, V. (1997) New roles for sport psychologists: Teaching life skills through sport to at-risk youth. *Quest, 49*, 100-113


APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

Dear Parent or Guardian,

This form is to gather information about your child participating in the project that is examining the effectiveness of a sport-based intervention on teaching life skills and mental skills for youth. This information will help us assess how well the program works. The “participant” mentioned below is your child.

Participant Gender: (Please circle)  Male  Female

Participant Age: _______________  Participant GPA: _______________

Participant Grade in School: _______________

Race of Participant: (Please circle)

Caucasian

African-American

Asian

Native American

Pacific Islander

Other (Please specify): _______________

Ethnicity:

Hispanic/Latino

Non-Hispanic/Non-Latino

Is the participant involved in any extra-curricular activities? (Circle all that apply)

Sports

Job

After school program (i.e., Boys & Girls Club)

Religious groups (i.e., youth group)

Boy/Girl Scouts
Other (Please specify): ______________________

Please circle which one applies to the household income:

- < $23,050
- $23,050-$32,500
- $32,500-$60,000
- $60,000-$100,000
- $100,000-$250,000
- $250,000+

Who lives in the primary household with your child? (example: mom, grandmother, step father)

Is your child a teen parent? (Please circle)
- Yes
- No

Has your child previously been removed from another school because of behavior or academic difficulties prior to Charter?
(Please circle)
- Yes
- No

Has your child ever engaged in alcohol or substance use? (Please circle)
- Yes
- No

Has your child ever been exposed to an emotionally or physically abusive environment?
(Please circle)
- Yes
- No

Has your child ever received or is currently receiving mental health services? (i.e., for depression, anxiety, etc.)
(Please Circle)
- Yes
- No
APPENDIX B

2014 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you where it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has your doctor ever said that you have a heart condition ☐ OR high blood pressure ☐?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? Please list condition(s) here:_________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Are you currently taking prescribed medications for a chronic medical condition? Please list condition(s) and medication(s) here:_________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Do you currently have (or have you had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past, but it does not limit your current activity to be physically active. Please list condition(s) here:_________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Has your doctor ever said that you should only do medically supervised physical activity?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answered NO to all of the questions above, you are cleared for physical activity. Go to Page 5 to sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2, 3, and 4.

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:
- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant – talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
• Your health changes – answer the questions on Page 2, 3, and 4 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.
1. **Do you have Arthritis, Osteoporosis, or Back Problems?**
   If the above condition(s) is/are present, answer questions 1a-1x If NO ☐ go to question 2
   
   1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)  
      YES ☐ NO ☐
   1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?  
      YES ☐ NO ☐
   1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months?  
      YES ☐ NO ☐

2. **Do you have Cancer of any kind?**
   If the above condition(s) is/are present, answer questions 2a-2b If NO ☐ go to question 3
   
   2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck?  
      YES ☐ NO ☐
   2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?  
      YES ☐ NO ☐

3. **Do you have a Heart or Cardiovascular Condition?** *This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm*
   If the above condition(s) is/are present, answer questions 3a-3d If NO ☐ go to question 4
   
   3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)  
      YES ☐ NO ☐
   3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)  
      YES ☐ NO ☐
   3c. Do you have chronic heart failure?  
      YES ☐ NO ☐
   3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?  
      YES ☐ NO ☐

4. **Do you have High Blood Pressure?**
   If the above condition(s) is/are present, answer questions 4a-4b If NO ☐ go to question 5
   
   4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)  
      YES ☐ NO ☐
   4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer YES if you do not know your resting blood pressure)  
      YES ☐ NO ☐

5. **Do you have any Metabolic Conditions?** *This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes*
   If the above condition(s) is/are present, answer questions 5a-5e If NO ☐ go to question 6
5a. Do you often have difficulty controlling your blood sugar levels with food, medications, or other physician-prescribed therapies?  
| YES ☐ | NO ☐ |

5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.  
| YES ☐ | NO ☐ |

5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, OR the sensation in your toes and feet?  
| YES ☐ | NO ☐ |

5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems?)  
| YES ☐ | NO ☐ |

5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?  
| YES ☐ | NO ☐ |

6. **Do you have any Mental Health Problems or Learning Difficulties?**  
*This includes Alzheimer’s, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome*

If the above condition(s) is/are present, answer questions 6a-6b  
If NO ☐ go to question 7

6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)  
| YES ☐ | NO ☐ |

6b. Do you ALSO have back problems affecting nerves or muscles?  
| YES ☐ | NO ☐ |

7. **Do you have a Respiratory Disease?**  
*This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 7a-7d  
If NO ☐ go to question 8

7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)  
| YES ☐ | NO ☐ |

7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?  
| YES ☐ | NO ☐ |

7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, labored breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?  
| YES ☐ | NO ☐ |

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?  
| YES ☐ | NO ☐ |

8. **Do you have a Spinal Cord Injury?**  
*This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c  
If NO ☐ go to question 9

8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)  
| YES ☐ | NO ☐ |

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?  
| YES ☐ | NO ☐ |
8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?

| ☐ YES | ☐ NO |

9. **Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event**

If the above condition(s) is/are present, answer questions 9a-9c

If NO ☐ go to question 10

9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments?)

| ☐ YES | ☐ NO |

9b. Do you have any impairment in walking or mobility?

| ☐ YES | ☐ NO |

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?

| ☐ YES | ☐ NO |

10. **Do you have any other medical condition not listed above or do you have two or more medical conditions?**

If the above condition(s) is/are present, answer questions 10a-10c

If NO ☐ read the Page 5 recommendations

10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?

| ☐ YES | ☐ NO |

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?

| ☐ YES | ☐ NO |

10c. Do you currently live with two or more medical conditions?

| ☐ YES | ☐ NO |

**Please list your medical condition(s) and any related medications here:________________________________________________________________________  _______________________________________________________________________________**

GO TO PAGE 5 TO SIGN THE PARTICIPANT DECLARATION.
PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

_I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire, I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes._

NAME_________________________________________ DATE________________________

SIGNATURE____________________________________ WITNESS_____________________

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER________________________________
APPENDIX C

OTTAWA MENTAL SKILLS ASSESSMENT TOOL

Think of the most recent performances in your sport while responding to the questionnaire.

<table>
<thead>
<tr>
<th><strong>Belief/Confidence:</strong> Believing in yourself is synonymous with being confident that you can accomplish your goals and overcome difficult situations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strongly Disagree</strong></td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>1. I believe that I am a mentally tough competitor.</td>
</tr>
<tr>
<td>2. I believe that I have the personal capacity to reach my goals.</td>
</tr>
<tr>
<td>3. I believe that I can succeed in my chosen activity in spite of any obstacles I encounter.</td>
</tr>
<tr>
<td>4. There have been times when I was jealous of my opponents’ success/great performances.</td>
</tr>
<tr>
<td>5. I am confident in most aspects of my performance.</td>
</tr>
<tr>
<td>6. I act confidently even in difficult sport situations.</td>
</tr>
<tr>
<td>7. After a poor performance, I still believe in myself.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Relaxation:</strong> Relaxation is a skill that can allow you to free your muscles of tension, lower your heart rate and control your focus of attention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strongly Disagree</strong></td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>8. I find it easy to relax.</td>
</tr>
<tr>
<td>9. I find it easy to relax quickly.</td>
</tr>
</tbody>
</table>
10. I can consciously decrease the tension in my muscles.  
11. I can relax effectively during appropriate moments in a competition.  
12. I often practice relaxation techniques.  
13. I use relaxation to calm my mind.  

**Focusing:** Focusing or “concentrating” is the ability to direct and maintain attention on what is required to perform

<table>
<thead>
<tr>
<th>14. I lose my focus during daily training.</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Don’t Agree/Don’t Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. I lose my focus during daily training.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>15. I lose my focus during important competitions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>16. I find it difficult to concentrate in certain training situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>17. During critical situations in competition, my thoughts become a blur.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>18. When fatigued, I find it difficult to focus.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>19. No matter who I’m talking to, I am always a good listener.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>20. I have difficulty finding effective strategies that will help me remain focused during competition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

**Mental Practice:** Mental practice involves setting aside time and space to rehearse a performance or segments of a performance in your mind

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Don’t Agree/Don’t Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. I have difficulty finding effective strategies that will help me remain focused during competition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>----</td>
</tr>
<tr>
<td>21.</td>
<td>I mentally practice my sport on a daily basis.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22.</td>
<td>I mentally practice my sport with maximum performance in mind.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23.</td>
<td>I mentally practice for critical situations in competition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24.</td>
<td>I can easily mentally practice an entire skill.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25.</td>
<td>I can mentally practice my performance wherever I am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26.</td>
<td>My mental practice is planned (i.e., it’s at a specific time each day, or I know in advance what I will rehearse and for how long).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27.</td>
<td>In training, I put myself into situations which could occur in competition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28.</td>
<td>In training, I like to create high levels of stress similar to competition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29.</td>
<td>I like to create situations in training in which I have to come from behind to win.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
APPENDIX D

LIFE SKILLS TRANSFER SURVEY

*Because of participating in the life skills program...*

<table>
<thead>
<tr>
<th></th>
<th>Really not true for me</th>
<th>Not true for me</th>
<th>Sort of true for me</th>
<th>True for me</th>
<th>Really true for me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I calm myself down after receiving a bad grade.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>After I receive a poor test grade, I take a deep breath to stop from getting angry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>I take a deep breath to calm myself after I receive a bad test grade.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>I stay positive when I am frustrated with my homework.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I have a positive attitude when faced with a challenge at school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>In school, I think positively even if I am having trouble learning.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>I am patient and keep trying when I am learning a difficult subject in school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>I keep trying when I am having difficulty with my schoolwork.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>When I get a bad grade, I try harder to improve next time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>I set goals to achieve my personal best in school subjects.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>I set goals to get better grades in school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>I outline the steps toward getting a better grade in school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>I set goals based on my own ability level in school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>I create a plan for getting better grades in school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td></td>
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<tr>
<td><strong>15.</strong> I set specific goals to improve my grades at school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Really not true for me</td>
<td>Not true for me</td>
<td>Sort of true for me</td>
<td>True for me</td>
<td>Really true for me</td>
</tr>
<tr>
<td><strong>16.</strong> I find good role models to help me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>17.</strong> I look for people who have good listening skills to help me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>18.</strong> I seek help from others who provide me with encouragement.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>19.</strong> I go to people who will help me solve a problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>20.</strong> I go to people who I can trust when I need help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
APPENDIX E
SUPER MODULES

SUPER
sports United to Promote Education and recreation

Leader Manual

Steven J. Danish
Life Skills Center
Virginia Commonwealth University
Contributions to various editions of this manual have been made by:

John P· Brunelle, Scott Green, A· Lisa Harmon, Christopher J· Hogan, Kathy Kendall, Al Petitpas, Linda Petlichkoff, Tanya E· Taylor, and Alice Westerberg.

SUPER

sports United to Promote Education and recreation
SUPER

Day 1

Setting Goals - Part 1
A goal is just a dream with a deadline.

-Lorraine Hale

PURPOSE
To share some of your dreams, experiences, and successes so that the participants understand how dreams can become goals. Teach the four steps to making goals reachable and internalize the first two steps (important to you and positive).

MATERIALS NEEDED
A target with an object appropriate to throw and hit the target with, SUPER Playbook and a pen or pencil.
KEY POINTS

- Participants will have memorized the four steps to making goals reachable (important to you, stated positively, specific, and under your control).
- Participants will have a working knowledge of the first two steps (important to you and positive).
Setting Goals – Part 1

SESSION TIME – Approx. 30 Minutes

I. TURNING DREAMS INTO GOALS (5 minutes)

Tell the group:

Dreams are what you want for yourself. You can have many different dreams. But if you want your dreams to come true, they require more than wishing. You must turn your dreams into goals. A goal is a dream that you work hard to reach.

Share one of your dreams with the group that you have turned into goal.

- Write at least one of your dreams and achievements below:

________________________________________________________________________

________________________________________________________________________

Sharing some of your dreams, experiences, and successes you will help the students understand how dreams can become goals.

Ask the group why goals are important and how they can help us. If they are having trouble thinking of ways, here are some tips.

- By giving them motivation.
- By helping them to make plans for the future.
- By giving them direction.
• By giving them a sense of success and pride in our accomplishments.

II. MAKING YOUR GOAL REACHABLE (5 Minutes)

The purpose of this set of activities is to show the group that the way they set their goals has a lot to do with whether they reach them.

Tell the group:

**There are four steps to making goals reachable. Goals must be:**

- Important to you
- Stated positively
- Specific
- Under your control

**Your goal must be IMPORTANT TO YOU**

**Trading a Dream** (10 minutes)

Have the group write a non-sport or non-activity dream that is important to them on a 3x5 card. Collect the cards, shuffle, and have them choose a new card without looking at it.

Give them a minute or so to think about the new dream on the card and ask them:

What is it like to have someone else's dream?

Do you think that this dream would be important to you?

Do you think that you would be willing to work as hard for the dream that was given to you, or do you think that you would work harder for the dream that you came up with on your own?
Ask them:

- If the goal were not important to anyone else (parents, coaches, friends), would it still be important to you?

Have the group write down in their Playbook a dream that they have that is important to them.

**Your Goal must be stated POSITIVELY**

**A. The Positive Game** (10 minutes)

The purpose of this activity is to demonstrate to the participant that energy follows attention. The participant will make a positive or negative statement to him or herself and then attempt to hit a target with an object specific to the sport or activity.

1. Set up a target specific to their sport or activity if a target does not exist in their sport pick a sport or activity with which the group is familiar.
2. Select two volunteers with different skill levels to participate in this activity, one at a time. Have the first volunteer stand a challenging distance from the target. NOTE: Choose a distance so that the average participant should be able to hit the target 50% of the time.
3. Tell the volunteer to repeat to him or herself, “I don’t want to miss” three to five times before attempting to hit the target. Have the volunteer make five attempts, each time repeating “I don’t want to miss” three to five times before attempting to hit the target. Count how many attempts hit the target.
4. Then have the same volunteer repeat to him or herself, “I will hit the target” three to five times before each attempt. NOTE: You may modify this statement so that it is a more sport specific positive statement. You may want to tell the individual to take a deep breath and relax before each attempt. Count how many attempts out of five hit the target.

Talk with the group about their reactions to what they just experienced. You may want to ask them the differences between:
• What they said for the first five attempts, and what they said for the next five attempts?
   (Emphasize that the statement for the first five attempts was more negative – it was telling them what they did not want to do rather than what they should do).

• How they felt when they took the first five shots compared to the next five shots?

   (Reinforce statements when they say that they felt more confident, more relaxed, and less nervous when they took the second five shots?). Then tell them:

   *When we state something positively, we create a picture in our mind of what it is we want to have happen, rather than something we don't want to have happen. Your body will listen to what you tell it to do.*

   Positively stated goals never have words like “cannot”, “not”, or “avoid” in them.

   Have the group rewrite their goal in their Playbook so that it is stated positively.

   Goals that are reachable are:

   • **Important to you**
   • **Stated Positively**

**IV. SUPER CIRCLE**

Have the group do **one** of the following activities:

**Option #1**

• Have the group members pick a **word of the day**!
Then have everyone stand-up in a circle and put their hands in the middle like they are about to do a cheer. Then on the count of three have them shout out the word of the day three times.

Option #2

- Ask one of the participants to read the quote for the day. After it has been read ask the group the following questions

The "What?" Question

What is it talking about?

The "So What?" Question

What does it mean to you?

How does it relate to what you learned today?

The "Now What?" question?

What might you share with others about what you have learned?

Thank the group for a good session and collect their Playbooks!
SUPER

Day 3

Setting Goals - Part 2

*If you aim at nothing you will hit it every time*

~Unknown
PURPOSE
Learn the four steps to making goals reachable and internalize the second two steps (specific and under your control).

MATERIALS NEEDED
Blind folds, 10 sheets of paper, a timed task that is specific to the participant’s skill level and environment and items needed for that task, a time keeper, 3x5 cards or similar sheets of paper, SUPER Playbook, and a pen or pencil.

KEY POINTS
- Participants will have memorized the four steps to making goals reachable (important to you, stated positively, specific, and under your control).
- Participants will have a working knowledge of the second two steps (specific and under your control).
SESSION TIME – Approx. 30 Minutes

I. REVIEW

Remember the first two characteristics of a reachable GOAL are:

- Important to you
- Stated Positively

II. TURNING DREAMS INTO GOALS continued

Your goal must be SPECIFIC

- If the goal is too general or not specific, you may have trouble knowing when you have reached it.

Blindfolded Relay Race (10 minutes)

This activity can be done in a large room or outside

1. Choose two pairs of volunteers who have not already participated in an activity.
2. Mark a beginning and ending line and develop two lanes, one for each pair.
3. Place 10 sheets of paper randomly along each lane. Make sure there is sufficient room in each lane for the sheets of paper to be randomly placed.
4. Blindfold one member of each pair.
5. Explain to the participants that the purpose of the game is to have the blindfolded person to go from the Start line to the Finish line as quickly as possible, making sure to step on each piece of paper in the lane in order. The partner is to direct the blindfolded participant to step on each piece of paper along the lane by giving directions that are as specific as possible. If any piece of paper is missed, the pair...
must return to the beginning and start again. **The partner cannot physically touch or guide the blindfolded participant.**

6. When they get to the Finish line, the partners should switch roles and return and repeat the activity from the finish line back to the start line. Again, each piece of paper must be stepped on in order. The winner is the pair that returns to the Start line first without missing any piece of paper.

When the race is over, ask the group what made it difficult or easy to guide (or be guided) through the race? (Emphasize that the more specific the directions, the easier it seemed for people to go through the race).

**Goals that are not specific enough often have words like “good,” “better,” “more,” and “less” in them.**

**Your goal must be UNDER YOUR CONTROL.**

Tell them:

*You can only reach goal you control. If the goal requires another person doing something, you cannot be sure the goal will be reached.*

**How Much of Your Performance Do You Control** (10 minutes)

1. Introduce a timed task that is specific to the participant’s skill level and environment. Something that the participant should be able to do successfully almost all the time.
2. Select two or three volunteers who have not already participated.
3. Have each participant state how well she or he will do at this task.
4. Have the volunteers perform this task individually, but add one unexpected distraction just as they are ready to start. Make the distraction different for each participant. For example, you could wave your hand in
the person’s face, yell or cheer, have them stand on one foot, tell a joke, have them try the skill blindfolded--anything to distract the participant

Have them:

1. Discuss whether their goal for the task was within their control.
2. Discuss what is in their control.
3. Discuss other kinds of things in their environment that they do not control.
4. Discuss what they do control.
5. Restate a goal that they control for the task

Tell them:

You can only reach goals that are a result from your actions; in other words, that are under your control. If the goal requires another person doing something, you cannot be sure the goal will be reached.

End this section by asking the group to repeat the four characteristics of a reachable goal.

III. SUPER CIRCLE

Have the group do one of the following activities:

Option #1

- Have the group members pick a word of the day!

Then have everyone stand-up in a circle and put their hands in the middle like they are about to do a cheer. Then on the count of three have them shout out the word of the day three times.

Option #2
• Ask one of the participants to read the quote for the day. After it has been read ask the group the following questions

The “What?” Question

What is it talking about?

The “So What?” Question

What does it mean to you?

How does it relate to what you learned today?

The “Now What?” question?

What might you share with others about what you have learned?

Thank the group for a good session and collect their Playbooks!
Confidence and Courage

Confidence demands a great deal of strength – a strong and determined will; It is marked by a sure and persistent belief in oneself and one’s true skill. Believe in your ability; Be determined to play your role; Allow nothing or no one to come between you and your reachable goal.

~ Sherman Curl
PURPOSE
To have the participants recognize what confidence is and how they can become a more confident person and believe in themselves.

MATERIALS
Super Playbook and a pen or pencil.

KEY POINTS
- Participants will understand the importance of believing in yourself.
- Participants will be able to identify how a confident person acts and feels.
- Participants will know the first steps to increase their level of self-confidence.
Confidence and Courage

SESSION TIME – Approx. 30 Minutes

Confidence is the belief that you can successfully do something.

Having confidence in yourself means believing in yourself

I. BELIEVING IN YOURSELF (5 minutes)

People who believe in themselves:

- Approach new situations positively
- Are not afraid to fail
- Learn from their mistakes
- Have realistic expectations
- Are not afraid to ask for help

II. INCREASING YOUR CONFIDENCE (5 minutes)

Ask the group: What can you do to gain confidence in the part of your game/life where you need it the most.

Actions you can take to increase your confidence:

- Set Goals
- Develop a practice schedule to practice skills you want to improve in
- Get feedback from coaches, friends and family
- Use people (coaches, teammates) who can do these skills better than you can as models
- Use the Four R’s – REPLAY, RELAX, REDO, READY
**Activity** (15 minutes)

Discuss with the group

1. Have everyone in the group think of a person or an animal that they think is courageous and confident.

2. Have everyone stand up. Once they are all standing, have everyone close their eyes and take a deep breath. Have them pretend that they are the courageous and confident person or animal they are thinking about.

3. Have them try to imagine how that person or animal feels like and how that person or animal might show that they are courageous and confident.

*Sometimes believing in yourself will make tough situations appear easier.*

*If you believe in yourself others will believe in you!!!*

**IV. SUPER CIRCLE**

Have the group do **one** of the following activities:

**Option #1**

- Have the group members pick a **word of the day**!

*Then have everyone stand-up in a circle and put their hands in the middle like they are about to do a cheer. Then on the count of three have them shout out the word of the day three times.*
Option #2

- Ask one of the participants to read the quote for the day. After it has been read ask the group the following questions

The "What?" Question

What is it talking about?

The “So What?” Question

What does it mean to you?

How does it relate to what you learned today?

The “Now What?” question?

What might you share with others about what you have learned?

Thank the group for a good session and collect their Playbooks!
SUPER

Day 5

Seeking Help from Others

No one is an island...

Every one is part of the world.

~Adapted from John Donne
PURPOSE
Have participants identify and select people with different support roles who can help them reach their goals.

MATERIALS NEEDED
SUPER Playbook and a pen or pencil.

KEY POINTS
- Participants will have an understanding of the two different types of social support.
- Participants will have identified 10 members for their Dream Team.
Seeking Help From Others

SESSION TIME – Approx. 30 Minutes

I. CIRCLE OF SUPPORT (10 minutes)

- Sometimes making good decisions involves getting help or support from others.
- This activity is an example of getting support from others.

To make it work, everyone in the circle needs to support everyone else. You need to make sure that the end product is a tight circle made up of people sitting on the knees of the person behind them with the person in front of them on their knees. As you do the activity, state each of the steps one at a time. Wait until the entire group has completed each step before proceeding to the next step.

To succeed in this activity requires teamwork. It is called Circle of Support.

Step 1: Everyone stand up and get into a large circle.

Step 2: Make sure that the tallest person is not next to the shortest person. (Have participants get rearranged).

Step 3: Hold hands with the two people next to you.

Step 4: Make sure the circle is perfectly round so adjust as needed.

Step 5: Take one regular step into the center.

Step 6: Make sure the circle is perfectly round again so adjust as needed.

Step 7: Now, take another step into the center.

Repeat 6 & 7 until everyone is standing shoulder to shoulder in a perfect circle.

Step 8: Let go of the hands of the people next to you.
Step 9: Everyone turn to your left, putting your right hip in toward the center.

Step 10: Look down at your feet. Move toward the center so that the toe of your right foot is almost touching the heel of the right foot of the person in front of you.

Step 11: Lightly place your hands on the shoulders of the person in front of you.

Step 12: At the count of three, slowly sit on the knees of the person behind you.

Step 13: Remember, if one of us falls, we ALL fall.

Step 14:1-2-3 Slowly sit down.

Keep trying until your group is successful.

Step 15: Let's see if we can hold this for five seconds and then slowly stand up. Count together. 1-2-3-4-5 Stand up!

II. GOAL KEEPERS AND GOAL BUSTERS (5 minutes)

Tell the group:

- There are people in our lives who can support us and help us achieve our goals. These people are called Goal Keepers. For example, a coach may help you by teaching you a new skill or your teammates may help you by cheering for you when you are playing or competing.

- There are also people who try to get in the way or prevent you from reaching your goals. These people are called Goal Busters. For example a Goal Buster might try and get you to stay out late the night before you have a big game or to use drugs or alcohol. Also a Goal Buster is any person who tells you that you won't reach your goal.

It is important that you choose Goal Keepers to help you reach your goal and to stay away from Goal Busters who will only get in the way of your success.

III. Creating a Dream Team (15 minutes)

Have the group:
• Create in their Playbook Dream Team of 10 types of individuals (parents, teachers, coaches, neighbors, etc.) who can help them reach their goals and dreams.
• Explain that there may be different Dream Team members but that there are important characteristics of a good Dream Team.

Tell the group that the characteristics are:
• They should be people you see often.
• They should be people who know your capabilities and your limitations.
• They should be people who are concerned about you.
• They should be people you can depend on.
• They should be people that you can help at another time.

Have them choose the members of their Dream Team and write them down. Tell them in addition to the characteristics above to:

• Include family members or others who provide love, support, and caring and will help you reach your dreams and goals when you face roadblocks.
• Include friends. They may be your best friends, people who you really trust, and/or people with whom you spend a lot of time.
• Include adults or other people who are older than you are and who help you and serve as good role models. They may be teachers, coaches, ministers, youth group leaders, and family friends.

When they have identified 10 Dream Team members have them:

• Put a star by Dream Team members who provide “caring help” such as listening and providing encouragement.
• Put a check by Dream Team members who provide “doing help” such as taking them places or helping with homework.

Explain to them:

• Some Dream Team members probably can help in both ways while others can provide only one type of help.
• They should make sure that their Dream Team can provide both kinds of help.

MY DREAM TEAM
Identify 10 team members. They can be family members, friends who you really trust, and/or adults or people older than you that help you and serve as good role models (e.g., such as teachers, coaches, ministers, youth group leaders)

- Put a star next to Dream Team members who give you “caring” help.
- Put a check next to Dream Team members who give you “doing” help.

1._______________________________________________________________

2._______________________________________________________________

3._______________________________________________________________

4._______________________________________________________________

5._______________________________________________________________

6._______________________________________________________________

7._______________________________________________________________

8._______________________________________________________________

9._______________________________________________________________

10._______________________________________________________________
IV. SUPER CIRCLE

Have the group do **one** of the following activities:

**Option #1**

- Have the group members pick a **word of the day!**

  *Then have everyone stand-up in a circle and put their hands in the middle like they are about to do a cheer. Then on the count of three have them shout out the word of the day three times.*

**Option #2**

- Ask one of the participants to read the quote for the day. After it has been read ask the group the following questions

  **The “What?” Question**

  What is it talking about?

  **The “So What?” Question**

  What does it mean to you?
  How does it relate to what you learned today?

  **The “Now What?” question?**

  What might you share with others about what you have learned?

Thank the group for a good session and collect their Playbooks!
Managing Emotions

When I was twelve, I behaved badly on court, swearing, cheating, throwing rackets – so my club suspended me for six months. When I came back I didn’t open my mouth…I felt that I played my best tennis being focused and concentrating.

~Bjorn Borg
PURPOSE
To emphasize to the participants the importance of playing smart and sharing your experiences of playing smart and learning how to play smart.

MATERIALS NEEDED
Super Playbook and a pen or pencil.

KEY POINTS
- Participants will have a working knowledge of what playing smart is and how they too can play smart and learn from their mistakes.
Managing Emotions

SESSION TIME – Approx. 30 Minutes

I. HOW TO PLAY SMART (5 minutes)

To play smart you need to learn how to control yourself

so you can be the best that you can be.

Have them think of ways we sometimes hurt our performance. Some examples are:

- Sometimes when we play badly, we put ourselves down.
- Sometimes we even call ourselves names.
- Often these are names we won’t let our friends, teachers or coaches call us!

Explain to the group:

There are times we get upset with ourselves (like when we play poorly). When this happens we sometimes blame other people. Blaming other for our mistakes isn’t helpful. Neither is calling yourself names. Instead, focus on what you did and how to correct it. This is where the 4 R’s help you to play smart.

II. FOUR STEPS TO PLAYING SMART (5 minutes)

1. REPLAY – know what happened and what you did

2. RELAX – Take a deep breath

4. **READY** – Keep the focus on what you need to do next.

   Discuss with the participants that these four steps can all be done within 5 seconds (e.g. in the middle of a game).

**III. HOW I PLAY IT SMART**

Think of a time when you made a mistake and became upset. Complete this worksheet before the session and share this experience with the group. Make sure that you use an example that can be done quickly.

**REPLAY**- Think about and write down what happened. Share with the group what happened.

**RELAX** - Write down three ways you can relax. Tell the group the three ways you thought of relaxing.
REDO - Write down what you are going to do next time and imagine yourself REDOING your plan. Share this with the group.

READY – Refocus and get back into the game. Share with the group how you would do this.

IV. HAVING EVERYONE PLAY IT SMART

Think of a scene or event that may occur in your sport or activity that may cause individuals to get upset. Here are some examples but make sure you use an example that is from your sport or activity.

- E.g. #1, You shoot the ball; it bangs against the backboard and player from the other team gets the rebound and passes to a teammate to start a fast break going the other way.

- E.g. #2, It is match point and your opponent serves you the ball. You hit the ball hard but it hits the top of the net and it falls back onto your side of the court.

- E.g. # 3, You are passed the ball as you are running towards the net. You kick the ball to score and it hits the goal post. A player on the other team gets the ball off the post and dribbles it down the field and the other team scores.
Have the group complete the following activity for the example you just described to them.

**REPLAY**
- Have the group imagine what just happened (the scene) and get one or two volunteers to describe it in their own words.

**RELAX**
- Have the group think of ways to relax when in this type of situation.

**REDO**
- Have the group discuss what they should do next in order to be ready for the next time. Then have them imagine themselves REDOING their plan.

**READY**
- Have the group imagine themselves getting refocused and back into the game.

**V. SUPER CIRCLE**

Have the group do **one** of the following activities:

**Option #1**
- Have the group members pick a **word of the day**!

*Then have everyone stand-up in a circle and put their hands in the middle like they are about to do a cheer. Then on the count of three have them shout out the word of the day three times.*

**Option #2**
• Ask one of the participants to read the quote for the day. After it has been read ask the group the following questions

The “**What**?” Question
   What is it talking about?

The “**So What**?” Question
   What does it mean to you?
   How does it relate to what you learned today?

The “**Now What**?” question?
   What might you share with others about what you have learned?

Thank the group for a good session and collect their Playbooks!
SUPER

Day 8

Relaxation

Successful people are able to rise above crisis by relaxing no matter what the external situation. Their belief in themselves protects them against shattering.

~ Adapted from Maxwell Maltz
PURPOSE
To identify and teach the importance of relaxation and the basic steps in relaxation. Participants will practice learning how to focus and breathe properly in order to be able to relax in stressful situations.

MATERIALS NEEDED
Super Playbook and a pen or pencil.

KEY POINTS
- Participants will have learned the importance of relaxation.
- Participants will have learned how to focus and breathe in order to help them relax when they are in a tense situation.
Relaxation

SESSION TIME – Approx. 30 Minutes

Tell the group:

Relaxation is a key skill for successful performance in and out of sports

I. IMPORTANCE OF RELAXATION (3 minutes)

Ask the group to think of times when it is important to be relaxed. Some examples are:

- Before competition
- Before a test
- Before learning a new skill
- After working hard at something
- When they are nervous

II. LEARNING HOW TO RELAX (8 minutes)

Ask everyone to think about what a bowl of cooked spaghetti is like. Tell them that when they are relaxed they might feel like a bowl of spaghetti.

Ask them to get into a comfortable position. Have them close their eyes and ask them to stay quiet. Once they are quiet ask them to imagine that they are like the bowl of spaghetti they were just thinking about.

Tell them that their shoulders should be relaxed and their arms relaxed at their sides and they feel like they could flop over like a piece of spaghetti.

Ask them:
• What does it feel like when they are a bowl of spaghetti?

III. LEARNING HOW TO BREATHE (5 minutes)

Ask everyone to get into a comfortable position again. Have them close their eyes. Tell them that they are going to take three deep breaths when you say go. Tell them that it is important that when they breathe in it should be slow and deep. They should feel it in their diaphragm (point out where their diaphragm is located). Have them take three deep breaths.

• Have them discuss what is feels like to be relaxed.

IV. USING RELAXATION IN SPORTS OR ACTIVITIES (10 minutes)

Tell the group:

Sometimes it is important to relax in the middle of playing a game or in the middle of a competition when there isn't much time. For example, you are still on the field, on the court or in a race.

Ask them for examples when this is true. Some examples may be:

• Right before a serve
• Taking a foul shot
• Right before a race (before getting into or onto the starting blocks)
• Right before a penalty kick or a corner kick

• One way to relax when there is not much time is to take three deep breaths like the ones we just practiced.
• While taking deep breaths it is also important to have something to focus on. For example you can focus on the ball, on the racket, or the field/court, or you can close your eyes and focus on something in your mind when taking the deep breaths.

Activity – Learning how to breathe and focus

1. Have everyone stand up.
2. Have each individual think of an object in their sport that they would like to focus on. Have them picture that object in their mind.
3. Give them time to focus on the object (approx. 30 seconds).
4. Then have everyone take three deep breaths like they practiced before.

Remind them that relaxation is an important part of performance in and out of sport.

V. SUPER CIRCLE

Have the group do one of the following activities:

Option #1

• Have the group members pick a word of the day!
Then have everyone stand-up in a circle and put their hands in the middle like they are about to do a cheer. Then on the count of three have them shout out the word of the day three times.

Option #2

- Ask one of the participants to read the quote for the day. After it has been read ask the group the following questions

The “What?” Question

What is it talking about?

The “So What?” Question

What does it mean to you?

How does it relate to what you learned today?

The “Now What?” question?

What might you share with others about what you have learned?

Thank the group for a good session and collect their Playbooks!
APPENDIX F

FIGURES

Figure 1. Participants’ scores on the managing emotions subscale. *Note.* The vertical blue lines depict change in phase between the baseline and intervention phase and again between the intervention and return to baseline phase. Horizontal red lines depict mean scores for that phase.
Figure 2. Participants’ scores on the goal setting subscale. *Note.* The vertical blue lines depict change in phase between the baseline and intervention phase and again between the intervention and return to baseline phase. Horizontal red lines depict mean scores for that phase.
Figure 3. Participants’ scores on the seeking help from others subscale. Note. The vertical blue lines depict change in phase between the baseline and intervention phase and again between the intervention and return to baseline phase. Horizontal red lines depict mean scores for that phase.
Figure 4. Participants’ scores on the confidence subscale. *Note.* The vertical blue lines depict change in phase between the baseline and intervention phase and again between the intervention and return to baseline phase. Horizontal red lines depict mean scores for that phase.
Figure 5. Participants’ scores on the relaxation subscale. *Note.* The vertical blue lines depict change in phase between the baseline and intervention phase and again between the intervention and return to baseline phase. Horizontal red lines depict mean scores for that phase.
Figure 6. Participants’ scores on the focusing subscale. Note. The vertical blue lines depict change in phase between the baseline and intervention phase and again between the intervention and return to baseline phase. Horizontal red lines depict mean scores for that phase.
Figure 7. Participants’ scores on the mental practice subscale. Note. The vertical blue lines depict change in phase between the baseline and intervention phase and again between the intervention and return to baseline phase. Horizontal red lines depict mean scores for that phase.
Table 1
Demographic Information

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<tr>
<th>ID</th>
<th>Age</th>
<th>Grade</th>
<th>Race</th>
<th>Ethn</th>
<th>Extra</th>
<th>SEC</th>
<th>Home</th>
<th>Parent</th>
<th>Remove/drop out</th>
<th>Subs</th>
<th>Abuse</th>
<th>Mental Health</th>
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<tr>
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<td>6</td>
<td>African-American</td>
<td>Non-Hisp</td>
<td>sports</td>
<td>low</td>
<td>Mom</td>
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<td>8</td>
<td>African-American</td>
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<tr>
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<td>Non-Hisp</td>
<td>Relig groups</td>
<td>mid</td>
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<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Note. ID= Participant ID; Ethn=Ethnicity; Extra=extra-curricular activities; SEC=socioeconomic status based on income level; Home=people who live in the household of participant; Parent=teen parent; remove/drop out=removed or previously dropped out from another school; Subs=history of substance abuse; Abuse=exposed to physically or emotionally abusive environment; Mental health=currently or previously received mental health treatments; Non-Hisp=Non-Hispanic ethnicity; Relig groups=religious groups; blank spaces on the table represent a lack of response on the demographic questionnaire.*
Table 2

Schedule for Module Implementation

<table>
<thead>
<tr>
<th>Day</th>
<th>Life Skill/Mental Skill</th>
<th>Basketball Skill</th>
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</thead>
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<tr>
<td>Before the study</td>
<td>Parents/guardians provided consent, participants provided assent, parents/guardians completed demographic questionnaire and PAR-Q+</td>
<td>Obtain baseline information</td>
</tr>
<tr>
<td>1</td>
<td>SUPER module: “Setting Goals-Part 1”</td>
<td>Conditioning</td>
</tr>
<tr>
<td>3</td>
<td>SUPER module: “Setting Goals-Part 2”</td>
<td>Conditioning</td>
</tr>
<tr>
<td>4</td>
<td>SUPER module: “Confidence and Courage”</td>
<td>Dribbling</td>
</tr>
<tr>
<td>5</td>
<td>SUPER module: “ Seeking Help from Others”</td>
<td>Passing</td>
</tr>
<tr>
<td>7</td>
<td>SUPER module: “Managing Emotions”</td>
<td>Shooting</td>
</tr>
<tr>
<td>8</td>
<td>SUPER module: “Relaxation”</td>
<td>Shooting free throws</td>
</tr>
<tr>
<td>10</td>
<td>Concentration and Focus</td>
<td>Stations: dribbling, shooting, jumping rope, defensive slides</td>
</tr>
<tr>
<td>12</td>
<td>Mental Preparation</td>
<td>Imagery script</td>
</tr>
<tr>
<td></td>
<td>Obtain return to baseline information</td>
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</tr>
</tbody>
</table>

*Note.* There were four days in the intervention phase that were used for testing only days and did not include a module.