WAYS TO BOLSTER RESILIENCE IN "HIGHER-RISK" CHILDREN AND ADOLESCENTS AND THEIR FAMILIES

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TOPICS TO BE DISCUSSED

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TO DO List and Website Resources

BIOGRAPHICAL SKETCH

Donald Meichenbaum, Ph. D, is Distinguished Professor Emeritus, from the University of Waterloo, Ontario from which he took early retirement 25 years ago. Since then he has been the Research Director of the Melissa Institute for Violence Prevention and the Treatment of Victims of Violence in Miami. (Please visit www.melssainstitute.org). Dr. Meichenbaum is one of the founders of Cognitive behavior therapy and in a survey of clinicians, he was voted "one of the ten most influential psychotherapists of the 20th century." He has received a Lifetime Achievement Award from the Clinical Division of the American Psychological Association. He was the Honorary President of the Canadian Psychological Association. He has presented in all of the Canadian Provinces, in all 50 U.S. states, and internationally. He has published extensively and has authored several books including Roadmap to resilience that he has made available as a website for FREE (Please visit roadmaptoresilience.wordpress.com). His most recent article " How to spot HYPE in the field of psychotherapy " was chosen the best article in the filed of psychotherapy. His latest book "Treating individuals with addiction disorders: A strengths-based workbook for patients and clinicians" is being published by Routledge Press.   He celebrated his 80th birthday publishing "The evolution of cognitive behavior therapy: A personal and professional journey with Don Meichenbaum" (Routledge Press).

As a therapist, I want to comment on how much I appreciate the ease of using the online version of your Roadmap to resilience book (roadmaptoresilience.wordpress.com).   It's so user friendly. I am able to go to the fitness areas and ask what area my patient might like to discuss. Equally, it is possible to go to the Appendices and take a look at the checklists or the topics and move forward from there. It is really brilliantly done. My client has said that he really likes working with Roadmap to Resilience and after having the opportunity to explore the online book in greater depth I'm certain I will use it with other clients.

It is a very generous gift for you to have shared your book in this way at this time. I thank you very much.

(NOTE: The FREE Roadmap to resilience website in the first month has had 15,000 visitors from 103 countries worldwide).

RESEARCH FINDINGS ON PTSD: SUMMARY OF DAY ONE

(Gleaned from <u>Handbook on PTSD Science and Practice</u>. Edited by M. Friedman, T. Keane and P. Resick, 2007. New York: Guilford Press; T.M. Keane, A.D. Marshall & C.T. Taft (2006, Posttraumatic stress disorder: Ethology, epidemiology, and treatment outcome. <u>Annual Review of Clinical Psychology</u>, <u>2</u>, 161-197. (Online http//clinpsy.annualreviews.org) and from D. Meichenbaum's <u>Clinical Handbook for Treating Adults with PTSD</u> - - available from dhmeich@aol.com**)**

<u>Epidemiological Findings</u>

-   PTSD is a universal reaction to severe stress.

-   PTSD has been found to occur across the life span

-   In the U.S., more than half (61% of men and 51% of women) report exposure to at least one traumatic event.

-   A significant subset of this population will experience multiple traumatic events.

-   While the exposure to traumatic events is exceedingly common, most individuals do not develop PTSD, nor other psychiatric disorders.

-   Only a fraction of North Americans (10%-20%) who experienced trauma will develop persistent PTSD. Chronic severe maladjustment following trauma is the exception, rather than the rule.

-   The lifetime prevalence rate of PTSD in North America is 7%-8%. A significant minority of victims fail to recover and continue to suffer from PTSD for many years.

-   At any specific period in time 1%-3% of the general population in the U.S. suffer PTSD (some 20,000 out of every 1 million), or approximately 8 million Americans have diagnosable PTSD.

-   For many people, PTSD is transient, but it fails to remit in approximately one-third of individuals who initially develop PTSD, even after many years.

-   The potential for the development of chronic PTSD is of particular concern when we learn that 15%-17% of Iraq and Afghanistan veterans are suffering from PTSD, which may be compounded by traumatic brain injuries. Approximately one half of male Vietnam veterans and one third of female Vietnam veterans who have had PTSD still have it today. These results are a warning sign for the need for immediate and follow-through care for the returning soldiers.

- The prognosis of recovery is generally considered to be quite poor among persons who continue to meet the PTSD criterion 1 to 2 years post traumatic events.

- PTSD has been described as a disorder of nonrecovery. Most posttraumatic distress is a normal, transient reaction from which complete recovery can be expected.

- PTSD is not limited to adults. The prevalence of PTSD in children who have been exposed to trauma ranges from 20%-30% depending upon the type of trauma.

- Traumatized children are often exposed to multiple traumatic events including various forms of abuse, maltreatment, exposure to domestic violence and growing up in violent neighborhoods and victimizing schools.

- The higher the risk for multiple exposure to trauma, the greater the likelihood for poorer outcomes and the more severe the PTSD. The exposure to repeated traumas increases, rather than decreases the probability of PTSD.

Gender Differences

- In the U.S., while men are more likely to be exposed to traumatic events than women, women are two to three times more likely to develop PTSD and related psychiatric problems.

- In part, this difference is due to the fact that women are exposed to more severe trauma than men, namely assaultive sexual abuse. This gender difference varies across countries. For example, in Ethiopia and Gaza, women evidence lower rates of PTSD than men, while in Algeria and Cambodia (like in the U.S.), women have higher rates of PTSD than men.

- Among combatant veterans the gender differences are more attenuated. For example, 30% of male Vietnam Theatre veterans (VTV) and 27% of female VTV meet lifetime criteria for PTSD. Such gender differences are in part due to the different roles played in the military. In addition female veterans have a greater likelihood of sexual victimization both in premilitary and military experiences.

- Women are also more likely to seek treatment following traumatic events and they tend to respond more favorably to treatment. (Treatment Effect Size is 1.39 for women and .40 for men) Men are more likely to hold negative beliefs about emotional expression that can interfere with the effectiveness of interventions that require cognitive processing such as in Prolonged Exposure. Anger, which often is experienced by men with PTSD, has been found to interfere with PTSD treatment.

- Of all types of traumatic events, rape has the highest likelihood of resulting in persistent

PTSD. Interestingly, there are no gender differences in rates of PTSD following rape in men and women. With more severe forms of trauma exposure, gender differences become less significant.

- The relationship between PTSD and psychiatric comorbid disorders vary by gender. For example, there is a higher risk for comorbid PTSD and Substance Abuse Disorders (SUDs) in women than in men. Women are more likely than men to develop SUDs subsequent to trauma exposure and PTSD. Women tend to use substances as a form of self-medication to cope with distressing symptoms. In contrast, men tend to have an increased risk for SUDs before or during traumatic events that lead to PTSD.

- In the general population, the rate of Major Depressive Disorders (MDD) is higher in women than in men. Among individuals with PTSD, both man and women have comparable rates of MDD. It is important to know the developmental sequence and function of comorbid disorders with PTSD.

- Women carry an additional burden as wives and mothers that can exacerbate PTSD. Marital status is a risk factor for women, but not for men. For example, the severity of the husband's PTSD symptoms has a greater impact on the wife's level of PTSD symptomatology, than does the wife's symptoms have on her male partner. Women also have higher caretaker stress.

- Research indicates that girls respond more strongly to trauma than do boys. Girls have higher risk for PTSD symptoms and have greater problems in coping with PTSD symptoms.

Consequences of Exposure to Traumatic Events for Individuals Who Develop PTSD

- PTSD is a complex disorder that can take a toll on individuals and family members. Those with PTSD are more likely to divorce, report trouble raising children, engage in intimate partner aggression, experience depression and other psychological problems, report poorer life satisfaction and physical health problems, become involved with the legal system, earn less and change jobs frequently.

- No matter what type of trauma is experienced (sexual assault, accidents, war zone experience, natural disaster, terrorist attacks), the trauma response appears to be similar. This does not mean that the type of experienced trauma is unimportant. For example, 45% of female rape victims develop PTSD, while only 9% of female victims of motor vehicle accidents develop PTSD. The degree of perceived threat and the magnitude of the loss of resources and the degree of secondary victimization have each been associated with the level of PTSD. Secondary victimization refers to the ongoing adversities that follow trauma exposure.

- There is a dose-response relationship. The greater the severity of the trauma, the higher the level of PTSD symptomatology. However, the level of distress symptoms <u>very</u> <u>soon</u> <u>after</u> a traumatic event does <u>not</u> predict the future course of the PTSD. After a few weeks following a traumatic event, the level of the symptom distress is a better guide for predicting future risk of PTSD. Persistent peritraumatic dissociation has been found to be predictive of later PTSD. The initial severity level of diagnosable PTSD is also strongly associated with the later severity level of the PTSD.

- PTSD is one of the most costly mental disorders in the U.S. in terms of health expenses, medical utilization costs and job productivity loses.

- Exposure to traumatic events and the development of PTSD are associated with poor physical health and medical complications. For example, childhood experience of trauma is associated with an increased likelihood of adult heart disease, a compromised immunological system, neurophysiological disorders and increased morbidity and mortality. Trauma can cause "wear and tear" on the body and increase the "Allostatic Load".

- 11% to 36% of patients who seek primary care have PTSD. They prefer to turn to medical care agents for help. Thus, there is need to screen for PTSD in medical settings.

- There is increasing evidence of trauma impacting negatively on neurohormonal, neurological and neuropsychological functions. For example, children who have been victimized and who develop PTSD fail to show the expected age-related brain growth in the corpus collosum and evidence frontal lobe deficits, with more pronounced trauma-related deficits in boys than girls. This can result in lower IQ, delayed speech, attentional and memory problems and attachment disorders.

- If normal stress hormones (e.g., cortisol levels) are activated over a prolong period of time due to exposure to trauma, brain physiology and function may be altered.

- There is also evidence of a reduced hippocampal volume and increased heart rate and abnormal startle responses to trauma-related reminders in individuals with PTSD.

- Caution is warranted, however, when considering such physiological differences between PTSD and non PTSD individuals. Research from twin studies (Vietnam Registry) indicated that the differences in hippocampal volume turned out to be a <u>vulnerability</u> <u>marker</u> for PTSD, rather than a consequence of exposure to trauma and PTSD. Such results raise the interesting prospect that biological markers may eventually be found to identify individuals who are more vulnerable to develop PTSD when exposed to trauma (Diathesis-stress model).

- Research on neuroimagery (fMRI) indicates that trauma exposure contributes to abnormal excessive stimulation of the amygdala and Prefrontal Cortex (PFC)

dysfunction. As to be discussed below, pharmacotherapy is designed to control ("Rein in") excessive amygdala activity.

- There is increasing evidence that genetics play a critical role in contributing to the vulnerability of developing PTSD. For example, combat exposure PTSD has been found to have a substantial heritability estimate, as evident from MZ (identical) and DZ (fraternal) twin studies of combat and non combat exposed twin pairs.

- There is a high likelihood of comorbid psychiatric disorders co-occurring with PTSD. For example, 30%-50% of men and 25%-30% of women have a lifetime of PTSD and Substance Abuse Disorders (SUDs). PTSD is most often likely to co-occur with depressive disorders, than with other anxiety disorders. Victimized individuals are at higher risk for suicide. The presence of comorbid psychiatric and medical disorders reduces the prognosis for a favorable response to treatment. The more chronic (long lasting) the PTSD disorder, the poorer the prognosis (e.g., in the case of Vietnam veterans).

- There is a need to provide integrated treatment (as compared to sequential or parallel treatments) for clients with comorbid PTSD disorders.
- Finally, it is important to appreciate that at times the exposure to traumatic events can produce posttraumatic growth and can have salutary effects, rather than contribute to psychopathology.

- In order to address these differences in response to trauma, we turn to research findings on the role of risk and protective factors and to research on the developmental pathways and mechanisms that contribute to PTSD.

Risk and Protective Factors: Developmental Pathways

1. It is important to keep in mind that PTSD is a spectrum disorder in which posttraumatic symptoms can be distributed along a continuum from mild to severe.

2. In fact, patients with partial or subsyndromal PTSD can also show decreased levels of work, school and social adjustment. Such subsyndromal individuals are more impaired than normal non-PTSD comparison groups, but significantly less impaired than individuals with full PTSD. It is important to learn if patients who presently evidence subsyndromal PTSD ever experience full PTSD or whether they were subsyndromal throughout. It is critical to conduct a life-span assessment.

3. PTSD symptomatology can "ebb and flow", "wax and wane", having a varying course. As noted, while the most common trajectory is recovery over time, for some traumatized individuals they evidence a deteriorating course. Others evidence initial PTSD, but show some improvement and then they may relapse.

4. Those individuals who evidence signs of recovery in the first three months following trauma usually do <u>not</u> go onto develop chronic PTSD. The strongest predictor of chronic PTSD are the severity of the trauma, the nature of the individual's immediate response such as dissociation and panic (experience of Acute Stress Disorder) and persistent negative emotions (guilt, shame, anger) and the presence of a non-supportive rejecting environment. Thus, we can begin to see that risk factors fall into the categories of the trauma event (severity), the individual's response (dissociation), and the nature of the supportive environment (type and level of social supports) and also pretrauma experiences (prior victimization experiences).

5. Other risk factors for the development of PTSD include:

    a) <u>gender</u>--as noted, women and young adults are at greater risk to develop PTSD than men and older adults

    b) <u>race</u>--in the U.S., being non-white is a risk factor for trauma exposure and for the development of PTSD

    c) <u>location</u>--where you live is critical in determining the likelihood of developing PTSD. It is estimated that 3 billion people in the world were affected by disasters between 1967 and 1991. 85% of these people live in Asia. PTSD is higher in non-developed countries than in industrialized countries, especially if the country is poor, war torn and conflict-driven. Being homeless and living in the inner city which is violence infested and impoverished increases the risk for developing PTSD. Exposure to violence is the leading cause of PTSD in both men and women.

2. The <u>type</u> of trauma one is exposed to is an important risk factor. The <u>lowest</u> <u>risk</u> for developing PTSD is to the most frequently occurring traumatic events (witness other suffering, death of a loved one). The <u>highest</u> <u>risk</u> for developing PTSD occurs for the least frequent traumatic events (sexual abuse). For instance, consider that following the terrorist attack on Sept. 11, 2001 that up to 10 million people in the U.S. experienced the death of a loved one, friend or colleague. In fact, in New York City, after the terrorist attack only 7.5% of Manhattan residents evidenced diagnosable clinical problems and this dropped to .6 % at six months. Up to 75 % of people who are confronted with irrevocable loss do <u>not</u> show intense distress. Complicated grief only occurs in a small percentage of cases (less than 20%). Such findings is a remarkable testimony to the resilience, courage and recovery in the face of trauma and adversities.

3. <u>Cognitive</u> <u>vulnerability</u> <u>factors.</u> Consistent with a Constructive Narrative Perspective of PTSD and the pioneering work of Elhers, Clark and Brewin, have been implicated as risk factors for the development of PTSD. There is increasing evidence that maladaptive cognitions in the form of the tendency to "catastrophize" and to hold negative appraisals and to express of low self-efficacy can each act as vulnerability factors to developing PTSD. For example, research of student firefighters during training and prior to deployment indicated that catastrophic thinking strongly

predicted the level of PTSD symptomatology 20 months after training was completed (Bryant and Gultrie, 2005). Cognitions measured shortly after the trauma, such as negative beliefs about oneself and the world, were risk factors for PTSD severity 6 to 9 months later (Dunmore et al. 2001). The nature of the "story" one tells oneself and others about aversive events and their implications can act as a risk factor for the eventual development of PTSD.

4. The search for the etiology maintenance of PTSD becomes even <u>more complex</u> when we recognize that there may be multiple developmental pathways to PTSD, and moreover, that the risk factors for the <u>acquisition of PTSD</u> may be different from risk factors for the <u>maintenance of PTSD.</u> These factorsmay differ by gender and race.

5. To make the puzzle even more complex, consider the research that highlights that there may be different subtypes of PTSD patients. A distinction has been drawn between:
   1) People with Simple PTSD

   2) People with Complex PTSD (like patients with Borderline Personality Disorders)

   3) People with PTSD of an <u>internalizing</u> subtype (evidence depression, anxiety disorders)

   4) People with PTSD with an <u>externalizing</u> subtype (impulsivity, anger prone, high likelihood of accompanying SUDs)

Each of these patient subtypes requires a different individualized treatment approach. "One treatment size does <u>not</u> fit all"

Psychosocial Treatment of Patients With PTSD

1. The implementation of Western style mental health treatments in other countries and cultures may <u>prove harmful</u>. There is a need to be <u>culturally-sensitive</u> when providing help and to engage clients (and others, such as Elders) as consultants in the development, implementation and evaluation of treatment interventions.

2. There is also a need to be <u>developmentally-sensitive</u>. Each age group responds differently to traumatic events (from childhood to the elderly). Each age group or cohort has specific developmental tasks that need to be addressed.

3. There is <u>much controversy</u> over the "active ingredients" in psychotherapies designed for PTSD and Complex PTSD. On the one hand, are hardly endorsements of exposure-based interventions, such as:

The development and use of exposure-based therapies to treat individuals with pathological anxiety and fear is one of the great success stories within the field of mental health treatment (Olatunji et al., 2009, p. 172).

While on the other hand, Wampold et al. (2009) highlighted that studies that dismantle exposure-based treatment procedures and/or omit the exposure component and that focus on here-and-now, person-centered problem-solving features are equally effective (e.g. see McDonagh et al. 2005, Journal of Consulting and Clinical Psychology, 73, 515-524; Schurr et al. 2003, Archives of General Psychiatry, 18, 481-489). Moreover, no differences in treatment outcomes are evident in treatments as diverse as CBT, EMDR, psychodynamic therapy and exposure-based interventions (See Benish et al. 2008, Clinical Psychology Review, 28, 746-758).

4. In a series of articles (Meichenbaum, 2000, 2009), I have proposed that there are common charge mechanisms that cut across the various exposure-based and other forms of treatments for victimized clients. These include the following:

    i. The development and maintenance of a supportive, nonjudgmental, therapeutic relationship with a skilled therapist.

    ii. Psychoeducation that includes a cogent rationale that leads to lagured therapeutic actions

    iii. Nuturing of hope by means of collaborative goal-setting that nurtures positive patient expectations. The treatment interventions should be "strengths-based".

    iv. Use of psychotherapeutic procedures that combat cognitive and behavioral avoidance on the part of patient and significant others.

    v. Cognitive restructuring procedures that address any maladaptive thoughts, beliefs, developmental schemas, accompanying feelings and dysfunctional behaviors.

    vi. Use of Constructive Narrative therapy procedures that place the patient trauma experiences into an "adaptive narrative" (processing the autobiographical memories).

    vii. Training and nurturing of intra and interpersonal skills and the incorporation of treatment guidelines to enhance generalization and maintenance of therapy effects such as relapse prevention training, self-attribution training (patient "taking credit") for change.

    viii. Integrative treatment of PTSD, Complex PTSD and comorbid disorders.

5. When exposure-based procedures such as Direct Therapy or Prolonged Exposure are used, the research indicates that such exposure based therapy does <u>not</u> exacerbate symptoms and are well tolerated by most clients.

6. CBT procedures may be supplemented with coping skills training (Stress inoculation training, Imagery-based interventions, and treatments designed to address comorbidity in an integrative fashion such as Lisa Najavits' Seeking Safety treatment program). Some combinations of integrative treatments have been found to be more effective than others. For example, the addition of exposure-based procedures to cognitive restructuring (CR) therapy has been found to enhance treatment outcomes, but the addition of CR to exposure did not contribute to comparable enhanced efficacy.

7. These CBT treatments are designed to help clients alter their "fear networks", help them process traumatic material and correct erroneous cognitions (e.g., CBT for guilt reactions).

8. PTSD has been characterized as a <u>disorder</u> of <u>autobiographical</u> <u>memory</u>, where recall of traumatic events are fragmented, emotionally-charged with high sensitivity to sensory and perceptual triggers, selectively focused on ongoing threats and vulnerabilities, suppressed and avoided. Clients may also ruminate about the negative implications of trauma experience which may not be shared with supportive others. Such avoidant behaviors (effortful avoidance of reminders of the trauma, engaging in unnecessary and excessive safety behaviors, expressions of anger, substance abuse, psychic numbing, keeping trauma experiences a secret) are all likely to contribute to and help maintain PTSD.

9. While the results of CBT interventions are promising, they are also <u>humbling</u>.

10. Approximately half of all CBT patients achieve full remission. In those cases where there is evidence of symptom improvement, there is often not a concurrent improvement in Quality of Life Measures. There is a need for treatment to focus on "here and now" issues, as well as "then and there issues". Present-oriented interventions that teach coping skills, bolster self-efficacy and nurture a new more adaptive narrative ("story telling") are as critically important as the cognitive and emotional reprocessing of the client's "trauma story".

11. As noted, head-to-head comparisons of various evidence-based treatments have generally led to equivalent outcomes.

12. The quality and nature of the therapeutic relationship is critical to outcome. The issues of safety and trust should be assessed and highlighted on a regular basis. Interventions should be strength-based and build on the individual's, family's and cultural resilience.

13. Not all victimized groups, nor all forms of PTSD symptoms, are equally responsive to treatment. For example, the lowest Effect Size (worse outcomes) have been found for

soldiers with combat-related PTSD. This group of veterans tends to have a more chronic course. Among female veterans their combat-related traumas may be compounded with sexual victimization, both in the military, as well as before entering the military. They may also experience higher rates of compassion fatigue. There is value in providing gender-specific intervention treatment programs.

14. Some PTSD symptoms like emotional numbing, negative symptoms of anhedonia, social withdrawal and isolation, and avoidance behaviors have proven less responsive to existing treatments.

15. The presence of avoidance symptoms impedes emotional processing. Such avoidance needs to be addressed therapeutically since treatment procedures that encourage clients to tell their "trauma story" in a safe, nonjudgmental setting is therapeutic. Therapists may use a variety of diverse treatment approaches to help their clients tell (construct) their stories in a more adaptive, resilient fashion. Therapists need to help their clients find meaning and reengage life. The "restorying" process has been characterized as a Constructive Narrative approach to treating clients with PTSD.

16. Another treatment procedure for PTSD clients is Eye Movement Desensitization and Reprocessing (EMDR) which entails imaginal exposure to traumatic images while the client moves his/her eyes back and forth following the therapist's distractions. This is a highly controversial treatment and as Rodenburg et al. (2009) observe, has been subject to "blistering discourse." (see Lohr et al, 1999) This is in part because:

      a) research on dismantling EMDR has indicated that the addition of the eye-movement component does not lead to apparent benefits;

      b) less than impressive benefits for the efficacy for EMDR, especially when compared to exposure-based interventions;

      c) in some studies there was a worsening of PTSD symptoms among those receiving EMDR compared to match controls;

      d) the lack of a theoretical model to explain why EMDR would work, and the counter argument that EMDR is much like CBT treatments for PTSD designed to teach PTSD clients to challenge dysfunctional cognitions in the context of mild levels of exposure. (Namely, "EMDR is old wine in a new bottle.")

      e) See critiques of EMDR by Lohr, McNally and Rosen, For example, see Lohr et al. (1999) Journal of Anxiety Disorders, 13, 185-207.

16. There is no evidence that the treatment of PTSD results in improved physical health.

17. There is also <u>no</u> <u>evidence</u> for so-called Power Therapists such as Callahan's Thought Field Therapy. Such interventions should <u>not</u> be used when more evidence-based interventions have been demonstrated to be effective in treating PTSD.

18. There is <u>no</u> <u>evidence</u> that Critical Incident Stress Debriefing (CISD) in the form of structured group interventions are effective in preventing long-term negative consequences. In fact, under certain conditions CISD may have the paradoxical effect of exacerbating PTSD.

Pharmacotherapy for PTSD

1. A range of medications have been used for treating people with PTSD. In fact, the U.S. Food and Drug Administration (FDA) has approved the use of Selective Serotonin Reuptake Inhibitors (SSRI) (sertraline and paroxetine) for the treatment of PTSD. These medications have been found to have fewer side-effects than other antidepressants and other medications.

2. The SSRI appear to work by "reining in" the excessive activation of the amygdala and restraining the influence of the medial prefrontal cortex (PFC).

3. The effectiveness of the SSRI for treating clients with PTSD is <u>modest</u>. The remission rate is approximately 30%. Another 20% show little or no improvement, where an approximately 50% exhibit notable improvement, but <u>only</u> partial remission.

4. When compared with psychosocial treatments for PTSD, treatment effects for pharmacotherapy are significantly smaller. There is also a higher dropout rate from pharmacological interventions.

5. Work is underway to develop a "morning after pill" designed to ameliorate symptomatology and reduce the risk of developing PTSD.

Core Tasks of Psychotherapy

The following tasks should be implemented when treating individuals who have PTSD and comorbid medical and psychiatric conditions.

1. Develop and maintain a therapeutic alliance (TA). Monitor TA on a regular basis.

2. Conduct psychoeducation with PTSD client and significant others. Share a Case Conceptualization with the client and then use a "Clock" metaphor to highlight the

interconnections between External/Internal Triggers (12 o'clock); Primary and Secondary Emotions (3 o'clock); Cognitions (Automatic Thoughts, Thinking Patterns, Schemas) (6 o'clock); and Behavioral Acts and Resultant Consequences (9 o'clock)--thus contributing to a "vicious cycle" that needs to be broken.

3.   Nurture hope and engage the client in collaborative goal-setting. Use of Three Time Lines

    Timeline 1--(From birth to the present). Trace the history of stressors, victimization experiences, and forms of treatment interventions.

    Timeline 2-- (From birth to the present). A history of signs of resilience and strengths. This "in spite of" Timeline can also include looking into the past as to how forefathers coped and survived.

    Timeline 3--(From present into the Future). An examination of short-term, intermediate and long-term goals and means to achieve them. Is there anything from Timeline 2 that can be used to achieve the treatment goals of Timeline 3?

4. Help the client manage PTSD symptomatology and provide integrated treatment for comorbid disorders. Ensure the client's safety and help improve the client's "Quality of life".

5. Build on the client's strengths and bolster resilience. Teach coping skills and follow treatment guidelines to increase the likelihood of treatment generalization.

6. Engage clients in "memory work" by helping them to reprocess trauma material. For example, use Prolonged Exposure, Cognitive Processing Procedures, Cognitive Restructuring. Include in vivo homework. Help the client construct a new more adaptive narrative.

7. Help the client find meaning and reengage life. For example, if indicated, use client's spiritual beliefs.

8. Help the client find meaning and reengage life. For example, if indicated, use client's spiritual beliefs.

9. Help the client avoid revictimization.

10. Build in Aftercare and follow-through interventions.

11. Evaluate and obtain client satisfaction measures.

12. Address the needs of the helper at the individual, social and organizational levels. Attend to vicarious traumatization in helpers.

THE NATURE OF THE CHALLENGE: INCIDENCE AND IMPACT OF TRAUMA AND IMPLICATIONS FOR INTERVENTIONS

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Experiencing and witnessing interpersonal violence is a significant public health problem, especially for children and youth. Consider the following illustrative data.

Exposure to Violence

- 20% of children in the U.S. will experience a traumatic event before age 4.

- 60% of youth in the U.S. aged 17 and younger have been exposed to violence, abuse, a crime, directly or indirectly.

- Surveys of police reports, interview with mothers, child welfare reports indicate that 40% to 90% of school children living in urban poor neighborhoods have witnessed or experienced a homicide and/or domestic violence.

- The experience of community violence is often accompanied by intra family violence. In 40% of cases of spouse abuse, child abuse co-occurs.

- There are approximately 2 million cases of child maltreatment (physical and sexual abuse, and/or neglect) each year in the U.S.

- Approximately 3.6 million children receive an investigation by a service agency for child maltreatment.

- It is estimated that 20 million children live in households with an addicted caregiver, an incarcerated parent, or mentally ill parent.

- "Risky" families (families with high conflict and aggression and cold unsupportive and neglectful relationships) are more likely to have children with disruptions in stress-responsive biological systems, poorer health behaviors, and increased risk for behavioral problems and for chronic illnesses, like heart disease.

- In fact, children are more prone to be subject to victimization than are adults. For example, the rates of assault, rape and robbery against those 12 to 19 years of age are two to three times higher than for the adult population.

- Such stressors are compounded by poverty. 25% of children in the U.S. (some 15 million) live below the poverty line.

- The poverty level of the family is correlated with the child under achieving academically.

   a) Children from poverty enter school 2000-3000 vocabulary words behind their middle and upper class peers. Vocabulary level by grade three predicts high school graduation rates.

   b) Students from minority families who live in poverty are 3X more likely than their Caucasian counterparts to be placed in a class for educably delayed. They are 3X more likely to be suspended and expelled.

   c) The overall academic proficiency level of an average 17 year old attending school in a poor urban setting is equivalent to that of a typical 13 year old who attends school in an affluent school.

   d) Students from families with income below the poverty level are nearly twice as likely to be held back by a grade. The dropout rate from school is highly correlated with grade retention.

- These statistics take on specific urgency when we consider that 15% of students are African American and 11% are Hispanic. If present birthrates continue, by the year 2030 minority students will constitute 45% of school-age students in the U.S., up from the current level of 30%.

- The exposure to such interpersonal violence is not limited to the U.S. The United Nations estimates that over 25 million children live in "conflicted-affected poor countries". This is further affected by the high exposure rate to natural disasters.

IMPACT OF TRAUMA EXPOSURE, VICTIMIZATION AND POVERTY

While any one of these factors such as living in poverty, experiencing abuse and neglect, witnessing violence or being a victim of violence constitutes high risk for poor developmental adjustment. Research indicates that it is:

The total number of risk factors present that it is more important than the specificity of risk factors in influencing developmental outcomes.

FAR REACHING EFFECTS OF ADVERSITY
(See TED Talk by Dr. Nadine Burke Harris- www.Ted.com/talks)

Adverse childhood experiences (**ACE**) assesses the long-term impact of multiple different categories of adversities including physical, sexual, psychological abuse; witnessing maternal battering; household substance abuse and mental illness; parental divorce or separation and parental criminal activity.

- ACE are common - - 2/3 of children experience 1 ACE event; 1/5 (3+ACE); 1/10 5+ different ACE events. It is the pile-up of cumulative diverse ACE categories (4 categories or more), that leads to neurobiological, behavioral and psycho-social health-related and/or psychiatric disorders. For example: versus those with 0 ACE scores

  ACE 4+ - - 500% increased chance of becoming alcoholic
  ACE 6+ - - 4600% increase chance of intravenous drug use
  ACE 4+ - - 3100% higher incidence of depression and suicide attempts
  ACE 6+ - - shorter life span

- ACE scores also predict early initiation of tobacco use, 2-4X early sexual activity resulting in teen pregnancy, multiple sexual partners, sexual transmitted disease, intimate partner-violence, being a victim of human trafficking.

- ACE scores also predict a variety of medical conditions cardiovascular disorders, obesity, diabetes, metabolic autoimmune and muscoskeleton conditions.

POSSIBLE MEDIATING MECHANISMS

- Exposure to multiple diverse traumatic victimizing experiences can alter brain architecture and function, derail developmental "wear and tear" on the body.

- Neurobiological changes resulting from exposure to ACE include alterations to the amygdala, hippocampus, anterior cingulate prefrontal cortex, nucleus accumbens, and at the neurochemical level alterations including dopamine, norepinephrine, epinephrine, cortisol, serotonin brain-derived neutrophic factor, endocannabinoids, glutamate and neuropeptides.

- When a child experiences adversity early in life their monocytes and macrophages (types of white blood cells) become calibrated to respond to future threats with a heightened pain inflammatory response, and by influencing the hormonal system and dysregulation of cortisol levels.

- Traumatic stress may alter the organization and "tuning" of multiple stress response systems, including the immune system, the autonomic system and the hypothalamic-pituitary-adrenal (HPA) axis and alter gene expression. For example, childhood maltreatment sensitizes the amygdala to over respond to threat.

- Childhood adversity has been associated with shorter telomeres. Telomeres are receptive DNA sequences that cap and protect the ends of chromosomes from DNA damage and premature aging.

- In terms of the developing brain, exposure to cumulative adverse events contributed to:

    a) Reduction in the volume and activity levels of major structures including the corpus callosum (connective fibers between the left and right side of the brain), limbic system (amygdala and hippocampus) that is involved in emotional regulation.

    b) Cerebral lateralization differences or asynchrony. Abused children are seven times more likely to show evidence of left hemisphere deficits.

    c) Impact the communication between the Prefrontal Cortex (PFC) (upper portion of the brain) and the Amygdala (lower portion of the brain). The "top-down" regulation of executive skills can be compromised by perceived threats and stressors.

    The bottom-up emotional processes (amygdala) can "hijack" the PFC.

- The earlier and the longer the exposure to cumulative ACE, the greater the neurological impact.

BEHAVIORAL CONSEQUENCES

- Victimized children are more likely to have:

  a) Lower IQ, delayed language development, lower school grades;

  b) Exaggerated startle responses, hypervigilance, physical tension, emotional dysregulation, tend to "space out" and dissociate;

  c) Attachment disorders and eating disorders such as bulimia. Especially girls who have been sexually abused have difficulty in connecting with others and modulating their negative emotions and evidence limited ability to self-soothe, and self-accept. They have fewer adaptive coping strategies and have problems handling strong emotions such as anger. They evidence behavioral impulsivity and affective lability.

- Early childhood maltreatment increase a child's risk of arrest by 11% during adolescence (from 17% to 28%); abuse and neglect increases the risk of engaging in violent crime by 29%, and arrest as a juvenile by 59%.

- Abused and neglected children begin their criminal activity almost a year earlier, have twice the number of arrests, and are more likely to be repeat violent offenders than nonabused children. Note that the incidence of neglect is more than twice that of physical abuse.

- 70% of girls in juvenile justice system have histories of physical and sexual abuse verses 20% of female adolescents in the general population. 32% of boys in the juvenile justice system have been victimized.

WHAT IS YOUR ADVERSE CHILDHOOD EXPERIENCES (ACE) SCORE
(See https://www.cdc.gov/brfss Behavioral Risk Factor Surveillance System)

1. *Did you live with anyone who was depressed, mentally ill, or suicidal?*

2. *Did you live with anyone who was a problem-drinker or alcoholic?*

3. *Did you live with anyone who used illegal street drugs or who abused prescriptions?*

4. *Did you live with anyone who served time in prison, jail or other correctional facility?*

5. *Were your parents separated or divorced?*

6. *How often did your parents or adults in your home ever slap, hit, kick, punch each other?*

7. *How often did a parent or adult in your home physically hurt you in any way?*

8. *How often did a parent or adult in your home ever swear at you, insult you, or put you down?*

9. *How often did anyone at least 5 years older than you, or an adult, try to make you touch them sexually?*

10. *How often did anyone at least 5 years older than you, or an adult, force you to have sex?*

What is your ACE score? How have you evidenced resilience, in spite of these adverse events?

EVIDENCE OF RESILIENCE

"Resilience does <u>not</u> come from rare and special qualities; but from the everyday magic of ordinary normative resources in the minds, brains and bodies of children; in the families and relationships; and in their communities. The conclusion that resilience emerges from ordinary processes offers a far more optimistic outlook for action than the idea that rare and extraordinary processes are involved." Ann Masten

-   Research indicates that 1/2 to 2/3 of children living in extreme victimizing experiences grow up and "overcome the odds", and go onto achieve successful and well-adjusted lives.

-   Only about 1/3 of abused and neglected children develop PTSD, complex PTSD (Developmental Trauma Disorder), clinical psychiatric disorders and get in trouble with the law.

CHARACTERISTICS OF RESILIENT CHILDREN AND YOUTH

Temperament factors - - easy going disposition, not easily upset, good emotional regulation, delay of gratification, impulse control, genetic influence (MZ <u>versus</u> DZ twin studies).

Problem-solving skills - - higher IQ, abstract thinking, flexibility of thought

Social competence - - communication skills, emotional responsiveness, empathy and caring, a sense of humor, including the ability to laugh at themselves. Bicultural competence - - able to negotiate a cultural divide. General appealingness.

Autonomy - - self-awareness, a sense of personal agency, sense of identity with kinship, ability to act independently, mastery orientation, grit, internal locus of control, self-efficacy and self-worth.

A sense of optimism - - maintain a hopeful outlook, a sense of purpose, problem-focused strategies (avoid seeing crises as insurmountable problems). Hold a growth Resilience Mindset.

Academic competence and school connectedness - - school readiness skills, academic competence, especially in reading and math. Commitment to learn. Build on "Islands of competence". Active in school activities and connection with someone in school, other than friends.

Presence of Social Supports - - has the perception of "go to persons", and has the ability and willingness to discuss problems. Ability to access social supports. Presence of "Guardian Angel", Mentors, Prosocial peer group. Authoritative parenting ("loving but firm"). Family rituals and activities, Rites of passage rituals, Intergenerational transmission of resilience - - use of story-telling. Religious and church affiliation. Respect for community rules and values. ***Is there a person, a "charismatic" adult the child can identify with and from whom they can gather strength?***

Evidence of Positive Redirection of One's Life-style - - an ability to breakaway from dysfunctional family, negative social influences - - antisocial peers, presence of an Ecological Niche, Situational Affordances, "Door opening opportunities", (job, athletics and talents, settings, romantic relationships, military, etc.) that acts as a "Surge of motivation to succeed", "Change of heart", "Late Bloomer".

"It is never too late to bolster resilience."

PATHWAYS TO BOLSTERING RESILIENCE

"It takes a community to bolster resilience in 'high risk' children, youth and their families."

(See www.Search.Institute.org for a discussion of how to help children and youth thrive.)

Protective factors can moderate the impact of traumatic victimizing experiences on child and youth development.

There are multiple pathways to bolstering resilience that involve diverse settings. We will consider school settings; clinical settings, especially in terms of trauma-focused cognitive behavioral interventions, and parent training programs, and community-based interventions.

SCHOOL-BASED INTERVENTIONS

(See Melissa Institute Website www.melissainstitute.org. Paper by Don Meichenbaum – Ways to implement interventions in schools in order to make them safer, more inviting and pedagogically more effective, as well as other related papers.)

BEWARE of slick promotional programs that have little evidence-based research and that are filled with HYPE.

Here are two such examples:

1. The Tapping Solution Foundation org. For a slick promotional YOU TUBE filled with HYPE see *htttps//www.youtube.com/watch?v=s99M8eJV4sk*

   For a critique of such so-called Energy-based interventions see
   https://en.wikipedia.org/wiki/Emotional_Freedom_Techniques

2. Dan Amen's SPECT analysis and so-called brain "ring of fire" evident in Hyperactive and other children see the following critique by Hall:

   https: //sciencebasedmedicine.org/dr.amens-love-affair-with-spect-scans/

 FOR A COPY OF "How to spot HYPE in the field of psychotherapy" email Don Meichenbaum at dhmeich@aol.com

1. Focus on the School Principal, as the catalyst of change. There are approximately 114,000 Principals in the U.S. See the Principal Report Card in the cited article by Meichenbaum on the Melissa Institute Website.

2. Conduct systematic assessments of students ACE scores and tailor interventions accordingly.

3. Use peer assessments to identify students at risk. For example, Ron Slaby had schools establish **SNAP BOXES** on campus that stood for "Students Need Assistance Pronto. These warning boxes would be monitored regularly.

   Use various peer nomination and peer warning reporting.

4. Use teacher nomination procedures. Have teachers put a check mark next to each name of students they have a relationship with. Identify students who do not have any connections. Ask students to answer the following questions:

   "If you were absent from school, who besides your friends would notice that you were missing, and would miss you?"

   "If you had a problem in school who would you go to for help?"

   "If I were a new student at your school, what would you tell me about your school? What would you show me?"

   "Tell me some things I might like about your school?"

   "Tell me some things I might not like?"

   "Can you show me on this map of your school where are places that I should avoid because they are not safe"

5. Conduct a School Climate assessment (See Scales by Furlong). See Melissa Institute Website www.teachsafeschools.org for ways to reduce bullying, school suspension, zero tolerance policies, grade retention programs.

6. See ways to Engage Parents in school activities in Meichenbaum and Biemiller's book Nurturing independent learners.

7. Help teachers improve classroom management procedures. (See www.apa.org/ed/cpse/homepage.html and www.teachsafeschools.org).

8. Focus on reading comprehension skills. See Melissa Institute Website on Reading Literacy Website.

9. Provide students who have neurological deficits due to ACE exposure with metacognitive prosthetic devices (MPDs) that provide needed academic supports (e.g., attentional and memory supports, instructional guidance, bottom-up and top-down "kernels" for learning.

Enhance students' executive functioning. See article on MI Website. (Use the "wheel chair" metaphor).

10. Advocate and implement for school mental health programs. For example, see Roger Weissberg on teaching social and emotional learning in schools (www.CASEL.org), and Lisa Jaycox's Cognitive Behavioral Intervention for Trauma in Schools (CBITs) program. Also see C.Santiago, T.Raviv and L. Jaycox "Creating healing school communities: School-based interventions for students exposed to trauma. (2018) American Psychological Association Publishers.

    CIBTS is a school-based early intervention program aimed at reducing children's symptoms related to existing traumatic experiences and enhancing their skills to handle future stressors. (***See Jaycox, L. 2004, <u>Cognitive behavioral intervention for trauma in schools</u>. Longmont, CO: Sopris West, and <u>Support for students exposed to trauma: The SSET Program</u> by Lisa Jaycox, Audra Lanfley & Kristin Dean, 2009, Rand Corporation.***)

11. Implement a "strengths-based" program, identifying <u>Islands</u> <u>of</u> <u>competence</u> for each student. Have students answer questions such as:

    ***One thing I would like my teacher to know about me is* _____**

    "I have* _____ *"
    "I can* _____ *"
    "I am* _____ *"

    Put students in a <u>helper</u> <u>role</u> and engage students to participate in community-wide social services of some sort.

12. Implement extra-curricular and School Drop Out Prevention Programs, Mentoring Programs. Conduct Student Satisfaction assessments. For instance:

    "One of my teachers who helped me when I was in a difficult situation was* _____ *. He/she did the following that had a real impact."

13. Build and broaden positive emotions in school like optimism, hope, gratitude, acceptance, empathy, compassion, grit, awe, humor, physical activity- exercise, problem-focused coping strategies and artistic expression and **RESILIENCE**.

    REMEMBER that resilience derives from "ordinary magic" and that there is no one way, nor "magic bullet" to bolster and nurture recovery from traumatic victimizing experiences.

There are ways to build in "neuroplasticity" and, in fact, alter ("turn on" and "turn off") gene expression by having students engage in resilient-engendering behaviors. ("***History is not destiny***").

Resilience is associated with the HPA Axis and SNS activity, neuropeptides, DHEA, and CR4 activity, and the mediated reward system that maintains (builds and broadens) positive emotions, even in the face of chronic adversities.

<u>CLINICAL</u> <u>SETTINGS</u>: HOW CLINICIANS CAN BOLSTER STUDENT RESILIENCE

1. Use evidence-based interventions. See MI Website papers by Marlene Wong, Esther Deblinger, Betty Pfefferbaum, Joan Asarnow, Jim Larsen, Steven Dykstra (See www.musc-tfcbt).

2. Be a <u>critical</u> <u>consumer</u> of psychotherapeutic interventions. See Don Meichenbaum and Scott Lillienfeld's article "How to spot HYPE in the field of psychotherapy", on the MI Website.

3. Conduct Parent Training Preventative Programs.

PARENTING PREVENTATIVE PROGRAMS

(See E. Chen, G. Brody & G. Miller, 2017 Childhood close relationship and health. American Psychologist, 72, 555-566.)

This article describes and evaluates several Parenting Programs including:

- Family Check-up Program – Connell et al., 2007

- Positive Parenting Program (Triple P) – Sanders et al., 2012

- Incredible Years Program – Webster-Stratton, 2005

- African American Families Training Program – Brody et al., 2015

- Foster Parents Program – Reid, 2000

- Children of Divorce Program – Luecken et al., 2015

- Loss of a Parent Program – Sandler et al., 2016

- Functional Family Therapy – Alexander et al., 2013

Also see Parenting Programs by Kolko for treatment of physical abuse (Alternatives for Families - - Cognitive behavior therapy); Combined Parent-child CBT - - Runyan and Deblinger); Multi-systemic Therapy for Child Abuse and Conflict - - (MST)- - Henggeler & Swenson; Parent-child Interaction Therapy - - Eyeberg & Chiffon; ACT parent program - - APA-sponsored.

Keep in mind that the level of distress evident in parents is influential in determining the degree of distress experienced by their children.

In the aftermath of traumatic and victimizing experiences "normalizing" the life for children and families acts as a buffering experience. Resuming school and play activities, restoring family routines and supporting cultural and religious practices, each act as protective factors.

In addition the child's and youth's connectedness to his/her family and to prosocial adults outside the family provides a buffer acts as a set of protective factors. Connectedness is evident by the:

a) Consistent presence of the parents at least in one of the following activities: when awakening; when arriving home from school; at evening meal time; at bed time;

b) Frequent shared activities with parents;

c) Family rituals and kinship relationships;

d) Intergenerational transmission of resilience - - Use of "story-telling" that fosters cultural identity;

e) Authoritative parenting practices – firm, but loving and supportive;

f) Parenting monitoring - - 4 "W"s when; where; with whom; what activities?

g) Child or youth doing family chores and engaging in altruistic behaviors that nurture empathy;

h) Child or youth feels they can share problems with their parents.

COMMUNITY-BASED INTERVENTION PROJECTS FOR CHILDREN AND FAMILIES

For example, Joy Osofsky's program included education for police officers at all levels on the effects of violence on children, a 24 hour hotline for consultation by police or families. A referral service was provided.

In addition, a needs assessment was conducted to determine "How violent is your neighbourhood?" A variety of assessment tools were used including art expressive drawings by children, maps of how they got from their home to school, parental, police and school personnel reports.

Engage local business leaders and participants to recognize the financial benefits to society of investing in such preventative programs. For example, highlight that high school graduates earn on average of $290,000 more during their life-span than do high school dropouts

and the high school graduates will pay $100,000 more in taxes. It has been estimated that governments lose three billion dollars in revenue for <u>each</u> <u>one</u> <u>year</u> cohort of high school dropouts. (See Belfield and Levin, <u>The price we pay</u>).

A CAVEAT

A caution about "The downside of resilience" offered by Jay Belsky (New York Times, Nov.30, 2014). He has explored why some children who have been exposed to adverse childhood experiences <u>benefit</u> <u>more</u> from interventions, while others tend to thrive without such interventions, as in the case of the extensive FAST TRACK program. Beginning kindergarten, at-risk students were provided 10 years of extra academic and social support, involving teachers, parents and peers. The participants were assessed when they reached age 25.

Those students who benefitted most from the intervention had a particular genetic makeup. Namely, those who carried a variant of a glucocorticoid receptor gene, which plays a role in how the body responds to stress, improved most from the intervention. The behavior of children who did <u>not</u> have this gene variant was unaffected by the intervention.

In other intervention studies, children who carried genes that indicated greater susceptibility to depression and ADHD, benefitted most from treatment.

This pioneering research is suggesting that genetic vulnerability may prove to be predictable markers of where intervention dollars should be spent. Children without such genetic vulnerability may become resilient without specific interventions.

This work is obviously at a beginning stage, but worth taking note of in planning any form of intervention.

Adverse Childhood Experiences (ACE study): Neurobiological and Psychosocial Sequalae

SCHOOL and COMMUNITY-BASED PREVENTATIVE APPROACHES: "TOP DOWN" and "BOTTOM-UP" INTERVENTIONS

Donald Meichenbaum, Ph.D.

How can the adverse effects of persistent poverty and all the stressors that accompany such exposure be overcome? How can the "vicious cycle" of poverty be broken? As Joseph Stiglitz, the Nobel Laureate and author of "The price of inequality" observes:

> *"The upward mobile American is becoming a statistical oddity. Today, the U.S. has less equality of opportunity than almost any other industrial country."*

While addressing the negative impact of poverty is a complex problem, in this presentation I will focus on what role schools and community-based interventions can play. Two preventative approaches will be highlighted, namely, "TOP DOWN" that employs evidence-based programs that have been implemented successfully across the full developmental cycle. The second approach is to use a "BOTTOM UP" intervention strategy that is designed to imbue the entire school environment with behavior influence procedures in order to create a "safe, inviting and educationally stimulating" environment.

Additional examples of possible preventative interventions can be found on the Melissa Institute Website *www.melissainstitute.org,* under the heading Conferences (left side of the Home Page). See especially, the Handouts for the 9th, 15th and 16th conferences. Also, see the Reference Section and Website addresses at the end of this Handout.

Before we examine these two forms of prevention interventions, let us first consider what the research literature indicated are the key assets that contribute to resilience in such "high risk" students and that helps them endure and overcome such adversities. A number of authors have enumerated the characteristics of resilient students (Buckner et al., 2009; Buckner & Waters, 1011; Farahmand et al. 2011, 2012; Kumankiko & Trier, 2006; Lopez et al. 2012; Masten et al. 2011; Meichenbaum, 2012; Stack, 1974; Tough, 2012). As enumerated in Table 1, these attributes include the development of behavioral and emotional self-regulation skills, and the fostering of cognitive and metacognitive executive skills, and prosocial competence. These skill areas need to be supported by school, family, and community resources.

Teachers are likely to identify "resilient" students as having the following characteristics and "resilient" adolescent students are likely to endorse the following statements:

> *"I am eager to explore new things."*

> *"I finish whatever I begin."*

> *"I think that putting out effort will improve my chances of success."*

> *"I am aware of other people's feelings."*

> *"I try to help other people if their feelings have been hurt."*

> *"I think it is important to help."*

> *"I treat others with respect."*

"I think about my future. I believe I will graduate high school and even graduate college. I will have caring relationships (a family) and a job that pays well."

A consideration of these characteristics challenges educators as to what they can do to help develop "thriving" students. What "TOP DOWN" and "BOTTOM UP" preventative interactions can be implemented to nurture these attributes?

"TOP DOWN" PREVENTATIVE INTERVENTIONS

As noted, "TOP DOWN" interventions derive from research-based programs that disseminate evidence-based treatment manuals and guidelines. These intervention programs may be:

(1) Universal that focus on the entire population (primary prevention and school-wide) and not based on identified risk strategies;

(2) Selected preventative secondary interventions that focus on a higher than average risk population, such as students who evidence a disruptive behavior disorder, or a mental disorder, or who are at risk for academic failure;

(3) Indicated preventative interventions that seek to help high-risk students who exhibit measureable behaviors, symptoms, and adjustment difficulties signaling the onset of a high-risk developmental trajectory. This tertiary form of prevention may warrant "wrap-around" services that require multiple resources. Shinn and Walker (2012) provide a detailed description of this Three Tier Model intervention strategy.

What role should schools play in the maintenance of the socio-emotional well-being of students since there is a dynamic interplay between student's emotional well-being and their academic success?

A number of researchers have addressed this question (see Adelman & Taylor, 2012; Durlack et al. 2012; Farahmand et al. 2011; Rones & Hoagwood, 2000; Shinn & Walker, 2010; Tough, 2012). As these authors highlight, there are several intervention options that include child only, child plus family, family only, In school, After school programs, coordinated interventions with mental health professionals following early identification programs.

How can school personal conduct a Needs Assessment in order to choose from the following list of intervention alternatives? Examine the list of illustrative intervention programs enumerated in Table 2 that have been implemented in schools, with families, and in communities. These illustrative programs cover the full range of populations from prenatal care in teenage pregnant students, through school readiness programs, and middle school bully-reduction programs, all the way to college preparation courses. The systemic and collaborative implementation of such programs could help "high risk" students and families break the vicious cycle of poverty and increase the likelihood of their "beating the odds."

When considering these school-based mental health interventions, a caveat is warranted. The most successful prevention programs have relatively modest deterrent effects, approximately a 15% to 25% reduction in the onset of problematic behaviors such as anxiety, depression, and

disruptive behavior problems. Effect sizes (ES) are a modest .30. These effects tend to dissipate over a 12 month period. Selected interventions tend to be more effective than school-wide Universal-based interventions. Relatively brief universal intervention programs are insufficient to yield long-term lasting effects. There is a need to build into any prevention program, treatment guidelines to facilitate the generalization and maintenance of the training effects. One cannot "train and hope" for generalization or transfer, but rather, interventionists need to include a set of procedures designed to increase the likelihood of generalization and maintenance, as outlined in Table 3.

A "**BOTTOMS-UP**" Approach to school-based intervention has been advocated by Dennis Embry and Anthony Biglan (Biglan, 2004; Embry, 2002, 2004; Embry & Biglan, 2008). They use the concept of "**KERNELS**" to describe simple readily available behavioral influence procedures that are evidence-based. Some of these behavioral influence procedures manipulate antecedents such as providing reminders, cues and guides to transitional behaviors like having signs posted, or, teachers flicking on and off classroom lights to signal students. Other behavioral influence **KERNELS** include personal consequences such as the use of teacher praise notes, prize bowls, posting student work. A third category of **KERNELS** focuses on creating behavioral scripts (routines) using language-based and conceptual (changed "Mindsets") interventions such as having students view themselves as "Peace Builders" or performing ascribed roles such as being a "teacher's helper".

Table 4 provides a list of potential ways that educators can incorporate a **BOTTOMS-UP** mode of behavioral interventions. These same type of **KERNELS** can be used by educators with the students' parents. (***See Meichenbaum's Handout for the 16th Melissa Institute Conference on ways to involve parents in the education of their children***).

How many of these **KERNELS** do you use with your students? Which **KERNELS** can you add? See The Melissa Institute Website ***www.teachsafeschools.org*** for other examples of **KERNELS**.

Finally, a critical factor in bolstering students' resilience and their academic competence is the effort and commitment of educators to engage and involve the students' parents . Rather than "blame" the parents for their non-involvement, there is a need to determine what initiatives educators have made to engage parents? Table 5 provides a Checklist of possible initiatives that can be undertaken. How many of these steps has your school made? Which steps can be included in your schools' efforts?

TABLE 1

Characteristics of Resilient Children

<u>Behavioral Self-regulation Skills</u>

Control impulses and slow down
Stay focused and avoid distractions
Delay gratification
Particular abilities or talents that are valued by others
Do well at school (multiple sources of "strengths")

<u>Emotional Self-regulation skills</u>

Have an easy temperament
Manage emotions-calm self down when provoked
Persistent, show grit, and evidence a "passion" for a given area
Optimistic, future orientation and positive outlook
Hopeful
Self-control and self-discipline
Have a sense of humor

<u>Cognitive and Metacognitive Skills</u>

Cognitively flexible
Evidence "executive"/metacognitive skills (planfulness, self-monitoring, self-interrogative, reflective, organized).
Aware of thought processes and choices

<u>Prosocial Skills</u>

Committed to a relationship within and outside family
School connectedness, participate in school activities and extracurricular activities
Has "Social Capital"- - Access prosocial networks, "Guardian Angel",
Advocate for self - - willing to seek help and access Kin
Hang around with the "right" people (prosocial mentors and peers)
Believe in the need "to give to get."
Mindful of thoughts and feelings of others
Willing to help others - - share in family responsibilities
Hold a part time job
Respect others and rules
Part of group who evidences cohesion or a collective sense of togetherness (e.g., church
   attendance, kinship gatherings)
Part of a group that has family rituals and routines and evidences a "collective efficacy"

TABLE 2

EXAMPLES OF "TOP DOWN" EVIDENCE-BASED INTERVENTIONS

School-based Interventions

School Readiness Programs
Head Start Programs
Perry Point Preschool Programs
Anti-bullying Programs
Bystander Intervention Training
Positive Behavior Support
Good Behavior Game
Peace builders Program
Promoting Alternative Thinking Strategies (PATHS)
Character Education Programs
Social-Emotional Learning Problem-Solving
School drop-out prevention programs
After school programs
Programs for pregnant teenage students (prenatal care)
Lunch and nutritional programs
College preparation programs - - One Goal Program

School Mental Health Programs

Target behaviors include:
CBITS – Cognitive-behavioral Intervention for Trauma in Schools
Trauma-focused Cognitive Behavior therapy
Copy Cat for students with Anxiety Disorders
Courses in treating depressed students and preventing depression in high-risk students
Treatment for children whose parent suffers mental disorders, substance abuse disorders and
  family violence
Student Bereavement Groups
New Beginning Program for students whose parents have recently been divorced
Students whose military parents have been deployed and/or returned injured

Family-based Interventions

Nurse-family home visitation program
Child-parent psychotherapy
Parent training programs (focus on parenting skills, monitoring)
ACT programs for parents
Incredible Years Program
Parent Management Training (Use computer technology, see Jones et al. 2012).
Triple P Program (Positive Parenting Practices)

Multidimentional Foster Care Treatment Program
Home-school Liaison Programs
<u>Community-based Interventions</u>

Civic engagement programs for students (Helping Others)
Reduction of the availability of guns
Medical Health Insurance for students
Income Supplement Programs
Earned Income Tax Credits (ETIC)

<u>Technology-based Interventions</u>

Websites for students (e.g., www.reachout.com)
Web-based treatment (See Meichenbaum - - Future of psychotherapy and computers on
www.melissaistitute.org)

TABLE 3

REPORT CARD ON HOW WELL YOUR TRAINING PROGRAMS FOSTER GENERALIZATION AND SUSTAINABILITY

In order to foster transfer at the <u>OUTSET OF TRAINING</u>, my training program:

➢ Establishes a <u>good</u> <u>working</u> <u>relationship</u> with trainees, so the trainer is viewed as a supportive constructive "coach."

➢ Uses explicit <u>collaborative goal-setting</u> to nurture hope. Discusses the <u>reasons</u> and <u>value</u> of transfer and relates training tasks to <u>treatment goals</u>.

➢ Explicitly <u>instructs</u>, <u>challenges</u> and <u>conveys an "expectant attitude"</u> about transfer.

➢ Uses <u>discovery learning</u>, <u>labelling</u> transfer skills and strategies. Use a <u>Clock</u> <u>metaphor</u>. (12 o'clock refers to internal and external triggers; 3 o'clock refers to primary and secondary emotions and accompanying beliefs/theories about emotional expression; 6 o'clock refers to automatic thoughts, thinking patterns such as rumination and beliefs and developmental schemas; 9 o'clock refers to behavioural acts and resultant consequences). These contribute to a "vicious cycle".

➢ Solicits trainees' <u>public commitment</u> and uses <u>behavioral contracts</u>.

➢ Anticipates and discusses <u>possible</u> <u>barriers</u> to transfer.

➢ <u>Chooses</u> training and transfer tasks <u>carefully</u> (builds in similarities and uses ecologically-valued training tasks).

➢ Develops a "<u>community of learners</u>" (e.g., advanced trainees, an Alumni Club).

In order to foster transfer <u>DURING TRAINING</u>, my training program:

➢ Keeps training <u>simple</u>- uses <u>acronyms</u> and <u>reminders</u> (wallet-size cards and a "Hope Chest").

➢ Uses <u>performance-based</u> training to the <u>point of mastery</u>. Provides regular feedback and has trainees self-evaluate and record performance.

➢ <u>Accesses prior knowledge</u> and skills, uses <u>advance organizers</u> and <u>scaffolded instruction</u>.

➢ Teaches <u>metacognitive skills</u>-involving self-regulation, planning and self-rewarding.

➢ Conducts training <u>across</u> <u>settings</u>, using <u>multiple</u> <u>trainers</u> and <u>environmental supports</u>, and <u>parents</u>

➢ Uses <u>cognitive</u> <u>modeling</u>, <u>think alouds</u>, <u>journaling</u>, <u>rehearsal</u> and <u>role playing</u> procedures.

➢ Promotes generalization through <u>between session assignments</u> and between session <u>coaching</u>. Have trainees engage in <u>deliberate</u> <u>practice.</u>

➢ Includes <u>relapse prevention</u> activities <u>throughout training</u> that decreases the chances of setbacks after training is completed. "Inoculates" against failure.

In order to foster transfer at the <u>CONCLUSION</u>, my training program:

➢ Puts trainees in a <u>consultative role</u> (uses reflection of reasons why engaging in these behaviors will help achieve the training goals, provides trainees with an opportunity to teach others, puts trainees in a position of responsibility).

➢ Ensures trainees <u>directly</u> benefit and <u>receives reinforcement</u> for using and <u>describing</u> their transfer skills.

➢ Provides <u>active followup supervision</u>-fades supports and "scaffolds" assistance, and where indicated, provide <u>continuation treatment.</u>

➢ Ensures trainees <u>take credit</u> and <u>ownership</u> for change (self-attributions). Nurtures <u>personal agency</u>.

➢ Ensures trainees design <u>personal transfer activities</u> and <u>become self-advocates</u>.

➢ Involves training <u>significant others</u> and ensures that they support, model and reinforce the trainees' new adaptive skills.

➢ Provides <u>booster sessions.</u>

➢ Conducts a <u>graduation ceremony</u> and offers a Certificate of Accomplishment.

TABLE 4

A "BOTTOM'S UP" LIST OF BEHAVIORAL INFLUENCE "KERNELS"

ANTICEDENT-BASED INTERVENTIONS

Post reminders and signs ("Bully-free Zone").
Post School's Mission Statement.
Post Classroom Rules and refer to them often.
Post daily, weekly, and monthly schedules on a regular basis.
Post reminder signs of GOAL, PLAN, DO, CHECK.
Include displays and pictures of the school's accomplishments (Reinforce concept of being a
  member of the school community).
Use non-verbal cues ("Teacher turn off and on classroom lights, buzzer to note transitions").
Use Advance Organizers when giving instructions (An overview of what is going to be taught
  and why).
Use Informed Instruction (How does the present lesson follow from previous lessons, and
  moreover, where the present lesson is headed? State explicitly the learning objectives. "When
  this lesson is completed you will be able to understand or do the following".) Instructions
  should include a beginning, middle and end statements.
Use "soft" reprimands (Be close by the student, use name and gentle reminders).
Use non-verbal reminders (hand or facial signals with students).
Use cue-cards and place them on student's desk ("Behavior Chain Analysis"). For example,
SLANT which stands for "Sit up, Listen, Ask Questions, Nod, Track the speaker").
Reduce distractions.
Use video self-modeling film of a behavioral sequence.
Use visits to new school settings (switch from elementary to middle school, or from middle
  school to high school). Address anticipatory uncertainty.
Practice skills ahead of time (fire drill and lock down practices),

CONSEQUATING DESIRED BEHAVIORS

Use verbal praise for effort, not just for product.
Use overhead compliments.
Use peer-to-peer praise notes.
Use prize bowls ("mystery" rewards) in classroom and in afterschool settings.
Use Principal lottery (Spend special time with person of status).
Use time out procedures.
Use response cost procedures.
Use overcorrection or positive practice.
Use public posting of student's work
Use public posting of the class accomplishments
"Catch them being good" and acknowledge using metacognitive action verbs when praising. *("I*
  notice you were using your plan… You caught yourself. You backed off.")

CHANGE BEHAVIORAL ROUTINES/SCRIPTS and MINDSETS

Assign student meaningful helper roles.

Have students engage in civic activities (help others).

Use team-based cooperative activities.

Use peer teaching (Put students in a consultative role).

Use bystander interventions (Change social norms - - "Golden rule").

Use choral responding.

Elicit commitment statements ("If … then" rules and "Whenever … if" rules).

Have students fill out planful statements and behavioral scripts.

Challenge students-use beat the clock, buzzer

Have students self-monitor (Use a Behavioral Checklist).

Have students journal, create a playbook, keep progress notes, track changes.

Use story-telling (metaphors, analogies) to teach routines and educational content. For example, use "Turtle technique".

Use direct instruction procedures

Use discovery-based learning (The "art of Socratic questioning," highlighting "What" and "How" questions).

Tap the process of student's thinking. ("*Walk me through how you chose that answer*.")

Model thinking – Use "think aloud".

Have students use self-modeling procedures (video demos).

Use the language of "becoming" and "possibilities" ("*As yet*," "*So far*").

Use Motivational Interviewing Procedures – help student discuss topic that he/she usually avoids in a non-challenging manner (Express Empathy, Develop Discrepancies of the way things are and the way they want them to be. Avoid Argumentation, and Support self-efficacy).

Use RE-verbs, (RE-do, RE-program, RE-learn, RE-connect, RE-silient, RE-bound, RE-think, RE-write).

Convey a "growth" mindset of the possibility of incremental change, as compared to an "entity" mindset (little hope for improvement). Convey that you can teach students the "tricks" and "strategies" that successful students use to perform such tasks. (See Dweck, 2008).

Use examples that "destinies are malleable". Stories of how students have "beaten the odds" and overcome adversities. Use Mentors.

Bolster students' school connectedness. Ask students the following questions:

> *"If you were absent from school, who besides your friends would notice that you were missing, and would miss you?"*
>
> *"If you needed help from someone in school, who besides your friends would you go to for assistance?"*

Encourage students to view themselves as "Peace builders".

Provide students with Metacognitive Prosthetic Devices (MPD's) (Memory prompts, instructional reminders, organizational supports, time management routines, study habits). Ways to support the Prefrontal Cortex of executive skills.

Use metaphors, "Tool box". "Traffic control center for the brain". "How to CBT themselves in

the moment" (CBT= Cognitive behavior therapy). "Use rules for yourself". "How to talk back to your amygdala" (part of brain in charge of emotions). "Use uh-oh response". "Go off auto-pilot". "Avoid mind traps". "Play detective".

Implement programs that encourage group support - - use of study groups

Encourage students to hang around with the "Right" people. Discuss the concept of "Right" people.

Encourage key abilities of grit, curiosity, conscientiousness. Learn the difference between wanting something and choosing it. Bolster self-confidence.

Have students "take credit" for improvements (Self-attributional training).

Provide resilience training. (***See Meichenbaum (2012), Roadmap to resilience - - www.roadmaptoresilience.org***).

TABLE 5

Parent Involvement Questionnaire

Donald Meichenbaum, Univ. Waterloo, & Andrew Biemiller, Univ. of Toronto

This questionnaire is designed to determine how you and your school involve parents in the education of their children. It provides a list of possible ways to involve parents in terms of:

(a) communication (both written and oral) about school activities and about specific topics such as homework;
(b) possible collaborative activities with parents and
(c) administrative support for parent involvement.

There are no right or wrong answers to these questions. The intent of this questionnaire is to have educators consider and reflect upon the many ways to involve parents in the education of their children. Certainly, the feasibility of some of these suggestions will vary depending upon the grade level, subject area, and school setting. Please duplicate this Questionnaire if you wish to use it. We have provided space for you to indicate other ways you and your school have involved parents. Please feel free to send these suggestions to us so that we can revise the questionnaire.

COMMUNICATION WITH PARENTS

Please answer the following questions by circling YES or NO.

A. Written communication with parents

YES   NO   1. At the beginning of the school year, I send a letter home to each parent.

2. In my written correspondence with parents. I:

YES   NO   (a) mention how much I look forward to working with their son/daughter and with them.

YES   NO   (b) comment on the need for parents and teachers to act as collaborators and partners and have a continuing exchange, and I encourage them to be an advocate for their child.

YES   NO   (c) indicate that I will call them when I need their help, as well as when their son/daughter does well.

YES   NO   (d) extend an invitation to parents to call me to arrange a visit to meet (highlight the importance of two-way communication).

YES NO   3. I provide parents with a written general description of what we will be working on during the term and why these activities are important.

YES NO   4. Later in the school year, I provide parents with an ongoing assignment calendar of the work we will be covering in class over the next few weeks and why this work is important (e.g., description of unit objectives, types of problems and assignments, and ways in which students will be assessed; lists of books to be used, recommended children's books, and upcoming school events).

YES NO   5. I provide parents with ongoing written communication in the form of a class newsletter about what the class has been doing and learning, and some of the things students will be learning in the near future. (Students can participate in the production of this newsletter.)

YES NO   6. I indicate to parents that over the course of the school year, their son/daughter will be asked to interview them (or other family members, relatives, neighbors) about learning and helping strategies, and about when they use math and written language in their day-to-day activities.

YES NO   7. I indicate that students will be bringing home a folder of their school-work labeled TAKE HOME/BRING BACK. There will be space for parents to initial and comment on this week.

YES NO   8. I provide parents with a survey/questionnaire to provide information about their child's reading behavior (e.g., average amount of reading time per week, leisure reading habits, favorite books, reading strengths and weaknesses).

YES NO   9. I occasionally send parents a Teacher-Gram and invite them to send back a Parent-Gram about their child's progress.

B. Oral communication (phone calls/meetings) with parents

YES NO   10. I call each parent (at least once per year, preferably once per term) to give positive feedback (i.e., convey something their child did well).

YES NO   11. The ratio of positive to negative phone calls that I make to parents per month is 3 or 4 to 1.

YES NO   12. I keep track (in a running log) of each parent telephone call, recording the date, the name of the student, whom I spoke to, the topic, the parent's reactions, and any follow-up plan.

YES NO   13. I schedule meetings with parents to review their children's progress.

YES NO 14. At these meetings, I usually indicate what their child has studied in class, and discuss their child's study habits (finishing assignments, studying, helping others), academic achievement, and classroom behavior.

YES NO 15. At parent-teacher conferences, I have students attend so they can actively participate (e.g., show work from their portfolios, become self-advocates). Students are advised beforehand on how to contribute to these sessions.

YES NO 16. I encourage students to share with their parents what they do in class, in their homework, and in their other school activities.

C. Communication with parents about homework

YES NO 17. I inform parents about my expectations concerning homework (e.g., amount, time schedule) and comment on the benefits of students' doing homework.

YES NO 18. I provide parents with a list of suggestions on how they can help their son/daughter with homework (e.g., ways parents and students can work out rules related to the setting, times, and routine, ways to motivate students to do homework, ways to provide help contingent on their child's request and need, ways to monitor homework loosely, ways to balance homework with other activities).

YES NO 19. I ask parents for their observations on their child's homework activities (e.g., difficulties, limitations, what went well). I ask parents to initial the homework assignments.

YES NO 20. I provide parents with specific suggestions for working with their children (e.g., read for 15 minutes with their children most nights; ask their children about their school activities and what they have learned each day in school).

YES NO 21. I provide parents with books and other learning materials to use at home with their children.

YES NO 22. I encourage parents to give their children home roles and responsibilities, especially those that involve serving others and that occur on a routine basis (setting the table, doing shopping, etc.).

D. Involvement of parents

YES NO 23. I invite parents into my classroom to observe teacher-led and student-led activities (e.g., how I read stories aloud to students, how students do cross-age tutoring, etc.)

YES NO 24. I review with parents how they can make their home more literacy-friendly (encourage their children's leisure reading behavior).

YES NO 25. I invite parents to assist in my class.

YES NO 26. I make parents feel welcome when they visit my class (e.g., have students give tours, have a display center with sample work available, have a list of things parents can do to help).

YES NO 27. I encourage parents to keep a running diary or journal of their children's progress and difficulties and to share this with me.

YES NO 28. I review with parents biographical information about their son/daughter and journal entries they have provided.

YES NO 29. I welcome parent evaluation of my teaching practices, students' progress, and class and school programs.

YES NO 30. I solicit information from parents about their interests, talents, and hobbies so I can request their involvement and help.

YES NO 31. I provide students with tasks or games in which they can involve their parents.

YES NO 32. I provide parents with a list of choices of how they might become involved at school and/or home with their child's education.

E. Administrative support for parent involvement

YES NO 33. My school views parents as partners in the students' education.

YES NO 34. My principal and/or department head encourages parental involvement and the maintenance of ongoing parental contact (in writing, phone calls, meetings).

YES NO 35. My school holds workshops for teachers on how to work collaboratively with parents.

YES NO 36. My school has created an environment that is inviting to parents (e.g., signs welcome parents into the school; office staff welcome them; teachers greet parents when they pass them in the hall; there is a parent reception area with relevant written material and newsletters).

YES NO 37. My school has a parent-teacher association that meets regularly.

YES   NO   38. My school solicits parent input on important decisions concerning their children (parents are members of the governing council of the school).

YES   NO   39. My school has a parent's night (or family night, or grandparent's gala) when parents can participate in tours and activities and discuss their child's progress with the teacher (e.g., a portfolio night when students can show their work).

YES   NO   40. My school invites parents to participate in school activities (e.g., staff the library, chaperone school trips, share ethnic activities, help with fund-raising).

YES   NO   41. My school has special events for parents to discuss particular topics (e.g., parent involvement, report cards, transitions to new grades such as middle to high school, selection of courses, drug abuse, etc.).

YES   NO   42. My school holds special evening sessions for parents on learning-related activities (e.g., how to help with homework, how to read to students, how to bolster students' self-esteem, why some students succeed in school).

YES   NO   43. My school has a parents' night on a specific subject (e.g., math night) so parents can understand what and how the students are being taught.

YES   NO   44. My school has a back-to-school night during which parents are invited to experience the kinds of activities and tasks their children are asked to perform in class.

YES   NO   45. My school involves students, teachers, and parents in cooperative learning activities in which they assist each other in achieving learning tasks and goals.

YES   NO   46. Parents attend an "open house" where students have opportunities to showcase their work. Students rehearse for this event.

YES   NO   47. My school has encouraged parents to identify with its mission statement

YES   NO   48. My school provides both before-school and after-school programs for students to help accommodate parents' work schedules.

YES   NO   49. My school is located in a high-poverty area, and we have undertaken such activities as having parent night in a local church or laundromat (e.g., offering free use of the laundromat with a parent visit).

YES   NO   50. My school provides or helps to coordinate with other agencies a home-visiting outreach program.

YES   NO   51. My school provides specific skill programs for parents (e.g., helping parents improve their literacy skills) or referrals to other services.

YES   NO   52. My school provides support to parents in obtaining their GED.

YES   NO   53. My school is involved in a parent literacy program (i.e., after-school educational assistance to children in the presence of their parents).

YES   NO   54. My school provides transportation and day-care services when parents are visiting the school.

YES   NO   55. Parents are notified immediately about any unexplained student absences.

YES   NO   56. My school has an active truancy prevention program that involves parents.

YES   NO   57. My school has established involvement and activities with local business and community leaders (e.g., an apprenticeship program).

YES   NO   58. Parents in my school view their involvement as a responsibility to their children.

YES   NO   59. Parents are asked to sign a contract indicating their responsibilities to the education of their children.

YES   NO   60. We monitor parent involvement and try to understand the factors that contribute to their noninvolvement (e.g., failure to attend meetings, volunteer, call or meet with the teacher, review students homework, portfolio,etc.).

Please indicate any additional activities and procedures you use to involve parents, or ideas about what you would like to see your school employ.

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WEBSITES

National Registry of Effective Programs and Practices
http://modelprograms.samhsa.gov/template.cfm?page=nrepbutton

California Evidence-based Clearinghouse
http://www4cw.org

Center for Early Adolescence
http://www.earlyadolescence.org

Adverse Childhood Experiences Study
www.acestudy.org

Assistance to Teenagers
www.reachout.com

Prevention of Depression
http://preventionofdepression.org

Gay, Lesbian and Straight Education Network
http://www.glsen.org/educator

Neighborhood Check-up Interventions
http://Promiseneighborhoods.org

Healthy People
http://www.healthypeople.gov

Positive Parenting Programs
www.tripleP.net

UCLA Center for Mental Health
http://smhp.psych.ucla.edu/rebuild/Rebuilding.htm
http://smhp.psych.ucla.edu/pdfdocs/enhancingtheblueprint.pdf

Family-based interventions and Parenting Skills: Sources of Parental Stressors
IT CE HOPE

Sources of Parental Stress

II   CE   HOPE

I - - Interruption of behavior and plans

I - - Implications for the future

C - - Concerns about safety

E - - Expectations violated

H - - History repeats itself

O - - Overload demands

P - - Personal peeves/rules

E - - Embarrassment in public

COUPLE AND FAMILY INTERVENTIONS FOR TRAUMATIC AND VICTIMIZING EXPERIENCES

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TABLE OF CONTENTS PAGE

CHALLENGES

1. Trauma is an extremely common occurrence with some 70% of the population who will experience such events at some point in their lives.

2. Trauma can impact couples and families in multiple ways:

   a. Impact ALL members of the family at the SAME TIME (e.g., natural disasters, violence, and various losses);

   b. Impact INDIVIDUAL couple or family members, having occurred in the distant or recent past (e.g., history of some form of victimization, exposure to cumulative Adverse Childhood Experiences, family violence or addiction, inter-generational transmission), or the experience of ONGOING CURRENT exposure to community violence, racial discrimination, family member in combat).

3. Interventions designed for specific targeted clinical groups such as co-occurring PTSD and Substance abuse disorders, Bipolar patients, family violence, chronic medical illnesses).

4. There is need to assess for " safety issues " and for the impact of " Burden of Care", especially in female partner in couple' members).

5. Use caution about when to intervene. For example, early intervention may undermine the natural healing processes and the impact of community social supports and other coping resources like the role of religion and spirituality.

INTERVENTIONS MAY TAKE VARIOUS FORMS

1. Education and family-facilitated supportive engagement procedures (Sherman, 2006)

2. Focus on specific clinical populations

    a. PTSD-- Boss,2001/ Cathrall,2004/ Figley,1989/ Johnson,2002, 2012

    b. Substance Abuse (See CRAFT- Community and Family Training to persuade substance abusers to enter treatment) McCrady & Epstein,2008.2009/Miller et al. 2019/O;Farrell & Fals-Stewart, 2006

    c. Specific psychiatric populations such as Bipolar patients, schizophrenics -- Baucom et al. 2014/ Milkowitz & Glynn, 1999/Mueser, 1999

3 Work with adolescents and their family members---Liddell, 2013/ Sexton & Alexander, 2003

4. Family intervention after natural disasters -- Figley & McCubbin, 1983/Walsh, 2003,2006

5. Diverse Models of Couple and Family Therapies

    a. Behavioral Marital Therapy -- Holtzworth-Munroe & Jacobson,1991

    b. Cognitive-behavioral Conjoint Therapy (CBCT) SEE BELOW Finkel et al., 2013/ Monson & Friedman, 2012/ Monson et al., 2017/Wagner et al 2019

    c. Emotion focused therapy -- Johnson ,2012

    d. McMaster Model--Epstein et al., 2003/ Ryan et al., 2005

    e. Ways to enhance RESILIENCE in Couples and Families-- Berg,1997 /Mackey, 2003 / McHenry & Price,2005/Meichenbaum, 2012 / Nichols & Schwartz, 2005/ Walsh, 2003, 2006

FORGING RESILIENCE IN COUPLES AND FAMILIES IN THE WAKE OF TRAGEDY --COMMUNITY-BASED INTERVENTIONS

Multi-systemic interventions use a variety of shared empowering collective "story-telling" procedures including community-based family group and spiritually -oriented meetings; establishing compassion centers; candle light vigils, anniversary remembrance ceremonies, life -affirming activities like constructing "future trees ", outreach places for worship, journal writing activities.

As Walsh observes--- traumatic events can shatter an individual's, couples' and family's assumptive world of invulnerability, security, predictability, sense of trust, hopes and dreams. Recovery is a gradual process over time, even though some traumatic losses are never fully resolved, Nevertheless, multi-systemic recovery efforts can help expand the vision of what is possible through shared efforts Some communities , like some individuals , are more resilient than others, but resilience in all can be nurtured.

Consider that all of these interventions are designed to change the nature of the "stories" that they tell each other, and what they tell themselves. and develop the accompanying coping skills.

CULTURALLY-SENSITIVE FAMILY-BASED INTERVENTIONS

Black Families   Boyd-Franklin, 2004

Latino Families   Falico, 1998

Native American Families   McCubbin et al. 1998

Multi-cultural Families   McGoldrick, 1998

Poor Families   Minuchin et al., 1998

THE ROLE OF THE THERAPEUTIC ALLIANCE IN COUPLE AND FAMILY THERAPY

WHO is conducting the treatment is more important than the WHAT that is included in the treatment approach.

See Friedlander et al. (2018). Meta-analysis studies of alliance-outcome relation in couple and family therapy. Psychotherapy, 55, 356 -371

See   Norcross J. & Lambert, M. (2018) Psychotherapy relationships that work. Psychotherapy, 55, Entire Issue.

1. The psychotherapy relationship makes substantial and consistent contributions to outcome independent of the type of treatment.

 2. The person of the psychotherapist is inextricably intertwined with the outcome of psychotherapy, more so when the clients are severely disturbed at the outset of treatment.

3. Cohesion in couple, family and group therapy, the degree of therapist empathy, collaboration,

treatment goal consensus, positive regard and affirmation, collecting and delivering client feedback have each been found to cultivate a therapeutic alliance across all modes of psychotherapy and across all age groups.

 4. The use of formal feedback on a session-by-session basis helps therapists to effectively treat clients who are at risk for deterioration. There is a need to adapt and personalize therapy.

 5. Bordin (1979) highlighted that the therapeutic alliance consists of:

    a) the agreement of the treatment goals between clients and the therapist;

    b) the agreement on the means (tasks) by which to achieve such goals (" pathways thinking") ;

    c) the positive emotional bond between the clients and the therapist.

6.   Illustrative items of evidence of therapeutic alliance of mutual collaboration and partnership:

   "My therapists and I respect each other."
   "I feel I am working together with my therapist in a joint effort."
   "Did you feel that you were working together with your therapist; that the two of you were joined in struggle to over come your problems?"

7. There is a need for therapists to develop and closely monitor their alliance with each partner or family member throughout the course of treatment. See Friedlander et al. for a discussion of the various Alliance measures that can be obtained on a session-by-session basis .
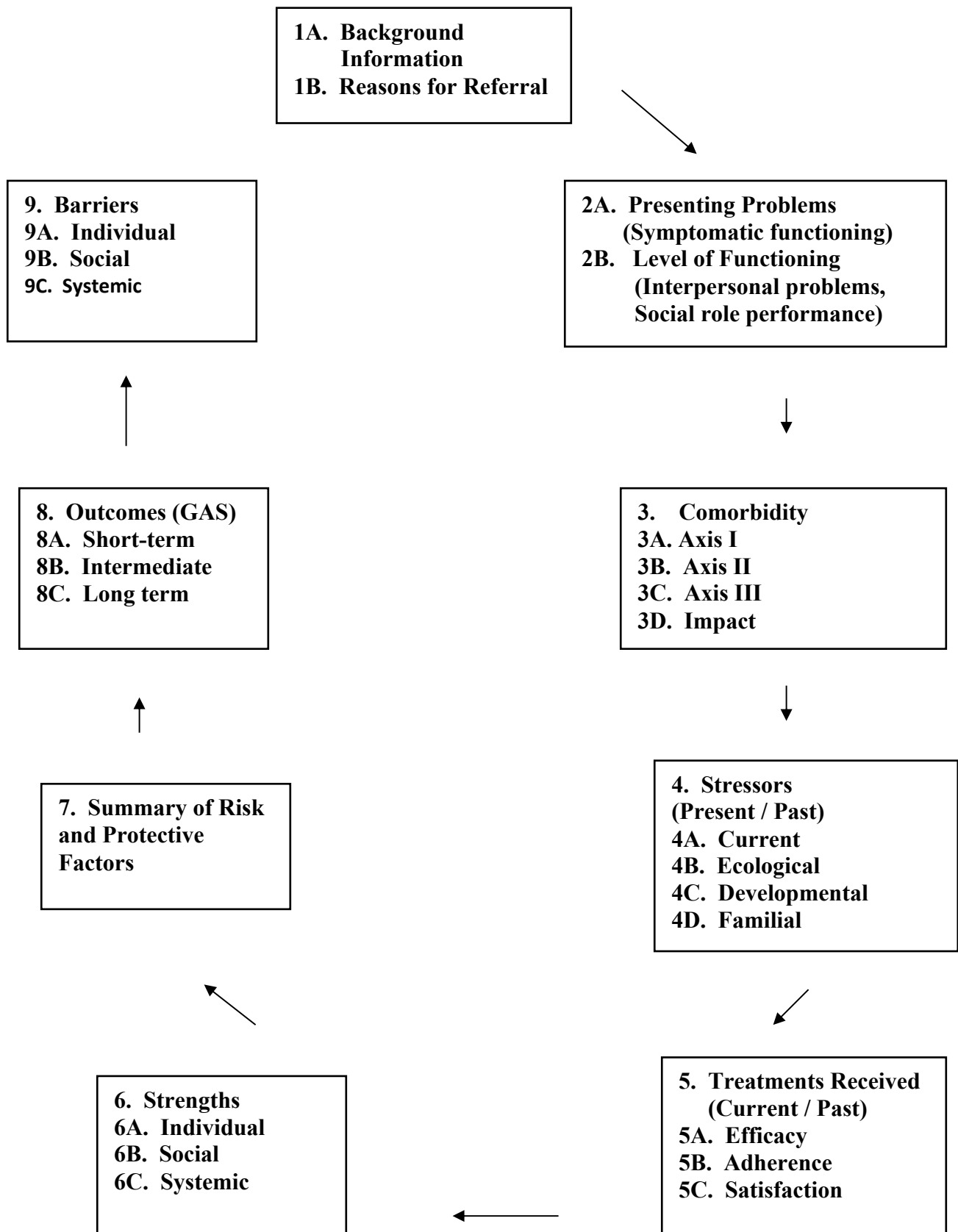
8. Even mandated clients can form strong working therapeutic alliances in treatment.

9. Be sure to pull in quiet or reluctant family members.

10. The therapist needs to be sensitive to within-couple and within-family alliances.

11. Assess for safety issues, especially when there is evidence of split alliances with the therapist.

GENERIC CASE CONCEPTUALIZATION MODEL

1A. Background Information
1B. Reasons for Referral

9. Barriers
9A. Individual
9B. Social
9C. Systemic

2A. Presenting Problems (Symptomatic functioning)
2B. Level of Functioning (Interpersonal problems, Social role performance)

8. Outcomes (GAS)
8A. Short-term
8B. Intermediate
8C. Long term

3. Comorbidity
3A. Axis I
3B. Axis II
3C. Axis III
3D. Impact

7. Summary of Risk and Protective Factors

4. Stressors (Present / Past)
4A. Current
4B. Ecological
4C. Developmental
4D. Familial

6. Strengths
6A. Individual
6B. Social
6C. Systemic

5. Treatments Received (Current / Past)
5A. Efficacy
5B. Adherence
5C. Satisfaction

FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see **if I understand:**

BOXES 1& 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

"What brings you here...? (distress, symptoms, present and in the past)
"And is it particularly bad when..." "But it tends to improve when you..."
"And how is it affecting you (in terms of relationship, work, etc)"

BOX 3: COMORBIDITY

"**In** addition, you are also experiencing (struggling with)..."
"And the impact of this in terms of your day-to-day experience is..."

BOX 4: STRESSORS

"Some of the factors (stresses) that you are currently experiencing that seem to **maintain** your problems are...or that seem to **exacerbate** (make worse) are... (**Current/ecological stressors**)
"And it's not only now, but this has been going on for some time, as evident by..." (**Developmental stressors**)
"And it's not only something you have experienced, but your family members have also been experiencing (struggling with)..." "And the impact on you has been..." (**Familial stressors and familial psychopathology**)

BOX 5: TREATMENT RECEIVED

"For these problems the treatments that you have received were-note type, time, by whom"
"And what was **most effective** (worked best) was... as evident by...
"But you had **difficulty following** through with the treatment as evident by..." (Obtain an adherence history)
"And some of the difficulties (barriers) in following the treatment were..."
"But you were specifically **satisfied** with...and would recommend or consider..."

BOX 6: STRENGTHS

"But **in spite of**...you have been able to..."
"Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

"Have I captured what you were saying?" (Summarize risk and protective factors)
"Of these different areas, where do you think **we** should begin?" (Collaborate and negotiate with the patient a treatment plan. Do **not** become a "surrogate frontal lobe" for the patient)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

"Let's consider what are your expectations about the treatment. As a result of our working together, what would you like to see change (in the short-term)?
"How are things now in your life? How would you like them to be? How can **we** work together to help you achieve these short-term, intermediate and long-term goals?"
"What has worked for you in the past?"
"How can our current efforts be informed by your past experience?"
"Moreover, if you achieve **your** goals, what would you see changed?"
"Who else would notice these changes?"

BOX 9: POSSIBLE BARRIERS

"Let me raise one last question, if I may. Can you envision, can you foresee, anything that **might get in the way**- any possible obstacles or barriers to your achieving your treatment goals?"
(Consider with the patient possible individual, social and systemic barriers Do not address the potential barriers until some hope and resources have been addressed and documented.)
"Let's consider how we can anticipate, plan for, and address these potential barriers."
"Let us review once again..." (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words. Involve significant others in the Case Conceptualization Model and treatment plan. Solicit their input and feedback. Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 5B, 4C, 6B, etc) Maintain

situation are...”
“Moreover, some of the people (resources) you can
  call upon (access)are...” “And they can be
  helpful by doing...” (**Social supports**)
“And some of the services you can access are...”
  (**Systemic resources**)

progress notes and share these with the patient
and with other members of the treatment team.

CORE TASKS OF PSYCHOTHERAPY WITH COUPLES AND FAMILIES

  1. Establish, maintain and monitor the quality of the therapeutic alliance on a session-by-session basis, using Feedback-informed assessment.

  2. Use Motivational Interviewing procedures and the Art of questioning--- "How" and "What" questions that evoke CHANGE TALK. Query about the couples' and families' implicit theories of the causes of the presenting problems and what in their judgment is needed to change?

  3. Couples and families who enter treatment with a shared sense of purpose and common views of the source of their problems have the best treatment outcomes. Use collaborative goal-setting to nurture a shared sense of purpose. Develop SMART Goals (Specific, Measurable, Attainable, Relevant, Timely).

  4. The use of a Case Conceptualization Model with feedback can help couples and families develop a shared purpose.

  5. Use a CLOCK metaphor to help couples and families appreciate the interconnecting interactive patterns of relating to each other and how they inadvertently, unwittingly, and perhaps unknowingly create the very problems that they are complaining about.

      12 O'CLOCK   External and internal triggers

       3 O'CLOCK   Primary and secondary feelings

       6 O'CLOCK   Automatic thoughts, thinking processes and developmental schemas
                      and beliefs

     9 O'CLOCK   Behavior and reactions of others

    View emotions (3 O'CLOCK) as "commodities" ASK

      "What did you do with all of your feelings?"
      " If you did that with all of your feelings, then what is impact, what is the toll, what
      is the price that you and others are paying? Is that the way you want things to be? "

    Help individuals appreciate how they get entrapped in creating a "VICIOUS CYCLE"

    Consider the way Sue Johnson in her Emotional Focusing treatment approach is actually

using the CLOCK metaphor.

THERAPIST "You hear her say that you are being too difficult." (12 o'clock). "You felt
helpless." (3 o'clock).
"You try to push it aside." (9 o'clock). "But your body expresses
hopelessness. (3 o'clock), and you say to yourself that I have blown it and
lost her (6 o'clock), so you withdraw." (9 o'clock).
"And then you get angry (3 o'clock) and that is the cycle that has overtaken
the relationship and leaves you alone (3 o'clock). and that brings tears to you."
(9 o'clock). "You say to yourself, 'I have blown it. I will never please her,
never have her love." (6 o'clock) "Is that it?"

6. Use TIMELINES to help couples and families identify strengths and evidence of resilience
that they as a group demonstrated.

TIMELINE 1 --conduct a life-span enumeration of stressors and all types of
interventions

TIMELINE 2 -- enumerate examples of signs of resilience and prior examples of
how couples and families have handled prior stressors and losses.

*" Can the both of you take a few moments to share with me what you found attractive
in each other when you first met?"*

" What was your courtship like?"

" Are those same features (attributes) still there now? "

*" What kind of stressors and losses have you experienced in the past? How did you
handle them? Is there anything you did back then that you can use now?"*

"You both describe yourselves as....."

"As children, neither of you seem to have gotten.... ?"

*"You all seem to want strategies to problem-solve more successfully with one another,
so that conflict doesn't keep escalating and get out of control? "*

*"We can work together helping both of you find your way back to the close feelings
you had for each other at the beginning of your relationship. "*

Finally, conduct TIMELINE 3 which begins with the PRESENT and considers what are the
issues to be addressed in the future.

7. Teach communication skills and conflict management skills. Check to see if this is a behavior

deficit or a performance deficit. Abilities are in their repertoire, but not using these skills with their partners.

8. Build in Generalization Guidelines and Relapse Prevention skills. Put clients in a Consultative Mode and nurture self- attributional statements (" Taking credit" statements). Arrange for Booster sessions, for example Weekend Retreats.

FORGING RESILIENCE IN THE WAKE OF TRAGEDY

Froma Walsh (2018) in her book "Strengthening family resilience "has provided several examples of how community and family-based resilient-oriented interventions have been successfully employed in the aftermath of terrorist bombing in Oklahoma City and the New York City 9/11 attack ; in the aftermath of Hurricane Katrina , and in reconciliation activities following civil wars; as well as in personal losses.

A variety of shared empowering collective story-telling interventions have been implemented including community-based family group meetings, establishing compassion centers, candle light vigils, anniversary remembrance ceremonies, life-affirming activities like constructing "future trees", outreach places of worship, journal writing activities. The participants are encouraged to record not only the bad, sad and scary events but also the helpful, brave and good things they experienced. What are the lessons they learned that can be made into a " gift " that can be shared with others?

Her descriptive accounts are bathed with RE -VERBS   indicating the beneficial value of:

RE-establishing routines and rhythms of life
Re-organizing responsibilities and social roles
Re-storing order, meaning and purpose
RE - Connecting and RE-engaging with social supports
RE-membering those who have been lost
Re-prioritizing goals
RE- newing hope and RE-gaining spirit
Re-authoring one's life

Walsh observes that traumatic events can shatter an individual's, couples, family and community assumptive world of invulnerability, security, safety, predictability, sense of trust, hopes and dreams. Recovery is a gradual process over time, even though some loses are never fully resolved, Nevertheless, multi-systemic recovery efforts can help expand the vision of what is possible through shared effort. Some communities, like some individuals, are more resilient than others, but resilience can be nurtured in all.

COGNITVE-BEHAVIORAL CONJOINT THERAPY (CBCT)

(*www.couplestherapyforptsd.com*)
(Monson and Freedman, 2012)

1. Cognitive-behavioral Conjoint Therapy (CBCT) includes 15 sessions of couples treatment consisting of 75 minute sessions. CBCT does not include individual sessions--only seen as couples. A pre-treatment individual assessment with each partner is conducted in order to obtain a couple's history and to assess for safety concerns. An emotionally safe therapeutic environment is established from the outset. The therapy sessions may include a co-therapist.

2. CBCT consists of THREE phases. The initial sessions may be held twice weekly and later sessions are held once a week. A three month set of booster sessions may be included, as well.

3. Participants are asked to complete out of sessions assignments. Monson and Freedman have summarized the therapeutic focus with an Acronym

R. E. S. U. M. E.

(Rationale, Educate, Satisfaction, Understanding, Meaning, End)

4. PHASE I -- Sessions 1 and 2 provides a rationale for treatment and a psycho-education about PTSD and related symptoms, and assesses for and ensures safety in the relationship. Rapport building and collaborative goal-setting are included. The therapist throughout acts as "coach" and encourages the couple to communicate directly with each other, not act as an intermediary or translator.

"Can you tell John what you want him to know about how you feel?"

The therapist should include session-by-session feedback.

5. PHASE II includes sessions 3 to 7 that helps couples to develop communication skills (active listening, paraphrasing, editing one's own thoughts, conflict management and social problem- solving skills). The couple is encouraged to engage systematically in gradual exposure activities designed to reduce PTSD-related avoidance behaviors, and that increase mutually pleasant activities and that enhance relationship satisfaction. ("Catch each other doing nice

things."). They are also taught ways to become sensitive to early warning signs and use mutually agreed upon Time Out procedures. They learn how to "shrink" the impact of PTSD in their relationship. Use the CLOCK metaphor.

Address issues of intimacy and ways in which the partner can be supportive when sexual abuse is the basis of the trauma. Also, consider the impact of the extended family members and the role of parenting stressors.

6. PHASE III consists of sessions 8 to 15. The focus is on the meaning of the traumatic events and problematic ways of thinking and accompanying emotional regulation skills. ("Hot spots" and "Stuck points") Use various cognitive restructuring and rethinking skills in order to address hindsight bias that engenders guilt and shame , prolong and complicated grief , moral injuries that exacerbate PTSD.

Another Acronym offered to summarize CBCT is **U.N.S.T.U.C.K.**

 U -- United and curious
 N -- Notice your thoughts
 S -- (Brain) Storm alternatives
 T -- Test out your thoughts
 U -- Use the best alternative
 C -- Change feelings, thoughts and behaviors
 K -- Keep practicing

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WEBSITES

VISIT *www.melissainstitute.org/scientific-articles-by-author*   to see a number of papers
    on various forms of couples and family-based interventions.

Cognitive-behavioral Conjoint Therapy for PTSD

 www.coupletherapyforPTSD.com

Family Resilience and Traumatic Stress

www.nctsn.org/resources/family-resilience-and-traumatic-stress-guide-mental

National Network of Family Resiliency

http:// www.agnr.umd.edu/users/nnfr/pun_unler.html

EXAMPLE OF WEBSITES FOR FAMILY-BASED INTERVENTIONS

Treatment Manual for Coping with Depression Course

www.kpchr.org/acwd.html

Interpersonal Therapy for Adolescents

www.interpersonaltherapy.org

Parent-child Interaction therapy

www.pcit.org

Yale Parenting Center and Child Conduct Clinic

www.yale.edu/childconductclinic
www.oup.com/ptm
www.alankazdin.com

Multidimensional Treatment Foster Care

www.hackney-gov.uk/fostering-MFTC.html

Multisystemic Therapy

www.mstservices.com

Triple-P - -Positive Parenting

www.triplep.net

Incredible Years Parenting Program

www.incredibleyears.com

Trauma-focused Cognitive Behavior Therapy

www.musc.edu/tfcbt

Brief Strategic Family Therapy for Adolescent Drug Abuse

www.drugabuse.gov/pdf/Manual5.pdf

Practice Wise – Evidence-based Youth Mental Health Services Literature Database

www.practice-wise.com

Hawaii Department of Health: Child and Adolescent Mental Health Division Annual Evaluation Report

www.hawaii.gov/health/mental-health.camhd/index.html

National Academy of Parenting Practices

www.parentingacademy.org
www.commissioningtoolkit.org

Clinically-based Interventions: Summary of Trauma-focused Cognitive Behavioral Therapy With Children

Treatment of Adolescents: Consideration of Changes in Adolescent Brain Development Implications for Treatment

Ways to Implement The Core Tasks of Psychotherapy: Target Groups

Ways to Bolster Resilience in Trauma Therapists:Individual, Collegical and Organizational Interventions

SUMMARY OF TRAUMA-FOCUSED COGNITIVE BEHAVIOR THERAPY WITH CHILDREN

Donald Meichenbaum, Ph.D.

IMPLEMENTATION OF TF-CBT WITH CHILDREN, YOUTH AND THEIR CAREGIVERS

(See Allen & Kinnniberg, 2014; Allen & Johnson, 2012; Blaustein & Kinnibergh, 2014; Cary & McMillen, 2012; Cohen et al., 2009, 2012; Creed et al., 2014; Grasso et al., 2011; Hays, 2009).

1. TF-CBT has been applied effectively with children who have experienced a variety of multiple traumatic events including child sexual abuse, maltreatment, exposure to domestic violence, natural disasters and those who experience traumatic grief. It has been employed with children who have developmental disabilities and where there is also comorbid disorders such as depression, grief, substance abuse. Ollendick et al. (2008) indicate that the presence of comorbid disorders did not diminish treatment outcomes.

2. TF-CBT has been applied to children ranging from ages 3 to 18. The treatment is usually conducted on a weekly basis over a few months, ranging from 8 to 24 weekly sessions.

3. Children with supportive caregivers who are involved in treatment exhibit greater benefit from mental health interventions than children whose caregivers are not involved in treatment. The parent's level of distress and engagement in parallel and conjoint sessions are predictive of treatment outcome.

4. TF-CBT has been altered in both a developmental manner using cognitive-behavior play therapy procedures and in a culturally-sensitive fashion. (See Cohen et al. 2012 and examples by Bigfoot and Schmidt, 2012 for Native American populations and deArellano et al., 2012 for Latino populations).

5. The therapist in TF-CBT structures sessions such that there is a focus on skill building and a direct discussion and processing of the traumatic and abusive experiences. Treatment addresses the impact of multiple traumas that may have co-occurred. There is a need to triage for basic needs and ensure ongoing safety. Trauma that is more severe in duration, perceived as life-threatening, and where the closer the relationship between the victim and the perpetrator, each contribute to more significant psychopathology. Abused children are more at risk for experiencing future episodes of maltreatment, bullying in schools, and other forms of traumatic events and revictimization.

6. The development, maintenance and monitoring of the therapeutic alliance with the child, youth and caregiver are central and critical to treatment effectiveness. There is a need for the therapist to be empathetic, genuine in developing a therapeutic relationship that engenders respect and trust, so clients feel heard, valued and respected. The therapist can use reflective listening skills, humor, and nurture hopefulness throughout.

7. Therapists can receive Web-based training of TF-CBT by assessing ***www.musc.edu.tfcbt***.

8. The components of TF-CBT have been summarized in a mnemonic **PRACTICE**.

   P – Psychoeducation and parenting skills
   R – Relaxation
   A – Affect expression and regulation
   C – Cognitive coping
   T – Trauma narrative development and processing
   I – In vivo gradual exposure
   C – Conjoint parent-child sessions
   E – Enhancing safety and future development

9. TF-CBT uses a Phase-oriented intervention flow-chart.

   Sessions 1-4 PRAC
   Sessions 5-8 TI
   Sessions 9-12 CE

10. Treatment usually entails individual sessions with the child and parallel sessions with the caregiver. The same therapist sees both the child and the caregiver and later conducts joint sessions when sharing and processing the trauma narrative.

11. Psycho-education is an ongoing process throughout the entire course of treatment and it takes various forms. For the child it may take the form of storybooks, games, role playing discussions, puppet play, and the like. These activities are designed to help normalize the client's experiences, educate about the nature and impact of abusive events and bolster safety skills. Allen and Kronenburg (2014) list a variety of children's story books that can be used with titles such as "The way I feel", "Double dip feelings", "Brave Bart".

12. There is a parallel psycho-education intervention for caregivers that educate about the incidence,impact of abuse and neglect. Parent training skills and the use of PRAISE are highlighted. There is need to sensitively consider the caregiver's level of distress, self-blame, and where indicated, history of abuse.

13. There is a need to elicit the story of abuse from the child or youth using the "art of questioning", or re-enactment puppet play, drawing, and the like. For example, the therapist can ask:

> *"Tell me more about…"*
> *"I wasn't there, so tell me about…"*
> *"I want to know all about…"*
> *"So X began touching your …"*

Address avoidance behavior in a supportive fashion.

14. Help the child and youth tell and write out, draw their account in a chronological order - - like chapters in a book, or panels in a cartoon book. Use thought bubbles to elicit accompanying thoughts and feelings.

15. Help the child develop, practice and teach various coping skills:

Relaxation using belly breathing, cool air techniques. Raggedy-Ann, cooked spaghetti metaphors, Guided imagery, Dream catcher activity.

Affect Modulation – name and tame feelings, increase vocabulary for feelings, use Feeling Chart, SUDs Ratings, Guessing games, Emotional Bingo, role playing, Thought Bubbles, assertive and safety skills. Have the child teach these skills to his/her caregiver, and develop a "Coping Plan". (Put the child in Consultative Mode and have his/her "take credit" for changes - - self-attributional training and relapse prevention procedures in order to enhance the likelihood of generalization and maintenance - - "lasting changes".

16. The development and sharing of a trauma narrative with the caregiver is a critical feature of TF-CBT. Help the child to tell his/her trauma story over several sessions. Discuss and role play with the caregiver how to be accepting and supportive during the conjoint session. The need to be a role model and ways to enhance the child's safety in the future (NO, GO, TELL).

17. Prepare the caregiver for the conjoint session of sharing the trauma narrative.

Explore what the caregiver knows about the abusive events.
Consider the caregiver's emotional reactions and own history of victimization.
Role play caregiver parent-child interactive discussion of trauma narrative.
With the child's permission have the child share artwork, narrative written stories with the caregiver.

18. In the context of preparing the caregiver for the conjoint session, explore the history and current victimization of the caregiver. In about 40% of the cases of child sexual abuse and maltreatment there is also evidence of Domestic Violence. The lingering effects of such abuse in the caregiver can undermine the treatment of the child.

19. Address any specific additional clinical issues such as grief work using Restorative Retelling procedures, Meaning-making activities, and the presence of sexualized and acting out behaviors.

20. Terminating Therapy

> Review skills learned and progress achieved.
> Build in Relapse Prevention training. Help bolster skills and confidence in meeting future challenges and any possible setbacks.
> Fade out the treatment sessions and build in follow-up contacts and booster sessions.
> Highlight the caregiver's role as a therapeutic resource for the child.
> Celebrate the child's and caregiver's Therapy Graduation.

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TREATMENT OF ADOLESCENT DEPRESSION and SUICIDAL BEHAVIOR

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THE NATURE OF THE CHALLENGE
MENTAL DISORDERS IN CHILDREN AND YOUTH

(Research findings gleaned from Berman et al., 2005; Bongar and Stolberg, 2009; Kazak et al., 2010; Kelley, et al., 2010)

It is estimated that 10% to 20% of youth (approximately 15 million children in the U.S.) meet diagnostic criteria for a mental health disorder, and many more are at risk for escalating long-term behavioral and emotional problems.

Among those with a recognized need, only 20% to 30% received specialized mental health care.

Up to 50% of youth in the child Welfare system have mental health problems.

70% of youth in the Juvenile Justice system have mental health problems.

Latino children are most likely to go without needed mental health care.

Although children comprise 25% of the U.S. population, only one-ninth of health care funding is directed at them.

Now let's consider some epidemiological data relevant to child and adolescent depression and suicide.

**CONSIDERING SOME FACTS ABOUT ADOLESCENT DEPRESSION AND YOUTH
SUICIDE**

*(Research findings gleaned from Berman et al., 2005; King, 1997; McIntosh, 2000; NIMH,
2008 and Nock et al. 2008)*

- Adolescent suicide is a major health problem and accounts for at least 100,000 deaths in young people worldwide, according to the World Health Organization.

- Suicide is the third leading cause of death among 10 to 19 year olds in the U.S..

- Among young adults (15-24), there is one suicide for every 100 to 200 attempts. Nearly 20% of adolescents in middle school and high school report having seriously considered attempting suicide during the past year.

- The Youth Risk Behavior Surveillance Survey (YRBS) found that nearly 15% of adolescents had made a specific plan to attempt suicide. 700,000 received medical attention for their attempts.

- Boys who identify as being gay or bisexual are up to 7X more likely to attempt suicide than other boys in their high school.

- 10 % of adolescents, who attempt suicide, reattempt within 3 months, up to 20% reattempt within 1 year, and 20% to 50% reattempt within 2 to 3 years. Prior suicide attempts is one of the most important predictors of completed suicide, with a 30-fold increase risk for boys and a 3-fold increase for girls. With each repeated attempt, the risk of lethality increases as attempters use more severe methods.

- The presence of a co-morbid psychiatric disorder significantly increases the risk of suicide attempts, particularly conduct disorders and substance abuse. 90% of adolescents and 60% of preadolescents who complete suicide had a mental disorder.

- The rate of suicide among adolescents has quadrupled since the 1950's.

- In the U.S., white youth have a higher rate of suicide, 3X the National Average. African American youth have a lower rate than white youth, with Asian/Pacific Islanders having the lowest rates. Hispanics have a relatively low suicide completion rate, but are significantly more likely than either white or African American adolescents to report suicidal ideation.

- 10% of children experience clinical depression before the age of 14. An early onset of depression is associated with a high risk of reoccurrence of depression and with the onset of other psychiatric disorders (mania, substance abuse, anxiety disorders and personality disorders).

- 20% of adolescents experience a clinical depression before they graduate from high school.

- Surveys of youth in grades 9-12 indicate that:
    a. 15% of students reported seriously considering suicide.
    b. 11% reported creating a suicide plan.
    c. 7% reported trying to take their own life in the past 12 months.

- In a typical high school class of 30 students, one student will seriously consider suicide, 2 or 3 (one boy and 2 girls) will attempt suicide, and one student will make an attempt sufficiently harmful to require medical attention.

- One half of those who are clinically depressed do not receive any treatment. Untreated depression is the number one cause of suicide.

- Only 1 in 3 youth who attempt suicide receive help following the attempt. 45% of adolescents who attempt suicide do NOT attend one psychotherapy session after an emergency visit for their suicide attempt.

- Each suicide intimately affects at least 8 people.

- Recent years have witnessed major advances in the treatment of depressed and suicidal youth, including the use of Social Internet Media. (***See list of Websites below***)

SOME FACTS ABOUT SUICIDE

As you consider the following statistics on adult suicide and comorbid psychiatric disorders, it is important to remember that <u>most forms of adult depression begin during childhood and adolescence.</u>

The suicide risk in adults with a history of adolescent Major Depressive Disorder is 5X higher than adults with late onset depression.

Suicide is a significant cause of death in the general population with approximately one million deaths by suicide each year world-wide.

In the U.S., the suicide rate is approximately 11 deaths by suicide for every 100,000 people.

15% of the U.S. population seriously considers suicide at some point in the course of their life, but only 1.4% of the population dies by suicide.

The suicide attempt to completion ratio is estimated to be 25 to 1, further indicating that a substantial number of people try to die by suicide, but only a few do. Many of whom do so only after multiple previous attempts.

Each year, approximately 33,000 individuals die by suicide in the U.S. (NIMH, 2009).

A quarter million suicide attempts in the U.S. are estimated to occur each year.

15% of those who attempt suicide will eventually take their lives. One third of those who complete suicide have had nonfatal attempts in their past.

Suicide death rate is approximately 10.9 per 100,000 people and this rate has remained unchanged for the past decades.

As many as half of individuals who die by suicide are in active treatment at the time of their death.

90% of them are suffering from a mental disorder at the time of their death.

The average re-attempt rates during treatment is as high as 47%.

Up to two thirds of those who die by suicide have had contact with a health-care professional in the month before their death.

A variety of psychiatric diagnoses increase the risk of patient suicide. These include generalized anxiety disorder, obsessive compulsive disorder, and substance abuse disorder.

Mood disorders account for 50% of all completed suicides.

Mental disorders are a risk factor for suicide. For example, patients with bipolar disorder, 25% to 50% will make a suicide attempt during the course of their illness, with 10% to 20% dying. For those suffering from schizophrenia, between 20% and 40% will make a suicide attempt and 5% will die. For major depression, 2% receiving outpatient treatment will die by suicide and 9% of depressed patients receiving inpatient treatment will die by suicide.

80% of all suicides are committed by males. Females attempt suicide more often than males, yet men are three times more likely to die from their attempt.

As compared to single attempters, multiple-suicide attempters evidence more significant suicidal thinking, depression, helplessness, higher rates of alcohol and substance abuse, poorest histories of interpersonal coping, greater perceived stress and the lowest reports of available and accessible social support. They also have more comorbid Axis I and Axis II disorders. They are also at greater risk for reattempts or death by suicide.

ASSESSMENT AND TREATMENT: A CHECKLIST OF CLINICAL ACTIVITIES FOR WORKING WITH DEPRESSED AND SUICIDAL YOUTH

1. Take a complete patient history. Use a Case Conceptualization Model that assesses for both proximal and distal risk and protective factors, potential barriers and strengths. For example, **Distal Risk Factors** that include prior suicidal behaviors; history of mental disorders such as depression, anxiety and personality disorders, disturbed family context and parental loss before age 12; sexual orientation. **Proximal Risk Factors** that include stressful life events, sexual and physical abuse; academic difficulties; functional impairment due to physical illness and injury; suicide in social milieu; and a cultural belief that suicide is "noble" and accessible means of suicide.

   Proximal risk factors <u>in</u> <u>combination</u> <u>with</u> one or more distal risk factors heightens suicide risk.

   Joiner (2005, 2010) has proposed an Interpersonal-Psychological Theory of Suicide that highlights the role of

   a) <u>thwarted belongingness</u>-unmet need to belong that involves a lack of frequent, positive social interactions and feelings of not being cared about by others;

   b) <u>perceived burdensomeness</u> - - belief that one is a burden and liability to others

   c) <u>acquired capability</u> to enact lethal self-injury and withstand the fear of death. This acquired capacity is developed over time through repeated exposure to painful and provocative events (habituation to fear and pain in self-injury).

   The clinician should assess for each of these psychological areas.

   <u>Thwarted belongingness</u>: "***Do you feel connected to other people?***"
   "***Do you have someone you can call when you are feeling badly?***"

   The clinician should consider the client's social support network, interpersonal losses and the level of social involvement, lack of family cohesion).

   <u>Perceived Burdensomeness</u> "***Sometimes people think that the people in my life would be better off if I was gone. Have you been thinking like that?***"

   The clinician should assess for feelings of "expendability"; significant others would be better off without them.

   <u>Assess Acquired Capability</u> ***Consider history of self-injuries and high-risk behaviors and Resolve Plans and Preparations.***

A history of nonsuicidal self-injury (NSSI) is a risk factor for suicidal behavior. Such NSSI may be intended to relieve tension, produce a feeling of aliveness, alter consciousness, gain attention, reflect a "cry for help".

2. Directly access for suicidality (suicidal thoughts, intentions, plans, accessibility and potential lethality).

> *"Suicidal patients quite often conceal their thoughts and/or simply deny having suicide ideation, particularly when they are intent on dying by suicide and wish not to be stopped. Verbalize suicidal ideation, while a cardinal indicator of heightened risk for potential, overt suicidal behavior is neither a necessity nor a sufficient condition for the assessment of risk for that behavior. A formulation of a patient's risk instead rests on an assessment of a number of acute risk factors reflecting a patient's intense suffering (despair, anguish). (See mnemonic below IS PATH WARM)."*

3. Assess for the presence of both depression and comorbid disorders using a life-span perspective. Depression is a risk factor in approximately 60% of those who die by suicide or who make a non-fatal attempt. But 40% have no evidence of depression. Only about 1% of Americans who have clinical depression will die by suicide within the next year. (Berman, 2010).

4. Obtain releases to connect with past therapists and secure the patient's medical and mental health records.

5. Formulate a diagnosis using DSM.

6. Document, document, document... **"Thinking out loud for the record" (See Below).**

7. Obtain Informed Consent **(See Rudd et al. 2009).**

8. Use supervisors, colleagues to discuss patient's suicidal risk and therapeutic steps taken. Document these contacts.

9. Build in a safety plan. A caveat has been offered by Berman (2010) who observed:

> *"There is <u>no evidence</u> that No Suicide contracts are effective in preventing suicide. Safety planning is considered a best practice, but its empirical effectiveness has <u>not</u> been tested".*

The primary focus of a Safety Plan should be on reducing acute risk factors and then treat the underlying vulnerability that predisponds the patient to be suicidal. The Safety Plan Model reduce the patient's capability and desire to act by removing access to means, counteract substance abuse, helping calm anxiety and aggression, engaging significant others, improving sleep and introducing stabilizing the environment.

10. Assess for the family dynamics and involve them if indicated.

11. Provide hope by assessing for strengths and signs of resilience (**"In spite of" behaviors**) and engage clients in collaborative goal-setting. The presence of social supports, religiosity, plans for the future, a history of coping skills, generally suggests lowered suicidal risk. However as Berman (2010) observes, "The presence of acute risk factors will trump the presence of protective factors every time".

12. Continually assess for ongoing risk for suicide and the possible need for increased supervision (e.g. psychiatric hospitalization). The days and weeks immediately subsequent to psychiatric hospitalization are a period of significant rest for suicide, thus a recent discharge from an inpatient psychiatric unit is a significant risk factor. Given this increased risk, Berman (2010) recommends that the first outpatient appointment following discharge occur within 48 hours of discharge; or less, it at all possible.

13. *"Throughout the therapy process continually communicate that you care and convey your commitment to doing whatever needs to be done to keep the patient alive- that every effort will be made to help the patient to decrease his/her pain, hopelessness and lethality" (Bongar and Stolberg, 2009, p. 16).*

ASSESSMENT OF SUICIDAL POTENTIAL
(*See Meichenbaum, 2009 on www.melissainstitute.org*)

An evaluation should assess the patient's
   a) suicidal ideation
   b) suicidal intent
   c) presence of an identified suicidal plan
   d) availability of means of self-harm (weapon, pills, peer encouragement
      of suicidal behavior such as Internet guidance)

Suicidal ideation refers to how much the individual is thinking about suicide as an option for psychological distress. This may be a concrete plan or expressed as a form of longing or fantasy. The clinician may ask:

   "Have you been thinking about killing yourself in any way?"

Shneidman (1996, p. 137) suggests the following questions to help the suicidal patient get out of a constricted mental state:

   "Where do you hurt?"
   "What is going on?"
   "What is it that you feel you have to solve or get out of?"
   *"Do you have any formal plans to do anything harmful to yourself, and
   what might those plans be?"*
   "What would it take to keep you alive?"
   *"Have you ever before been in a situation in any way similar to this and
   what did you do and how was it resolved?"*

"Such questions can help suicidal persons generate alternatives to suicide, first by rethinking (and restating) the problem, and then looking at possible other courses of action. New conceptualizations may not totally solve the problem the way it was formulated, but they can offer a solution the person can live with. And that is the primary goal of working with a suicidal person." (Shneidman, 1996, p. 137)

The greater the magnitude and persistence of suicidal thoughts, the higher the risk level for eventual suicide. But the clinician should keep in mind that transient thoughts about the meaning of life and suicide is normative for adolescents, with some 63% of high school students reporting some degree of suicidal ideation at some point. For instance the data from the Youth Risk Behavior Survey of some 15,000 high school youth indicated that 17% reported seriously considering suicide. Such suicidal ideation becomes clinically significant when it is more than transient and when it becomes a major preoccupation and it is tied to accompanying behavioral actions or when it is tied to reattempts (Berman et al., 2006).

Suicidal intent refers to the patient's commitment to die. Does the patient have a suicidal plan? The more detailed and specific the plan, the greater the risk of patient suicide. It is important to

determine the <u>potential lethality</u>, <u>accessibility</u> of the method, and any actions taken by the patient to prepare for the event.

Youth Suicidal Risk Factors

- Previous Attempts
- Depression and/or Substance Abuse
- Family history of mental disorders, Substance Abuse
- Stressful situation or loss
- Exposure to repetitive and excessive bullying that may be tied to sexual orientation, sexual identity and social rejection. Victim of cyber-bullying. The recent cases of youthful suicides attest to this risk factor (Cases of Phoebe Prince- - 14 years of age; Jaheen Herrera and Carl Joseph Walker-Hoover, both 11 years of age who committed suicide).
- Exposure to other teens who have died by suicide
- LGBT orientation
- History of physical and/or sexual abuse
- Poor communication with parents
- Incarceration
- Lack of access or unwillingness to seek treatment

Youth Suicide Warning Signs

- Depressed mood
- Substance abuse
- Frequent running away or incarcerations
- Family loss or instability, significant problems with parents
- Expressions of suicidal thoughts, or talk of death/afterlife
- Withdrawal from friends and family
- Difficulties in dealing with sexual orientation
- Anhedonia
- Unplanned pregnancy
- Impulsive, aggressive behavior, frequent expressions of rage
- Rumination- focus on the fact that one is depressed or one's symptoms of depression, and or the causes meanings and consequences of depressive symptoms. Repeated self-focused negative thinking (brooding).
- Sudden changes in behavior, friends or personality
- Changes in physical habits or appearance
- Non-suicidal self-injurious behavior (NSIB). Youth who cut themselves regularly have a significant risk of suicide.

Strongest Predictors

- Previous suicide attempt
- Current talk of suicide/making a plan

- Strong wish to die/preoccupied with death (i.e. thoughts, music, reading)
- Depression (hopelessness, withdrawn)
- Substance use
- Recent attempt by friend or family member
- Suicidal plans/methods/access
- Making final arrangements

SUICIDE ASSESSMENT STRATEGIES: USEFUL MNEMONICS
(*See Berman, 2010; Somers-Flanagan & Somers-Flanagan, 1995*)

IS PATH WARM?

- **I** Ideation- threatened, communicated or otherwise hinted at such as by looking for ways to kill oneself
- **S** Substance Use - excessive or increased use of alcohol or drugs

- **P** Purposelessness - feelings of lacking in purpose, value or increased seeing no reason for living
- **A** Anxiety – increased anxiety, agitation or insomnia

- **T** Trapped – feeling like there is no alternative, no way out, other than suicide to escape intolerable feelings; need to terminate oneself to end feelings of shame or guilt
- **H** Hopelessness – feelings and/or thinking that nothing can or will ever change for the better

- **W** Withdrawal – increased isolation from family, friends, work or usual activities

- **A** Anger – feelings of rage, wish to seek revenge against alleged evil others, uncontrolled anger
- **R** Recklessness – acting with disregard for consequences, engaging in risky activities seemingly without thinking
- **M** Mood Changes – experiencing dramatic mood changes, cycling

ASSESSING THE PLAN: SLAP

- **S**pecificity: suicide plan details
- **L**ethality: how quickly could plan lead to death
- **A**vailability: how quickly could patient implement the plan
- **P**roximity: how close are helping resources

MAP I3

- **M** – Motivation

- **A** – Access to Lethal Means
- **P** – Plan
- **I #1**- Intent
- **I #2** – Identifiable Victim (self or other, in case of homicidal threat)
- **I #3** – Inability to identify factors which might prevent them from following through

Assessment: SAD PERSONS

- **S**ex
- **A**ge
- **D**epression
- **P**revious attempt
- **E**thanol/substance abuse
- **R**ational thinking
- **S**ocial supports lacking
- **O**rganized plan
- **N**o spouse/unavailability of parent
- **S**ickness

Assessment: SAD PERSONS

- 3-4   = close follow up
- 5-6   = strong consideration of hospitalization
- 7-10 = hospitalization

D-HIPIS

1. UNDERLINED DEPRESSION:
   a. *How have you been feeling lately?*
2. HISTORY:
   a. *Have things ever gotten so bad that you thought about
      killing yourself?*
   (If no, document this, if yes follow below)
   b. *Have you ever attempted suicide?*
3. IDEATION:
   a. *Are you worried about killing yourself now?*
4. PLAN:
   a. *Do you have a plan to harm yourself? When, where, how would they
      carry out their plan?*
   b. *If they have a plan, do they have access to the firearms to carry it out?
      Are the means lethal?*
5. INTENT:
   a. *How likely do you think it is that you will follow through on your plan?*

(Rate on scale from) 0 (no intent) to 10 (total intent)

6. <u>SELF-CONTROL</u>:

    a. ***If you felt like harming yourself, what would you do to make sure you are safe? They should agree to contacting someone (parent or guardian or trusted adult) before acting.***

Note: Thoughts of death or wanting to "go to sleep" should be pursued, but are not specifically suicidal.

USE THE ART OF QUESTIONING

(See Shea, 1998, 2004)

        The clinician should ask questions that pull for specific facts, sequential behavioral details and that elicit the patient's train of thoughts and perceived thwarted needs. Assess for the presence of perceived burdensomeness, perceived absence of social supports (feeling of social marginalization) and prior high-risk self-injurious behaviors. (Joiner, 2008). Ask the patient, and where indicated, significant others to recreate the step-by-step suicide attempt. For example, the clinician should be able to assess the detailed nature of the suicidal attempt. The clinician should also include questions that assess for the presence of protective factors or "buffers" to suicide.

What method of suicide was contemplated and what was implemented?
How close did the patient come to completing suicide: For example:
    How many pills did you take?
    Did you put the razor blade to your wrist?
    Tell me what happened next?
How serious were the actions taken?
How serious were the patient's intentions?
Did the patient tell anyone of the attempt?
Did the patient tell anyone beforehand?
Did the patient make the attempt in an isolated area or in a place where he or she was likely to be found?
Did the patient engage in preparatory steps (e.g., write a suicide note, say goodbye to significant others, give away prized possessions, take other steps?)
Was the patient's attempt well planned or an impulsive one?
How long did the patient think about this suicidal plan?
What other ways has the patient thought of killing oneself?
Did alcohol or drugs play a role in the attempt?
Were interpersonal factors a major role in the attempt?
Did a specific stressor or set of stressors prompt (trigger) the suicide attempt?
At the time of the attempt, how hopeless did the patient feel?

Why did the attempt fail? How was the patient found, and how did the patient finally get help?

How does the patient feel about the fact that the attempt was not completed?

> *What are some of your thoughts and feelings about the fact you are still alive?*
> *Are you sorry your suicide attempt failed?*
> *Can anyone be of help?*

The clinician should assess for previous suicidal attempts.

> *What is the most serious past suicide attempt?*
> *Does the patient view the current stressors and options in the same light as during the past attempts?*
> *Are the current triggers and this patient's current emotional state similar to when the most serious attempts have been made?*
> *How many previous suicide attempts has the patient engaged in? Has the patient exhausted all hope?*

Assess for Current Safety Plan

The clinician can ask:

> *What would you do later tonight or tomorrow if you begin to have suicidal thoughts again?*
> *Right now, are you having any thoughts about wanting to kill yourself?*
> *Do you still have the gun (pills) in the house?*
> *Have you ever gotten the gun out with the intention of killing yourself?*
> *In the past, what stopped you from pulling the trigger?*

Assess for Protective Factors or "Buffers" to Suicide

The clinician can select from the following questions.

> *Help me understand the reasons for hurting yourself or killing yourself?*
> *What problem(s) are you trying to solve?*
> *What would you tell a close friend who was in the same circumstances (situation)?*
> *How else could you reasonably view your situation?*
> *What steps can you take to begin to change your life, rather than kill yourself?*
> *How might you make your life better in the future?*
> *How can you reinvest in life?*
> *What do you like best about yourself?*
> *What happened recently that made you feel good?*
> *What do you like better, your eyes or your hair?*
> *The one thing that would help me no longer be suicidal would be _____ ?*
> *Is suicide the best way for you to cope or change the situation?*

Who are 3 people you will call if you are feeling like hurting yourself? (Get specific names and contact numbers). Which one would you be most comfortable in calling? Promise me, that if you feel suicidal you will call ___ (not just leave a message) about how you are feeling before you try to hurt or kill yourself?

Note: The research indicates that the use of <u>No Harm Behavioral Contracts</u> does not reduce the risk of suicide and can be catrogenic (increase suicidal risk). (See Rudd et al. 2004, 2009).

DOCUMENT THE RECORD

"If it was <u>not</u> recorded and documented, it is assumed it did <u>not</u> occur. Rather, think out loud for the record."

Bongar and Stolberg (2009) propose that good record keeping is <u>paramount</u> and should include the following:

1. A systematic and thorough assessment of suicidal risk (present and past), and how this was determined by the therapist (Enumerate any measures that were used, the interview questions that were covered and the answers given).

2. Indicate the information that alerted the clinician to the suicidal risk.

3. List the risk and protective factors and actions taken (e.g., Include a copy of the Safety Plan, the Treatment plan and compliance data, for example with regard to psychotropic medication).

4. Document ongoing risk assessment and consultation efforts.

5. See Meichenbaum (2005) for a listing of the risk and protective factors that should be systematically assessed and documented when working with a suicidal client. Also see *www.melissainstitute.org.* for a **DETAILED HANDOUT** in assessing and treating suicidal patients (children, adolescents and adults). (Go to the Melissa Institute and Check Author Index. Scroll to Meichenbaum and call up paper entitled *"35 Years of Working with Suicidal Patients: Lessons Learned"*)

   Topics covered in The Handout include:

   1. **Incidence of suicide and clinical practice: Implications**

   2. **The Suicidal Mind: A Constructive Narrative Perspective (Treatment Implications)**

3. **Assessment Strategies: Interview Questions for Children, Youth and Adult Assessment Tools (Ongoing Risk Assessment)**

4. **Clinical Interventions with Depressed and Suicidal Youth**

5. **How to Implement Core Tasks of Psychotherapy**
   a) Addressing issues of comorbid disorders
   b) Incorporating relapse prevention procedures
   c) Ensuring safety throughout
   d) Using a Patient Checklist: A "Take home" Toolkit for Suicidal Patients

TREATMENT RESEARCH EFFECTS

(See reviews by Compton et al., 2006; Jacobs & Brewer, 2004; Kelly, 2010; McCarty & Weisz, 2007; Neil & Christenson, 2009; Weersing & Brent, 2006; Weisz, McCarty & Valeri, 2006)

1. Overview of Research Findings
2. Nurturing a Therapeutic Alliance
3. Developmental Considerations: Changes in the Adolescent's Brain Development (Treatment Implications)
4. Continuum of Care: Intervention Strategies
   Primary (Universal)
   Secondary (Selected)
   Tertiary (Indicated)
5. Consideration of Various Forms of Treatment for Depressed and Suicidal Youth
   a. Cognitive-behavior therapies (The discussion of Coping with Depression Course and TADS teenage depression study)
   b. Dialectical Behavior Therapy
   c. Interpersonal Therapy
   d. Family-based Interventions
   e. List of Treatment Manuals
   f. Pharmacological Intervention
   g. Synergistic (Combined) Treatment Approaches
   h. Internet Resources and Interventions

1. OVERVIEW OF RESEARCH FINDINGS

(See comprehensive Reference List for Additional Resources)

There are more than 550 child and adolescent psychotherapies in use. Psychotherapy with youth has been found to be better than no treatment and youth psychotherapy appears somewhat less effective than adult psychotherapy.

Meta-analyses of evidence-based (EBT) psychotherapy with youth, compared to Treatments as Usual (TAU) yielded an Effect Size (ES=.34), and this ES decreased at a one year follow-up, indicating no lasting treatment effects. When EBT youth treatments were compared with bona-fide (stronger comparison groups), the ES decreased to .24 (Kelley et al., 2010).

A meta-analysis by Weisz et al. (2006) on the effects of psychotherapy for depression in youngsters revealed that treatment methods for depression are <u>less effective</u> than for other adolescent disorders.

In fact, the comparison literature with youth is quite "limited," with only some 16 studies that meet randomized control standards.
Different youth psychotherapies have been found to be <u>similarly</u> <u>effective</u>.

Treatment dropout rates by youth from psychotherapy ranges from 28% to 85%. Youth engagement procedures such as the use of Motivational Interviewing is a critical component of treatment.

Research indicates that the quality of the therapeutic alliance is the most critical feature predicting treatment outcome with youth (Karver et al., 2005; Shirk & Karver, 2003; Spielman et al., 2007).

"The best overall risk management strategy remains a sensitive and caring therapeutic alliance within the context of the best possible clinical care" (Bongar & Stolberg, 2009, p. 10).

The therapeutic alliance with the parent is also critical in determining youth participation in treatment.

Such factors as the provision of a clear engaging treatment rationale, collaborative treatment planning, goal clarification with regard to outcome expectations, and a therapeutic "bonding" or support-building (perceived helpfulness, trust, and communication) and the development of hope were found to be predictive of treatment outcome.

Hope is a way of thinking about goals: a wish or desire for something accompanied by the expectation of obtaining it. Hope is the ability to produce pathways to attain goals (pathway thinking) and move on the path toward these goals (agency thinking). Hope and positive outcome expectations are interdependent processes (Snyder, 2005; Kelley et al. 2010).

Providing ongoing feedback such as parent ratings of the youth's symptoms (Youth Outcome Questionnaire- YOQ Burlingam et al. 1996) and related feedback measures on a session-by-session basis has been found to enhance treatment outcomes (Kelley et al. 201), (See *http://www.talkingcure.com* of Scott Miller for examples of these measures and for examples of Bickman's feedback measures see *http://peabodyvanderbilt.edu/ptpb*). Such data-based treatment decision-making enhances treatment outcomes.

In summary, even though the treatment outcomes with depressed and suicidal youth are "humbling," there is some evidence that treatment interventions can be helpful, especially if the quality of therapeutic alliance and treatment (session-by-session) feedback informs decision-making. For example, Weisz et al. (2006) observe

> *"For those who seek an alternative to antidepressants, psychotherapy offers a reasonable option, generating a small to medium Effect Size (ES =.34) that generalizes to comorbid anxiety symptoms and shows substantial holding power for some months after treatment ends." (Weisz et al. 2006, p. 144).*

In two large multi-site randomly controlled studies, the combination of cognitive behavior therapy (CBT) and anti-depressant medication has been more beneficial than either treatment alone for adolescents with Major Depressive Disorder (MDD) (TADS,2007), and superior to medication alone for adolescents with treatment-resistant MDD (Brent et al. 2008).

These CBT approaches included self-monitoring of depressive symptoms, pleasant activity scheduling and behavioral activation, cognitive restructuring and social skills training. The social skills training component included ways to initiate a conversation, appropriate conversation topics, proper eye contact and facial expressions and assertiveness training. The training protocol also included family-based treatment modules. Youth and parents are taught about the connections between feelings, thoughts and behaviors and how this "negative" spiral can be interrupted in more adaptive ways. The psychoeducation should include a discussion about recurrence and risk factors, role of possible treatment barriers like stigma, warning signs, coping strategies, and benefits from treatment. Also discuss adherence issues to medication and psychotherapy.

A variety of psychotherapeutic engaging activities are used with youth. For example, Asarnow et al. (2005) use a "hot seat" game in which group members call out negative thoughts to the youth who is on the "hot seat" and who must immediately answer back with a more "positive" thought. Another group member serves as a "coach" for the youth in the "hot seat." For younger children, CBT may include cartoon-like characters with thought bubbles above them where the child can write his or her thoughts. The therapist may use a Feelings Thermometer, a Feelings Watch, games, role play, and even have youth make a movie where they enact their learned coping skills. These movies are shown to their parents in a multi-family group, as a means to help their parents learn how to help their children use the coping techniques at home.

There is value in reviewing regularly with parents the work done with depressed youth, so they can facilitate these interventions at home.

There is a need particularly to build into CBT active experiential learning, particularly the hands-on activities. These activities may be play-based in which youth are taught ways to "run depressive thoughts off my land," how to engage in a "good coach-bad coach," ways to alter self-talk; and how to use a coping Fish Card Game, Coping Cat Workbook, and the like. In short, in order to foster full engagement of youthful clients, there is a need to include age-appropriate experiential, hands on activities. These CBT clinical interventions can be supplemented by

school-based interventions. The following list of Websites provide examples of screening approaches, psycho-educational and experientially-oriented coping activities.

School-based Screening and Skills-oriented Training Programs

Theguide.fmhc.usf.edu/

elainet@u.washington.ed

kalafat@rci.rutgers.edu

teenscreen@childpsych.columbia.edu

beth.mcnamara@comcast.net

highschool@mentalhealthscreening.org

school-basedmentalhealthtoolkit

lafrom@stanford.org

info@livingworks.net

Ask4help@yellowribbon.org

In addition, students can be encouraged to visit various Mental Health Websites for Adolescents (Review the websites before you recommend them).
www.CopeCareDeal.org

http://www.frozenflame.web.com/sparx.html

www.thelowdown.co.nz

http://au.reachout.com

2. NURTURING A THERAPEUTIC ALLIANCE

QUESTIONS THAT ARE DESIGNED TO NURTURE A COLLABORATIVE THERAPEUTIC RELATIONSHIP WITH ADOLESCENTS

(See B. Bertolino, 2003, <u>Change-oriented therapy with adolescents and young adults</u>. New York: Norton; See D. Meichenbaum, 2004, <u>Treating individuals with anger-central problems and aggressive behavior</u>. Clearwater, FL.-<u>dhmeich@aol.com</u>)

The following set of questions are designed to help engage adolescents and their parents in therapy. As Bertolino (2003) has highlighted, small changes in the language and "story-telling" can open new possibilities for future change. The "art of questioning" is one of the most valuable tools clinicians can use.

1. **Conduct a Situational Analysis**
   How often does the problem typically happen?
   Where does it happen?
   When does it usually occur and how long does it last?
   When does it end?
   Who is present?
   How do they respond?
   What have you tried to do to help address this problem?

   Assume future solutions through future talk
   Use expression such as *yet* and *so far*
   <u>So far</u> things have not gone right for you
   You haven't found a way to stay out of trouble yet

   I would like to <u>invite you to consider noticing</u> any differences in the problems that brought you here and telling me about them when we meet again. For example**,**

   Are there any changes when you get depressed?
   How depressed do you become?
   How long does the depression lasts?
   What do you do with your depression?
   Ask one question at a time.

2. **Turn problem statements into goals and future actions**
   So you <u>would like to see</u>...
   So one of the things <u>we would focus</u> on is to find a way to change...
   So <u>when you get the sense that</u>..., <u>what will be</u> different for you?
   So when you put the trouble behind you, <u>I wonder</u> (I'm curious) how will your life be different?

3. **Translate the client's absolutistic statements that use "all", "nothing" or that reflect "black-white" thinking into partial statements.**
   Much of the time...
   In the last while...
   Always?
   Never?
   Any exceptions?

4. **Solicit feedback on sessions.**
   How was today's session?
   What was helpful or unhelpful?
   Did we talk about what you wanted to talk about?
   Did we work on what you wanted to work on?
   How was the pace of our session? Did we go too fast or too slow, or was the pace just
        about right?
   Was there anything missing from our session that you would like to see us include in the
        next session?
   Is there anything I should have asked that I did not ask?
   Is the way we are proceeding to address your concerns fitting with the way you
        expect change to occur?
   What ideas do you have about how I can help you with this?
   I want to take the time to make sure I understand where you (or each person) are
        coming from. Is that okay with you?
   I would like to hear your ideas about what you think should happen next in our sessions.
   There are many possibilities. We could...or you could decide to...
   What might make the next session a little better for you?
   Are you okay with that?
   I have to tell you that I am a bit confused about...
   I'm still wondering if...
   Correct me if I am wrong.
   Are there any changes you would recommend for our future sessions?
   Did you feel heard and understood?
   Is there anything you would like me to do differently in future sessions?
   How would you explain your experience in therapy today to others who might be
   curious?
   What might make coming here again a little better for you?

   I will be checking in with you regularly in order to find out what's been helpful to you,
   what's not helpful, what's working and what's not working. Is that okay with you? I want
   to find out what we have done together that has been of benefit to you. This way I will be
   able to learn from you if our working together has helped or if anything needs to change
   in terms of the services we provide or whether a referral to another service would be of
   more help.

5. Relapse Prevention Questions: Learning from setbacks (slips)

What signs were present that things were beginning to slip?
What have you learned from this setback?
What will you do differently in the future as a result of this knowledge/experience?
What can you do differently in the future if things begin to slip?
Is there anything that might come up between now and next time we meet that might pose
      a threat (hurdle, barrier) to the changes you have made?
Can you think of anything that might come up that would present a challenge (barrier)
      for you staying on track?

6. Taking Credit For Change

What have you noticed that has changed?
What specifically seems to be getting better?
Who first noticed that things had changed?
When did you first notice that things had changed?
What did you notice happening?
What did you do that resulted in...?
How did you get yourself to do that?
How did you get that to happen?
How was that different than before?
How did that help you?
Where did you get the idea to do it that way?
What did you tell yourself?
What do you think made the difference?
If X were here, what would he/she say has contributed to the change you brought about?
What does it say about you that you have been able to...?
What kind of person are you that you have been able to ...?
Where did this X (courage, will-power) come from?
What kind of inner strengths do you draw on in such moments of difficulty/adversity?
What kind of inner qualities do you possess that allow you to...?
What would others say are qualities that you possess that help you when you need them?
Consider how change comes about with your parents. How can we work together so these
      changes continue into the future?
What have you already learned about how to make it through a day at school?
How have you managed to go so many days in a row at school without having a X?
How will you let people know when you become angry without hurting anyone else or
      yourself?
Who will you want to be sure to talk to this week at school?
Until we meet again next week, who can you depend upon (or call upon) when you begin
to notice bad feelings (or trouble) coming on?

7. Fostering Generalization

Can you tell me a little about how things are since the last time we met?
How can we use what we learned last week to help you deal with the problem you are
      having with...?
Pretty tough situation. Is there anything you could do...?
I am wondering if you could...
What might happen if you...?
I am not certain you are ready for that yet.
That sounds pretty hard. Maybe, we should think of something else to do...
Why is it important to correctly guess what someone's intentions are or what they want?
What, if anything, has been different since the last time we met?
The last time we met, you mentioned that on a scale of one to ten, things were at a five.
      Where would you say things are today?
Were you surprised by how you were able to...?
What did you do differently?
What did you do when you found out that...?
Do you ever find yourself out there in your day to day experiences asking yourself the
      questions that we ask each other, here in our meetings?

3. DEVELOPMENTAL CONSIDERATIONS: CHANGES IN THE ADOLESCENT'S BRAIN DEVELOPMENT (TREATMENT IMPLICATIONS)

"The teenage brain is a work in progress"
"Go to your room until your cerebral cortex matures"

A major concern of any treatment approach with adolescents is the need to tailor the interventions in a developmentally sensitive fashion, given the recent findings about neurological changes in the teenage years. Consider the following findings and the treatment implications.

Laurence Steinberg (2008, 2009 a,b) has summarized the anatomical changes in the brain during adolescence.

1. There is a <u>decrease</u> in gray matter in <u>prefrontal regions</u> of the brain during adolescence, reflecting a <u>synaptic pruning</u> (namely, the process by which unused neuronal connections are eliminated), resulting in improved information processing and logical reasoning.

2. <u>Changes</u> in the <u>dopaminergic activity</u> involving a proliferation, reduction and redistribution of dopamine receptors in paralimbic or prefrontal cortical regions. Dopamine plays a critical role in the brain's reward system. This remoulding of dopaminergic activity can contribute to sensation seeking behaviors, given the youth's heightened salience to rewards.

3. <u>Increase</u> in <u>white matter</u> in <u>prefrontal regions</u>, reflective of myelinition improving the efficiency of neural signalling. Whereas synaptic pruning occurs during early adolescence, the myelination process takes place toward the latter phases of adolescence and into early adulthood. This contributes to the development of executive functions, such as response inhibition, planning ahead, weighing risk and rewards and the consideration of multiple sources of information.

4. There is also an <u>increase in brain connections</u> among cortical areas and between cortical and subcortical regions. Such increased connectivity facilitates the development of emotional regulation and facilitates social information processing.

   These structural changes and the accompanying changing patterns in brain activities contribute to the <u>gradual development</u> of <u>self-management skills</u>. As Steinberg concludes:

   "Brain systems implicated in basic information processing reach adult levels of maturity by mid-adolescence. Whereas, those that are active in higher order executive functions, self-regulation and the coordination of affect and cognition

do <u>not</u> mature until late adolescence or even early adulthood" (2009, p. 744).

Or described more poetically,

"The combination in middle adolescence of an early arousal reward system and a still immature self-regulatory system has been likened to '<u>starting an engine without yet having a skilled driver.</u>'"

From 14 to 16 (pre to mid-adolescence) impulse control, reward sensitivity, sensation seeking, risk taking, and reckless behaviors, and having an easily arousal reward system are all prevalent. From 16 to early adulthood, such behaviors as impulse control, anticipation of future consequences, strategic planning and resistance to peer influences increase.

Steinberg's research demonstrates that the brains of teens lack the maturity to enable them to consistently control their impulses, resist peer pressure and appreciate the risks of their actions. They require "metacognitive prosthetic devices or tools" to develop self-regulatory and peer-resistant behaviors. Teens, especially in early adolescence, have reward-seeking arousal systems, but the ability to put the brakes on is still maturing.

Therapists need to adapt their interventions accordingly to meet these growing capacities. "Teenagers are less mature than we might have thought, especially, in the early stages of adolescence" (Steinberg, 2009).

<u>TREATMENT IMPLICATIONS</u>

1. There is a need to assess the cognitive capacity and meta-cognitive self-regulatory capacity of depressed and suicidal youth.
2. Need to provide the youth with "Meta-cognitive Prosthetic Devices" (MPDs), which may include Memory prompts, Advance organizers, Intermittent Summaries, Training in "Self-Talk" (***"What you tell your brain?"),*** Problem-solving training and Ways to seek help.
3. See Melissa Institute Website ***www.teachsafeschools.org*** for examples of how to build in MPD training, Miller at al. (2007) and Treatment Manuals by Joan Asarnow and her colleagues.

4. CONTINUUM OF CARE FOR TREATMENT OF DEPRESSION IN CHILDREN AND ADOLESCENTS

Illustrative interventions
Primary (Universal)
Secondary (Selected)
Tertiary (Indicated)

Primary Interventions

1. Provide community-wide and school-wide interventions that reduce risk factors and bolster resiliency coping skills ala work of Lewisohn, Rohde, Clarke, Seligman, Reivich and those who bolster competences. (***See Melissa Institute Conferences on Resiliency training www.melissainstitute.org and Cuijpers, 1998).***

2. Provide early interventions in nurturing parent-infant attachment interventions, home-nurse visiting programs, Hawaii project. (see Chorpita et al. 1996).

3. Provide school-wide interventions. For example, see the National Association of School Psychologist's Website ***http://wwwmentalhealthscreening.org/sos_highschool.*** This website describes an SOS Suicide Prevention Program that includes an educational video, workbook, a brief 7 question screening tool and an ACT program, where students are taught how to Acknowledge, Care and Tell. Another useful resource is the School-based Youth Suicide Prevention Guide.
(***http://www.fmhi.usf.edu/institute/pubs/bysubject.html***)
(*http://cfs.fmhi.usf.edu/ufsinfo/hotpubs.cfm*)

4. Following a suicide, schools often provide postvention interventions. Some cautionary observations about how to conduct such post-suicide interventions have been offered by Mazza (1997). He observes (p. 391):

> ***Several studies showed that postvention programs have the opposite effect, that is adolescents who were at the greatest risk for suicidal behavior showed increasing levels of hopelessness, more maladaptive coping strategies, and less evaluative skills after the postvention programs were completed.***

Following a student or faculty suicide, there is a need to carefully not glorify the death, to attribute the suicide to the presence of mental disorders such as depression and not attribute it to "stress" per se, to provide accurate information to curtail rumours, to provide supports. Suicide reflects a psychiatric disorder related to depression and affective disorders, rather than the cumulative effects of stressors that most youth experience. Highlight that suicide is a rare occurrence, and that help is available. See

Joiner (2010) for a discussion of myths concerning suicide. Also, see Callahan (1996) and the listed Websites for guidelines on how school personnel can conduct postvention interventions.

Secondary Interventions

1. Identify children and youth who are "at risk" for becoming depressed and suicidal and provide preventative interventions. Two examples: The ACE Program that measures the cumulative number of Adverse Childhood Experiences (*www.ACEstudy.org*) and program that identifies youth who are at risk because of the cumulative number of "risky" behaviors. For example, a score of 4 or more on the ACE measure raises the probability of suicide by 1220%. Or for instance Miller and Taylor (2005) found that the more problem behaviors an adolescent has, the greater his or her risk of suicidal behaviors. Problem behaviors were defined as including violent behavior, binge drinking, cigarette smoking, high risk sexual behavior, disturbed cutting behavior and illicit drug use. Compared to adolescents with zero problems, the odds of medically treated suicide attempts were 2.3 times greater than among respondents with one risk factor, 8.8 with two, 18.3 with three, 30.8 with four, 50 with five and 227 with six behavior problems. Rates of youth suicide among specific ethnic groups such as Native Americans is over 3 times the national average. Culturally sensitive interventions can be used on a preventative basis. (See La Frombosie, 1996; Witko, 2006).

2. Given the significant higher incidence of suicide among gay, lesbian and transgender youth, especially if they are bullied, there is a need for active, effective <u>school-wide</u> <u>bully prevention procedures</u> and supportive interventions for youth who are at risk. (See *www.teachsafeschools.org* for examples of such interventions).

3. The offspring of depressed parents ala the work of W.R. Beardslee and children of divorced parents and family violence and abusers are at particular risk to develop depression.

4. Youth who are brought into emergency rooms for violent behavior and comorbid depression and those youth who come into Primary Care offices provide an opportunity for interventions. See work by Asarnow, Jaycox and Kruesl.

   The work of Kruesl et al. (1999) highlights the value of parent education in emergency departments. The emergency room is a major contact point for at-risk youth and their families. Some 77% of such youth do <u>not</u> attend recommended follow-up sessions. See work by Joan Asarnow on ways to alter this pattern. Also see Brent et al. (2000) for description of how to have parents of suicidal youth remove guns from the home.

5. Provision of School-based interventions (See Coping With Depression Course by Lewisohn and Rhode- description below and *www.kpchr.org/acwd/acwd.html*).

Tertiary Interventions

1. Skills-based interventions
   a) Cognitive-behavioral therapies ala TADs Study (***See description below***)
   b) Dialectical behavior therapy ala work of Miller, Rathus and Linehan
   c) Problem-solving and communication skills training ala work of Stark.
   d) Interpersonal therapy ala work of Mufson and colleagues.

2. Family-based interventions ala work of Brent et al. (1995, 1997)

3. Pharmacologically-based interventions. (***See discussion below***).

EXAMPLES OF COGNITIVE-BEHAVIORAL INTERVENTION PROGRAMS:
SCHOOL and CLINICALLY-BASED TREATMENT APPROACHES

Lewisohn <u>Coping With Depression Course</u>
(See Clarke et al., 2001, Lewisohn et al., 1990, 1993 1999)

Classroom presentation- use with grade school and high school students. Use group exercises 6 to 10 adolescents (16 twice weekly 2-hour sessions over a period of 8 weeks) and parallel parent groups (3 informational meetings).

a) Use mood monitoring- identification and association of mood states, activities, cognitions

b) Social skills training and experiential learning- use self-modeling in which children repeatedly observe videotapes of themselves engaging in non depressive and desirable behaviors

c) Increase pleasant activities

d) Relaxation skills

e) Constructive thinking-test dysfunctional cognitions

f) Communication skills training and conflict reduction techniques

g) Negotiation and problem-solving skills

h) Use role playing

Parents are informed about general topics discussed, skills taught and how to be supportive. The parents' own depression was not directly discussed in the parent meetings. Focus is on ways parents can reinforce and promote positive changes in their children.

Recovery rate of 60% with <u>Coping With Depression Course</u>.

Stark and colleagues developed CBT that included 24-26 sessions of small school-based meetings with additional in-home family meetings. Focus of interventions was on self-control training, assertiveness and social skills training, cognitive restructuring, problem-solving and relaxation training. Parents and teachers are taught how to support children in practicing new skills.

Overall Median Effect Size with CBT for depression with children is .64 to .67. CBT led to remission in 65% of cases, a higher rate than either supportive therapy or family therapy (Brent et al., 1997).

FEATURES OF THE TREATMENT OF ADOLESCENTS WITH DEPRESSION STUDY (TADS)

(See Journal of American Medical Association: JAMA, 2004, 292, 807-820 and Cognitive and Behavioral Practice, 2005, Vol. 12, Number 2)

1. Treatment study was conducted across 13 different sites using random assignment of 439 moderately to severely depressed adolescents (Ages 12-17, Mean age 14.6). The youth met the diagnostic criteria of Major Depressive Disorder- MDD on the Children's Depression Rating Scale- Revised. (Mean Group score of 60, reflecting moderate to severe depression, Poznanski & Moknos, 1995).

2. 80% of the subjects were experiencing their first episode of depression. Medium length of depression was 42 weeks and the average length of depression was 71 weeks.

3. One-third of the adolescents had past suicidal behavior, experienced current suicidal ideation and/or parasuicidal behaviors such as cutting. Other high risk behaviors included drugs use, promiscuity, runaway behavior, school refusal, and dangerous Internet use (e.g., arranging meetings with people who were met on-line).

4. 50% of the adolescents had comorbid psychiatric disorders, (27% had anxiety disorders and 10% had social phobias which contributed to the maintenance of their depression). Although learning disabilities were not specifically assessed, 6% of the sample was enrolled in special education classes, 15% had a history of repeating a grade. Such learning problems in children who are depressed are common. 23% were diagnosed with comorbid Disruptive Disorders and Oppositional Behavior Disorders (negative, hostile, defiant). 14% met the criteria of ADHD.

5. Race- 74% were Caucasian; 12% Black/African American; 4.8% Latino.

6. Exclusion Criteria- Adolescents with very problematic comorbidities of serious conduct disorder and substance abuse were excluded. Adolescents with high risk of suicidal behavior as defined as suicide attempts that required hospitalization within the previous 3 months were also excluded. They also excluded teens who missed more than 25% of school days in the preceding 2 months. If school absences were deemed to be depression-related then this exclusion criterion could be overruled (this occurred in 6% of the cases).

7. Adolescent subjects were randomly assigned to one of four individualized treatment conditions.

Combined Treatment of Antidepressant Medication (Fluoxetine 10- 40 mg/day)

CBT alone

Fluoxetine alone

Placebo pill equivalent

8. <u>Treatment Format</u>- <u>Three Phases</u> (**Flexible Application of Manualized Treatment**)

Phase I- Acute Treatment- 12 weekly sessions that involve individual sessions with depressed adolescent and parent involvement (2 psychoeducational sessions and 1 conjoint family session).

Phase II - Continuation Treatment – 6 weeks

- weekly sessions for partial responders where additional new skills training sessions are conducted
- bi-weekly sessions for full responders (consolidation of skills)
- last session for both full and partial responders focusing on relapse prevention

Phase III – Maintenance Treatment – 18 weeks

Visits every 6 weeks where the focus is on skills consolidation, maintenance of treatment goals and relapse prevention.

Therapy sessions are <u>moderately structured</u>, especially during the first 6 sessions of acute treatment where core skills are taught. Each session is divided into 3 sections of approximately 20 minutes.

<u>First Section</u> is a check-in with the adolescent about concerns, issues, and current condition regarding depressive symptoms since the last session.

<u>Second Section</u> learn and practice new skills. Relate to personal concerns and life experiences. Use didactic instruction, modeling, role playing, Socratic questioning. *(Build in treatment guidelines for generalization)*

<u>Third Section</u>- Plan "homework" to be conducted before the next session. *(Follow guidelines on how to conduct "homework")*

The therapist used a Treatment Manual to guide the teaching of the 8 required skills and the therapist in collaboration with the youth and his/her parents can choose from 5 additional skills. The skills to be addressed were as follows:

COMPONENTS OF CBT WITH ADOLESCENTS
WITH MAJOR DEPRESSION (TADS STUDY)

8 - - REQUIRED SKILLS

1. Establish a <u>Working Therapeutic Alliance</u> with adolescent and parent, united on common treatment goals and conducting <u>psychoeducation</u> about depression and about the Treatment Model with both the adolescent and his/her parents

2. Systematic Mood Monitoring

3. Collaborative Goal-Setting

4. Increasing Pleasant Mood-enhancing Activities

5. Improving Problem-Solving Skills

6. Recognizing and Modifying Automatic Thoughts, Cognitive Distortions and Underlying Negative Assumptions (Implicit "if-then" propositions)

7. Formulating Helpful (more adaptive) Counter-thoughts and Combating Core Beliefs concerning a Negative View of Self, the World and the Future

8. Taking Stock of what has been helpful as a result of the Acute Treatment (Stage I, 12 weeks of treatment) and what skills would likely be of help in the upcoming period.

5 - - OPTIONAL SKILLS

1. Improving Social Interactions

2. Nurturing Assertive Skills

3. Training Communication, Negotiation and Compromise Skills, especially around issues of Autonomy

4. Training Relaxation Skills

5. Teaching Affect Regulation skills

INCLUSION OF CONTINUATION AND MAINTENANCE TREATMENT SESSIONS

MAJOR FINDING

Based on a rating on the Clinical Global Impression Measure where adolescents were judged as being "much improved" or "very much improved" at the end of the 12 week acute treatment phase, the following results emerged.

	Degree of Improvement
Combined Treatment	71%
Medication Alone	61%
CBT Alone	43%
Pill Placebo	35%

As Kratchwill at al. (2005, p. 162) observe:

> *"Initial results from TADS (TADS, 2004) indicate that following acute treatment (12 weeks) Fluoxetine combined with CBT was better than either Fluoxetine alone or CBT alone. Comparison also showed that Fluoxetine alone outperformed CBT, which in turn was statistically indistinguishable from placebo group, with clinically significant suicidal ideation dropping most in the combination treatment group."*

COGNITIVE-BEHAVIORAL SAFETY PROGRAM - - SAFE ALTERNATIVES FOR TEENS AND YOUTH

Asarnow and her colleagues (1999a, 2006, 2007, 2010) have developed a variety of interventions which are time-limited (e.g., 12-16 sessions within three months) that are individually tailored and that specifically target suicide and risk reduction. The intervention programs typically include:

(1) family and community-based interventions (schools, peers, community) to support youth safety and adaptive behaviors;

(2) cognitive-behavioral interventions and the development of a Safety Plan;

(3) care linkage strategies, linking youth to needed active follow-up care. There is a need to create a "Circle of Support." (Keep in mind that a previous suicide attempt increases the risk of a reattempt by 30 fold).

FAMILY-BASED INTERVENTIONS

Restifo and Bogels (2009) examine the family processes that contribute to the development and maintenance of youth depression. They identify risk factors that include parental rearing style, family environment, marital conflict and psychopathology, family abuse and neglect. The relationships between youth depression and these family factors are both reciprocal (bi-directional) and transactional (behaviors that engender responses). They discuss the need for family-based psychotherapeutic interventions with depressed children and youth, given the limited effectiveness of cognitive therapy and the success of such family-oriented treatments with youth with externalizing disorders, substance abuse and eating disorders (Diamond and Josephson, 2005). For example, dysfunctional cognitive styles in children and youth have been associated with negative parenting practices such as the level of criticism and the lack of parental involvement (i.e., high Expressed Emotion) and the ways that adolescents establish autonomy (Asarnow et al. 1994; Robin & Foster, 1989). Depressed youth report less pride in their families, trust, respect, cohesion, loyalty and view their families as less adaptable when under stress, and more enmeshed and isolated.

It is important to recognize that while parent depression is a risk factor for offspring depression, it is also linked to the development of other forms of psychopathology such as anxiety and substance abuse disorders. Some 10 studies have tested the effects of treating maternal depression on child depression (Gunlicks & Weissman, 2008). Other treatment approaches have focused on parent-child relationship factors such as conflict resolution, improving communication and parental support.

A number of treatment approaches have included a parent component (Cognitive Therapy, Behavioral Activation, Coping with Depression Course, Interpersonal Therapy, Attachment-based Family Treatment, Systemic Behavior Family Therapy, Family Psychoeducation). (See Restifo and Bogels 2009, for a review).

These varied treatment programs include such components as:

a) Collaborative goal-setting following family assessment and feedback;

b) Education about depression, role of risk and protective factors, and increased sensitivity to developmental issues;

c) Safety planning and recognition of warning signs and ways to reduce the risk of relapse and suicide;

d) Attempts to change dysfunctional family interactional patterns;

e) Family problem-solving skills training;

f) Family communication skills training;

g) Improving parenting skills and the use of behavioral contingency schedules and positive reinforcement and reduction of High Expressed Emotions behaviors;

h) Fostering of positive parent-adolescent attachment behaviors (family cohesion resiliency-building activities);

i) Whenever indicated, provide separate interventions to address parent psychopathology and marital conflict;

The Treatment for Adolescent Depression (TADS) study which was described, demonstrates the feasibility of targeting multiple family risk factors using flexible treatment modules that can be integrated into a cognitive-behavioral therapy approach.

At this point, there is no comparative outcome data that provides a profile matching between the mode of intervention options and risk factors (see McCarty & Weisz, 2007). Involving families and providing them with support does lead to improved retention levels that correlates with treatment outcomes. See the following Manualized Family Therapy Protocols for treating depressed youth.

Attachment-based Family Therapy	Diamond et al, 2002
TADS Family Modules	Wells & Albano, 2005
Systemic Behavioral Family Therapy	Brent et al, 1997
Coping with Depression Course	Lewishon et al, 1990
Dialetical Behavior Therapy	Miller et al, 2007
Multisystemic Family Therapy (MFT)	Henggeler et al. 2002; Huey et al. 2004. Also see Littell, 2005, 2006 for a critique of MFT
Safety Program and Stress Busters Emergency Department Family Intervention Manual Youth Partners in Care Stress and Your Mood	Asarnow et al, 1999 a,b, 2002
Emergency Room Psychoeducation for Parents	Brent et al, 2000; Kruesl et al, 1999

PHARMACOLOGICAL TREATMENT

➢ In the last decade, the prescription rate of antidepressants for children, youth and young adults has tripled.

➢ Approximately 11 million antidepressant prescriptions were written for children and adolescents in the U.S.

➢ It is unclear if antidepressants are safe or effective in children under 5 years of age.

➢ Only 23% - 30% of depressed youth receive treatment.

➢ SSRI are the pharmacological treatment of choice with adolescent depressions. They have a higher response rate, greater tolerability than TCA's and limited side-effects. (See Weller & Weller, 2000). But overall, the outcome literature compared to adults is quite limited.

➢ The rate of relapse with older children is around 40% in the first 6 to 12 months after withdrawal from pharmacological treatment. Need to consider maintenance dosage.

➢ 60% of youth with MDD show a positive placebo response.

➢ For a description of treatment guidelines and promising results see Emslie et al. (1997) and Hughes et al. (1999).

➢ *"The evidence for the effectiveness of SSRIs compared with placebo in the treatment of depression disorders in children and adolescents is far from compelling." (Cochrane, 2007 Review of SSRIs and Child and Adolescent Depression)*

➢ There is often a synergistic impact of the treatment combination of pharmacotherapy and CBT interventions.

Meta-analysis from 17 blind clinical trials comparing fluoxetine with tricyclic antidepressants and placebo showed no significant reductions in suicidal acts as a result of taking antidepressants (Beasley et al. 1992)

The FDA has issued a Black Box warning that antidepressants increase the risk of suicidal thinking and behavior in children and adolescents with major depressive and psychiatric disorders. But this is controversial. Fewer than 20% of adolescents who commit suicide in the U.S. each year are or have ever taken antidepressants.

WORKING TOGETHER TO REDUCE ADOLESCENT SUICIDE: A "TO DO" LIST

Donald Meichenbaum, Ph.D.

The following list enumerates a variety of Core Tasks or a "**TO DO**" interventions list designed to reduce adolescent suicide. They are organized by settings: <u>School</u>, <u>Medical</u>, <u>Clinical</u> and <u>Special Needs</u>. How many Core Tasks do you engage in? In which area would you consider yourself an "**EXPERT**"? By the designation of "EXPERT," this means that you know how to conduct this Core Task, can demonstrate or teach others, and have others come to you for consultation. In contrast, which Core Tasks would you consider to be a "**Budding Skill**" for which you would like more information? Which Core Tasks do not apply to your work and you do <u>not</u> want more information, <u>at this time</u>?

A PROPOSAL- - now imagine a Website that you could (1) access or download to your I-Phone, I-Pod; (2) then you could scroll down on an "<u>as-needed basis</u>," and (3) click that Core Task and obtain information and a video demonstration on how to implement each Core Task designed to reduce Adolescent Suicide. Moreover, consider how such a Website could be Interactive, whereby you can submit to the Website your specific suggestions on how to implement that Core Task, so it can be shared with others.

<u>What</u> <u>additional</u> <u>Core Tasks</u> <u>would you add</u> <u>to this list</u>? <u>Please email suggestions</u> <u>to Don Meichenbaum</u> (***dmeich@aol.com***).

The Melissa Institute is looking for individuals or organizations to support the development of such a Training Website. **Any supporters out there?**

A "TO DO" LIST OF WAYS TO REDUCE ADOLESCENT SUICIDE

Consider your level of "expertise" in regard to each Core Task. Next to each **TASK** that applies to your setting indicate **E = Expert, BS = Budding Skill, and NA = Not Applicable**.

SCHOOL SETTINGS

_____ 1. Identify "high risk" students for developing depression and suicidal behaviors.

_____ 2. Use Screening Self-Report Measures and other indicators.

_____ 3. Have a referral system in place for identified students.

_____ 4. Provide school-wide resilience-building activities.

_____ 5. Provide evidence-based coping with depression course and build in generalization guidelines.

_____ 6. Educate teachers and other "gate-keepers" about warning signs, referral procedures and myths concerning depression and suicide. Educate them about the adolescents' "developing brain" and implications.

_____ 7. Provide students with information about depression and suicide. Raise awareness and train them on how to be of assistance. (***For example***, ***how to ask questions! "I am concerned about you. Are you thinking of hurting yourself? Are you thinking of suicide?")***

_____ 8. Incorporate discussion of suicide (facts, myths, Art of questioning, specific information about referral sources). Use role-playing and practice. Use class discussion, drama groups and demonstrations. Focus on Middle-School aged students (Grades 7 and 8).

_____ 9. Have a drop-in center for students in need.

_____10. Give out pens, have posters with Crisis Hotline numbers, Websites and Internet resources. Use bilingual posters and other information.

_____11. Teach computer literacy skills and responsibility. Combat cyber-bullying and how to avoid Websites that encourage suicidal acts.

_____12. Implement a bully-proof school-wide program, especially be sensitive to sexual orientation issues since gay, lesbian and transgender youth are most high-risk for victimization and suicide.

_____13. Implement an explicit school-wide program to enhance school-connectedness.

_____14. Identify, monitor, and when indicated, refer "high-risk" students to mental health agencies. For example, repeat suiciders, students of parents who committed suicide, victimized students, (PTSD with comorbid problems), students who come from homes of marital conflict, homeless youth, runaways, students who are returning to school after a suicide attempt. Designate a staff member to identify and track such at-risk students and to co-ordinate secondary intervention programs and wrap-around services.

_____15. Establish and maintain a good working relationship with local mental health center.

_____16. Provide mental health services in school such as CBITS- - Cognitive behavior intervention training in schools.

_____17. Include parents in any planned intervention programs. Have a Parent Night on "Meeting Student's Mental Health Needs." Indicate on School Website and Newsletter available services and how these can be accessed.

_____18. When a student suicide occurs, be careful about possible contagion effects. Conduct a network analysis of the suicidal student and identify other potential "high-risk" students.

_____19. Following a student or faculty suicide be cautious in how you conduct postventions. (Provide information and combat rumours; do not sensationalize the death; attribute suicide to the presence of a psychiatric disorder such as depression and not to cumulative stress that many students experience; consider how best to honor the suicidal individual). (*See **FMHI Youth Suicide Prevention School-based guide***)

_____20. Provide support to students and staff who were most impacted by the loss (See work on treatment of complicated grief reactions).

_____21. Provide training and resources for staff on ways to address needs of depressed and suicidal students. Educate them about Social media Internet resources. Include a Professional Developmental Training on "Meeting the Mental Health Needs of Our Students."

_____22. Work with the media on how they should cover the story of a suicide in your school.

_____23. Work with the School District to collect data on student mental health needs and collect and report data on the effectiveness of these interventions. School Superintendent should collect data on the degree of "Expertise" for each school. How many of Core Tasks are available in each school?

_____24. What other Core Tasks should be added to this List for School Settings?

a) _____
b) _____

(***Please e-mail suggestions to dhmeich@aol.com***)

MEDICAL SETTINGS

_____25. Train Primary Doctors and other gate-keepers on the warning signs, Screening Questions, assessment tools, Motivational Interviewing Questions for working with adolescents who are depressed and evidence suicidal potential. Include a discussion of epidemiological data, comorbid disorders, referral information, value of synergistic treatment approaches of psychotropic medication and psychotherapy, myths concerning suicide, the research on the adolescent's "developing brain" and the treatment implications.

_____26. Provide detailed referral resources and ensure follow up and follow-through. (Most students in need never receive treatment and evidence non-adherence to medication).

_____27. When prescribing antidepressant medication conduct adherence counseling procedures, involve parents, monitor side-effects and conduct follow-up assessments.

_____28. In the Emergency Room, the medical team should conduct interventions with suicidal youth and their parents. Educate and engage parents in ways to implement a Safety Plan (remove guns, pills, monitor warning signs, use referral sources).

_____29. When indicated, hospitalize suicidal youth and implement a collaborative treatment program. Ensure safety, while hospitalized and when discharged.

_____30. What other Core Tasks should be added to this list of Medical Settings?
a) _____
b) _____

(***Please e-mail suggestions to dhmeich@aol.com***)

CLINICAL SETTINGS

_____31. With referred youth use a multigating assessment approach and a Comprehensive Case Conceptualization Model with accompanying feedback procedures.

_____32. Assess explicitly for suicidality and the presence of comorbid disorders.

_____33. Use treatment engagement strategies and Motivational Interviewing procedures with both referred youth and their parents.

_____34. Engage in Collaborative treatment goal-setting and monitor progress.

_____35. Use <u>evidence-based treatments</u> (Individual, Group, Family, Home-based psycho-therapeutic approaches).

_____36. Build in <u>session-by-session</u> <u>feedback</u> from youth and parents for <u>both</u> the client and the therapist to inform treatment decision-making.

_____37. Conduct treatment in a <u>culturally</u> and <u>gender-sensitive fashion</u>. Consider sexual orientation issues.

_____38. Be sensitive to <u>developmental issues</u> such as changes to youth's "developing brain."

_____39. Conduct <u>adherence counselling</u>, if medication is prescribed.

_____40. Be sure to include <u>parent education</u>, <u>participation</u>, and where indicated, refer parents who are "in need."

_____41. <u>Connect back with the school</u> and help with student transition, especially after a suicide attempt.

_____42. How many of the following clinical skills do you feel "Expert" at implementing and for which do you want further skills training? (**E = Expert, BS = Budding Skill**)

__ 1. Develop, monitor, and repair "ruptures" in therapeutic alliance with youth and their parents.

__ 2. Use treatment engagement strategies and motivational interviewing techniques.

__ 3. Conduct suicide assessment, and where indicated, crisis management.

__ 4. Assess for comorbid disorders. Conduct a developmental behavior chain analysis.

__ 5. Assess for strengths and potential barriers.

__ 6. Use a Case Conceptualization Model and provide feedback.

__ 7. Use Time Lines and Collaborative Goal-setting as ways to nurture hope. Use a Hope Kit.

__ 8. Use a Safety Plan, Informed Consent, (Do not use Behavioral Contracts to not harm oneself).

__ 9. Assess for possible parent involvement in terms of psychoeducation, parent participation in treatment and family therapy.

__10. Provide psychoeducation to youth and parents about the interconnections between feelings, thoughts and behaviors.

__11. Use Pleasant Activity Scheduling and Behavioral Activation Procedures.

__12. Teach skills in a gender, developmental and culturally-sensitive manner. Note the variety of skills to be addressed such as emotion-regulation, distress tolerance, problem-solving, social and communication skills, parent conflict resolution, and the like.

__13. Build in Generalization Guidelines to increase the likelihood of transfer and maintenance of treatment efforts. Provide home-based interventions.

__14. Conduct Cognitive Restructuring Procedures. Use of Coping Cards and related procedures.

__15. Ensure training occurs in an experiential and engaging manner (e.g. "Hot Seat," Metaphor, role-playing, movie-making, etc.).

__16. Treat the presence of comorbid disorders in an integrated fashion (e.g., PTSD, Substance Abuse, Anxiety Disorder, Conduct Disorder, Borderline Personality Disorder, Serious Mental Disorders like Bipolar and Schizophrenia).

__17. Conduct Relapse Prevention procedures.

__18. Provide ongoing telephone consultation and follow-through.

__19. Provide support and consultation to therapists who work with depressed and suicidal patients.

__20. Use Additional Resources
    (See Websites and Reference Section for Treatment Manuals)

_____43. What other Core Tasks should be added to this list of Clinical Settings?
    a) _____
    b) _____

   (***Please e-mail suggestions to dhmeich@aol.com***)

SPECIAL NEEDS SETTINGS

_____44. Juvenile Justice Setting. Screen for depression, suicidality and comorbid disorders. Monitor carefully for safety and ongoing risk assessment. Refer for evidence-based Treatments.

_____45. Overlooked Populations- Latino youth, homeless youth, run-away youth. Implement an active out-reach program. Use peer-based interventions.

_____46. Native American Populations- - work with cultural groups and use cultural traditions and heritage. Use American Indian Life Skills Training Curriculum.

_____47. What other Core Tasks should be added to this list of Special Needs Settings?
    a) _____
    b) _____

   (***Please e-mail suggestions to dhmeich@aol.com***)

TEST YOUR KNOWLEDGE ABOUT ADOLESCENCE

Answer each question by circling True (T) or False (F)

T. F. 1. Normal adolescent development is a tumultuous period of "storm and stress"

T. F. 2. Puberty is a negative event for most adolescents.

T.F. 3. The adolescent's brain is fully developed.

T.F. 4. Adolescent thought is childlike.

T. F. 5. The vast majority of adolescents have negative feelings toward their parents.

T.F. 6. The majority of adolescents evidence mental health problems.

T.F. 7. One cannot trust the accuracy, nor the reliability of adolescent's self-report.

T.F. 8. Adolescents prefer to share personal information with their parents, rather than self-disclose this material to their peers.

T.F. 9. Adolescence is a uniform developmental process from ages 11 to 18.

T.F. 10. Psychotherapy with youth has proven ineffective.

(See the end of the Reference Section for Correct Answers)

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(Answers to Test Your Knowledge of Adolescence. All Answers are FALSE)

WEBSITES

For information on Cognitive-behavior Therapy Training in Trauma-focused Cognitive-behavior Therapy, Cognitive Processing Therapy, and related programs

www.musc.edu/tfcbt
http://cpt.musc.edu
www.nctsnet.org

Training in Cognitive Behavior Therapy for Substance Abuse
http://www.drugabuse.gov/txmanuals/cbt/cbt1.html

The Cognitive Therapy Pages
http://www.habitsmart.com/cogtitle.html

Cognitive Behavior Therapy
http://cognitive-behavior-therapy.org/

<u>Evidence-based Interventions</u>

APA Task Force Reportation EBPP with Children and Adolescents
www.apa.org/pi/cyf/evidence.html

Bernal, G. Treatment Manual for Depressed Puerto Rican Youth
http://ipsi.uprrp.edu/recursos.html

Coping with Depression Course
www.kpchr.org/acwd/acwd.html

Florida Mental Health Institute School-based Youth Suicide Prevention Guide
http://www.fmhi.usf.edu/institute/pubs/bysubject.html

http://cfs.fmhi.usf.edu/cfsinfo/hotpubs.cfm

MacArthur Foundation Network on Youth Mental Health
www.childsteps.org

SAMHSA Suicide Prevention Program
http://modelprograms.samhsa.gov

Evidence-based Suicide Prevention Programs
www.sprc.org/feature_resources/ebjp/ebjp-factsheets.asp#type

Registry of Evidence-based Suicide Prevention Programs
www.sprc.org/featured_resources/ebpp/ebpp_factsheets.asp#type

Treatment of Adolescents with Depression Study (TADS)
http://trialweb.dcri.duke.edu/tads/tad/manuals/TAD_CBT.pdf

What Works Clearing House
www.whatworks.ed.gov/
www.effectivechildtherapy.com

For information on depression:

Dr. Ivan's Depresion Central
http://www.psycom.net/depression.central.html

Wing of Madness
http://www.wingofmadness.com

Psychology Information Online: Depression
http://www.psychologyinfo.com/depression/

For understanding depression in children:

Are you Considering Medication for Depression?
http://www.utexas.edu/student/cmhc/booklets/meds/meds.com

Child &Adolescent Bipolar Foundation
http://www.pbkids.org

Depression in Children and Adolescents
http://www.klis.com/chandler/pamphlet/dep/depressionpamphlet.htm

Depression in Children and Adolescents: A Fact Sheet For Physicians
http://www.nimh.nih.gov/publicat/depchildresfact.cfm

Depression and Bipolar Support Alliance
http://www.ndmda.org/

Northern County Psychiatric Association
http://www.ncpamd.com/Depression_%20Adults_Children.htm

For medication and/or psychotherapy of mood disorders

Psychotherapy versus Medication for Depression
http://www.apa.org/journals/anton.html

For Additional Resources

American Association of Suicidology
http://www.suicidology.org/

American Foundation for Suicide Prevention
http://www.afsp.org/

American Psychiatric Association Practice Guidelines for the Assessment And Treatment of Patients with Suicidal Behaviors
www.psych.org/psych_pract/treat/pg/suicidalbehavior_05-15-06.pdf

Applying Best Practices
www.mentalhealth.samhsa.gov
www.effectivechildtherapy.com
www.paxis.org
www.search_institute.org
www.naspweb.org
www.colorado.edu.cspv/blueprints/

Burden of Suicide Report
www.mcw.edu/FileLibrary/Groups/InjuryResearchCenter/pdf/Bos_final_9_5.pdf

CDC's SafeUSA Guide to Preventing suicide
http://www.cdc.gov/ncipc/pub-res/youthsui.htm

CDCStatisticsOnSuicide
www.cdc.gov/ncipc/dvp/suicide

Charles E. Kubly Foundation
www.charlesekublyfoundation.org

Center for Disease Control and Prevention National Center for Injury Prevention and Control
http://www.cdc.gov/ncipc/

Connecting the Dots to Prevent Violence: American Medical Association
(Also call 312-464-4520)
http://www.ama-assn.org/ama//pub/category/3242.html

How to Report on Suicide
www.afsp.org/media

JED Foundation: Ways to Safeguard College Students Against Suicide
www.jedfoundation.org

Joint Commission for Hospital Accreditation (JCAHO)
http://www.jointcommission.org/PatientSafety?NationalPatientSafetyGoals

Joint Commission National Patient Safety Goals
http://www.jointcommission.org/PatientSafetyNationalPatientSafetyGoals

National Organization for People of Color Against Suicide
www.nopcas.com

National Institute of Mental Healthsuicide Fact Sheet
http://www.nimh.nih.gov/research/suicide.cfm

National Institute of Mental Health (2008) Suicide in the U.S.: Statistics and Prevention
http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention.shtml

National Resource Center for Prevention and Aftercare
http://thelink.org

National Strategy for Suicide Prevention
http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp

National Suicide Hotline
1-800-Suicide

National Suicide Prevention Lifeline
1-800-273-TALK

NIMH Frequently Asked Questions About Suicide
http://www.nimh.nimh.gov/research/suicidefaq.cfm

**Resource Guide for Implementing (JCAHO) 2007 Patient Safety Goals
On Suicide**
www.mentalhealthscreening.org/events/ndsd/JCAHO.aspx

Review of Suicide Measures for Adults
http://www.nimh.nih.gov/research/adultsuicide.pdf

Review of Suicide Measures for Children
http://www.nimh.nih.gov/research/measures.pdf

Selected Bibliographies on Suicide Research-1999
http://*www.nimh.nih.gov/research/suibib99.cfm*

Search Institute: 40 Developmental Assets
http://www.search-institute.org

Suicide Assessment and Clinical Interviewing
http://www.suicideassessment.com

Suicide Awareness Voices of Education
www.save.org

Suicide Prevention Information
http://www.mentalhealth.org/

Suicide Prevention Lifeline
1-800-273-TALK (Also on Facebook and Twitter)

<u>Lifeline Website</u>
www.suicidepreventionlifelink.org

<u>Blog</u>
www.crisis-centersblog.com

<u>Lifeline Gallery</u>
www.lifelinegallery.org

<u>My Space</u>
www.myspace.com/800273TALK

<u>You Tube</u>
www.youtube.com/800273TALK

Suicide Prevention Website
www.StopASuicide.org

1-800-273-TALK
1-800-273-8255

Suicide Statistics from CDC's National Center for Health Statistics
http://www.cdc.gov/nchs/fastats/suicide.cfm
The Surgeon General's Call to Action to Prevent Suicide
http://www.surgeongeneral.gov/library/calltoaction/default.htm

World Health Organization Statistics on Suicide
http:www.who.int/on/

Yellow Ribbon Organization
http:www.yellowribbon.org/
Call 303-429-3530

<u>**Ongoing Research**</u>

Treatment of Adolescents with Depression Study (TADS)
(Go to Clinical Trials page of NIMH)
http://www.nimh.nih.gov/studies/index.cfm

National Institute of Health Clinical Trials Database
http://www.clinicaltrials.gov/

<u>**Supportive Agencies**</u>

Child and Adolescent Bipolar Foundation
http://www.pbkids.org

Depression and Bipolar Support Alliance
http://www.dbsalliance.org

<u>**Psychoeducational Materials for Youth and Their Families**</u>

Adolescence Directory On-Line (ADOL)
http://education.indiana.edu/cas/

Cope Care: A Mental Health Site for Teens
http://www.copecaredeal.org/Default.aspx
http://www.inspire.org.au/about-us.html
http://au.reachout.com

Teen Center
http://www.wholefamily.com/aboutteensnow/dramas/

Teen Health
http://www.teenhealth.org/teen/index2.html

Treating Depressed Children: Therapist Manual and Parent Component
http://www.workbookpubling.com/depression.html

<u>**Websites for Depressed Youth**</u>

http://www.frozenflameweb.com/sparx.html
http://www.thelowdown.co.nz
http://www.inspire.org.au/about-us.html

http://au.reachout.com

Conference Sponsored Websites

Melissa Institute for Violence Prevention
www.melissainstitute.org

Ganley Foundation
www.ganleyfoundation.org

COPING WITH YOUR PATIENT'S SUICIDE

Donald Meichenbaum, Ph.D.

The first patient I ever treated as a graduate student at the Veteran's Administration hospital in Danville, Illinois died by suicide. While my supervisor and fellow clinical students tried to reassure me that his death was not my fault, nor due to my clinical incompetence, I felt "deep down" that his suicidal death was a reflection of my inexperience. This incident caused me to wonder if becoming a clinical psychologist was the correct occupational choice.

In the 40 years since this initial clinical episode, I have had three other clients die by suicide being either one of my clients, or the client of a trainee I was supervising.

In fact, clinicians often have to treat suicidal clients. Consider the following findings:

- Full time psychotherapists will average up to 5 suicidal clients per month, especially among those clients who have a history of victimization and substance abuse;
- 1 in 2 psychiatrists and 1 in 7 psychotherapists report losing a client to suicide;
- 1 in 3 clinical graduate students will have a client who attempts suicide at some point during their clinical training and 1 in 6 will experience a client's suicide;
- 1 in 6 psychiatric clients who die by suicide while in active treatment with a health care provider;
- Work with suicidal clients is considered the most stressful of <u>all</u> clinical endeavors. Therapists who lose a patient to suicide, experience such a loss as much as they would the death of a family member. It can become a career-ending event.
- Such distress in psychotherapists can be further exacerbated by the possible legal actions. 25% of family members of suicidal patients take legal action against the suicidal patient's mental health treatment team (Bongar, 2002; Kleespies, 2017).

What can psychotherapists do in the aftermath of the suicidal death of his/her patient?

In a paper entitles "35 years of working with suicidal patients: Lessons learned", I summarize the "Dos and "don'ts" of working with suicidal patients and the need to Document, Document, Document risk and protective factors and accompanying interventions in progress notes (Meichenbaum, 2005). The American Association of Suicidology has offered the following advice on "What to do if you lose a patient to suicide. These include both Procedural and Psychosocial steps to follow. I have inserted some additional suggestions.

1. Procedural (Immediate) Steps

A. Notify your supervisor and supportive colleagues. B. Notify the Director of your Service. C. Contact the Hospital Attorney. D. Consider contacting the client's family members and ask whether you should attend the client's funeral, only with the family member's permission.

2. Meeting your emotional needs.

A. Seek support from your supervisory, colleagues and significant others. B. Attend to your needs to "mourn", in any form, this may take. C. Monitor any stress-engendering self-blame, hindsight bias thinking processes. D. Use cognitive strategies to cope with the emotional aftermath of the client's suicide. Engage in the mindful path of self-compassion (Gerber, 2009).

3. Education (later with supervisor, colleagues or review groups).

A. Review progress notes. B. Write a case summary of the ongoing risk assessment and the course of treatment interventions. C. Enumerate the lessons learned and share this with interested and supportive others. Make a "gift" of your clinical experience with others, transforming the loss into a "teachable experience".

A number of clinicians have offered ways to bolster the psychotherapist's resilience, and nurture post-traumatic growth in the aftermath of a client's death by suicide. See Hernandez et al., (2010), Norcross and Guy (2007), Pope and Vasquez (2005), and Wicks, and Maynard (2014). Elsewhere (Meichenbaum, 2006, 2014, 2017), I have discussed ways to bolster resilience in psychotherapists and ways to "help the helpers".

Finally, find ways to work with others to reduce suicide.

REFERENCES

Bongar, B. (2002). The suicidal patient: Clinical and legal standards of care. Washington, DC: American Psychological Association.

Gerber, C.K. (2009). The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions. New York, NY: Guilford Press.

Hernandez, P., Engstrom, D. & Gangsee, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. Journal of Systemic Therapies, 19, 67-83.

Kleespies, P.M. (2017). The Oxford Handbook of behavioral emergencies and crises. New York: Oxford University Press.

Meichenbaum, D. (2005). 35 Years of working with suicidal patients: Lessons learned. Canadian Psychologist, 46, 64-72. (Also on www.melissainstitute.org Website).

Meichenbaum, D. (2006). Trauma and suicide. In T. Ellis (Eds.), Cognition and suicide: Theory, research and practice. Washington, DC: American Psychological Association.

Meichenbaum, D. (2014). Roadmap to resilience. Williston, VT: Crown House Publishing.

Meichenbaum, D. (2017). Self-care for trauma psychotherapists and caregivers: Individual, social and organizational interventions. On the Melissa Institute Website, www.melissainstitute.org.

Norcross, J.C. & Guy, J.D. (2007). Leaving it at the office: A guide to psychotherapists' self-care. New York, NY: Guilford Press.

Pope, K.S., Vasquez, M.J. (2005). How to survive and thrive as a therapist. Washington, DC: American Psychological Association.

Wicks, R.J. & Maynard, E.A. (Eds.) (2014). Clinician's guide to self-renewal. New York, NY: Oxford University Press.

TO DO LIST

1. Discuss what is the impact of children experiencing cumulative Adverse Childhood Experiences?

2. How can you assess for children's ACE-responses? What risk and protective factors will you include in your assessment process?

3. You have been asked to help set up and evaluate a trauma-informed school. What specific guidelines and advice would you offer? How would you incorporate Primary, Secondary and Tertiary interventions?

4. What are "Metacognitive Prosthetic Devices" (MPD) and how would you employ these with "high risk" children? How can you engage educators and parents as collaborators?

5. You are asked to present to parents on ways to cope with home schooling for their children during the pandemic. What specific advice would you offer in terms of how to communicate with their children, parenting skills, and their own coping with stress?

6. How can you conduct Trauma-focused cognitive-behavior therapy (TF-CBT) in a developmentally sensitive fashion? How can you incorporate cognitive-behavioral play therapy?

7. Discuss ways you would conduct treatment with a variety of adolescent groups such as LGBTQ, victims of human trafficking, and depressed and suicidal youth.

8. You have been asked to consult at a Residential Treatment Program for children and youth. What advice would you offer to help them achieve lasting changes? How can they incorporate generalization guidelines into their treatment program?

9. How can you help bolster resilience in trauma therapists using individual, collegial and organizational interventions?

WEBSITES

Don Meichenbaum
   Email Address: dhmeich@aol.com
   Melissa Institute: www.melissainstitute.org
      (See Resilience Resources for articles and COVID-19 Resources)
   FREE Book: roadmaptoresilience.wordpress.com

See You Tube video "Alive Day Memories: Home from Iraq"

Motivational Interviewing.org

www.motivationalinterviewing.org

Competence Curriculum for Cognitive Behavior Therapy

http://www.uclac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks

Cognitive Processing Therapy

www.CPT-forPTSD.com

Cognitive-behavioral Couple Therapy

www.coupletherapyforPTSD.com

Other Treatment Websites

www.self-compassion.org

http:www.ptsd.va.gov

www.seekingsafety.org

CHILD AND ADOLESCENT WEBSITES

Adverse Childhood Experiences

www.acestudy.org

Dr. Nadine Burk Harris TED TALK on You Tube

Listen to Webinar by Dr. Kate McLaughlin "Neurodevelopment Mechanisms linking childhood adversity with psychopathology"

http://youtube/5hvdnR4xks

National Child Traumatic Stress Network

www.nctsnet.org

Trauma-focused Cognitive Behavioral Therapy

www.musc.edu/tfcbt

Center for School Mental Health (SHAPE)

www.shape.org/TRA-IA

http://theshapesystem.com/trauma

Cognitive Behavioral Interventions for Trauma in Schools (CBITS)

www.cbitsprogram.org

Center for Childhood Resilience

www.childhoodresilience.org

Adolescent Trauma Training Center Integrative Treatment of Complex Trauma (ITCT-A)

www.attc.usc.edu

Effective Child Therapy

http://effectivechildtherapy.com

Problem Solving Discourse - - You Tube with Dr. James Larson

http://www.youtube.com/watch?v=SQlbeAk-6FA
Wraparound Milwaukee on Vimeo

http://Vimeo.com/38060393