Building on What is Strong: Building Resilience in Children and Communities

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Integration Solutions, Inc.
What I thought I was going to do when I started teaching ...

http://aplusphysics.com/flux/aplusphysics/teaching-students-to-teach-themselves/

https://101clipart.com/teacher-teaching-students-clipart/
And then we start school and some days ...

"Every day it's the same thing. My class starts out as Sesame Street and by three o'clock it ends up as Jerry Springer."

"From six to to eighteen, they're always at that age."
Sometimes it's someone just having a bad day or making a poor choice ...

But some behaviors may be an indication of something more ...

- Depression
- Anxiety
- Trauma
According to the National Institute of Mental Health, about 1 in 5 children have a Mental Health Disorder

Symptoms of Depression

Mixture of Symptoms displayed across Depressive Mood Disorder in DSM 5

- Sadness
- Loss of pleasure or interest
- Anxiety
- Irritability and/or Agitation
- Restlessness
- Avoidance
- Difficulty organizing thoughts
- Negative View

- Feeling Isolated
- Helplessness and Hopelessness
- Worthlessness and/or Guilt
- Self Harm or Suicidal Thoughts
- Sleep Disturbance
- Change in Weight or Appetite
Anxiety

According to SAMHSA’s report, *Behavioral Health, United States – 2012*, lifetime phobias and generalized anxiety disorders are the most prevalent among adolescents between the ages of 13 and 18 and have the earliest median age of first onset, around age 6. Phobias and generalized anxiety usually first appear around age 11, and they are the most prevalent anxiety disorders in adults.
Symptoms of Anxiety
Mixture of Symptoms displayed across Depressive Mood Disorder in DSM 5

Excessive Anxiety or Worry more days than not...
- Restlessness, feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating
- Irritability
- Muscle tension
- Sleep disturbance
Trauma
Exposure to Violence in Childhood

46 million of 76 million children are exposed to violence, crime and abuse each year

## Types of Stress

<table>
<thead>
<tr>
<th>Positive Stress</th>
<th>Tolerable Stress</th>
<th>Toxic Stress</th>
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</thead>
<tbody>
<tr>
<td>Normal and essential part of healthy development</td>
<td>Body’s alert systems activated to a greater degree</td>
<td>Occurs with strong, frequent or prolonged adversity</td>
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<tr>
<td>Brief increases in heart rate and blood pressure</td>
<td>Activation is time limited and buffered by caring adult</td>
<td>Disrupts brain architecture and other organ systems</td>
</tr>
<tr>
<td>Mild elevations in hormonal levels</td>
<td>Brain and organs recover</td>
<td>Increased risk of stress-related disease and cognitive impairment</td>
</tr>
<tr>
<td>Example: Tough test at school or a playoff game</td>
<td>Example: Death of a loved one, divorce, natural disaster</td>
<td>Example: abuse, neglect, caregiver substance dependence or mental illness</td>
</tr>
</tbody>
</table>

**Social—emotional buffering**

- Parental Resilience
- Early Detection
- Effective Intervention

**Intense**

- Prolonged
- Repeated
- Unaddressed

Information and slide part of Harris (2013) *Buzz on Brain and Babies Presentation*
Each year in the United States, more than 1,400 children—nearly 2 children per 100,000—die of abuse or neglect.

In 2005, 899,000 children were victims of child maltreatment. Of these:
- 62.8% experienced neglect
- 16.6% were physically abused
- 9.3% were sexually abused
- 7.1% endured emotional or psychological abuse
- 14.3% experienced other forms of maltreatment (e.g., abandonment, threats of harm, congenital drug addiction)

• One in four children/adolescents experience at least one potentially traumatic event before the age of 16.¹
• In a 1995 study, 41% of middle school students in urban school systems reported witnessing a stabbing or shooting in the previous year.²
• Four out of 10 U.S. children report witnessing violence; 8% report a lifetime prevalence of sexual assault, and 17% report having been physically assaulted.³

**Types of Traumatic Stress**

- **Acute trauma** is a single traumatic event that is limited in time. Examples include:
  - Serious accidents
  - Community violence
  - Natural disasters (earthquakes, wildfires, floods)
  - Sudden or violent loss of a loved one
  - Physical or sexual assault (e.g., being shot or raped)

- During an acute event, children go through a variety of feelings, thoughts, and physical reactions that are frightening in and of themselves and contribute to a sense of being overwhelmed.
• **Chronic trauma** refers to the experience of multiple traumatic events.

  These may be multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—or longstanding trauma such as physical abuse, neglect, or war.

  The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact.
• **Complex trauma** describes both exposure to chronic trauma—usually caused by adults entrusted with the child’s care—and the impact of such exposure on the child.

• Children who experienced complex trauma have endured multiple interpersonal traumatic events from a very young age.

• Complex trauma has profound effects on nearly every aspect of a child’s development and functioning.

Young children who have experienced trauma may:
- Become passive, quiet, and easily alarmed
- Become fearful, especially regarding separations and new situations
- Experience confusion about assessing threat and finding protection, especially in cases where a parent or caretaker is the aggressor
- Regress to recent behaviors (e.g., baby talk, bed-wetting, crying)
- Experience strong startle reactions, night terrors, or aggressive outbursts
School-age children with a history of trauma may:

- Experience unwanted and intrusive thoughts and images
- Become preoccupied with frightening moments from the traumatic experience
- Replay the traumatic event in their minds in order to figure out what could have been prevented or how it could have been different
- Develop intense, specific new fears linking back to the original danger
School-age children may also:
- Alternate between shy/withdrawn behavior and unusually aggressive behavior
- Become so fearful of recurrence that they avoid previously enjoyable activities
- Have thoughts of revenge
- Experience sleep disturbances that may interfere with daytime concentration and attention
In response to trauma, adolescents may feel:

- That they are weak, strange, childish, or “going crazy”
- Embarrassed by their bouts of fear or exaggerated physical responses
- That they are unique and alone in their pain and suffering
- Anxiety and depression
- Intense anger
- Low self-esteem and helplessness
• These trauma reactions may in turn lead to:
  - Aggressive or disruptive behavior
  - Sleep disturbances masked by late-night studying, television watching, or partying
  - Drug and alcohol use as a coping mechanism to deal with stress
  - Over- or under-estimation of danger
  - Expectations of maltreatment or abandonment
  - Difficulties with trust
  - Increased risk of revictimization, especially if the adolescent has lived with chronic or complex trauma
Adolescents who have experienced trauma may use alcohol or drugs in an attempt to avoid overwhelming emotional and physical responses. In these teens:
- Reminders of past trauma may elicit cravings for drugs or alcohol.
- Substance abuse further impairs their ability to cope with distressing and traumatic events.
- Substance abuse increases the risk of engaging in risky activities that could lead to additional trauma.

Child welfare workers must address the links between trauma and substance abuse and consider referrals for relevant treatment(s).
Death

Conception

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

- Adverse Childhood Experiences
- Disrupted Neurodevelopment
- Social, Emotional, and Cognitive Impairment
- Adoption of Health-risk Behaviors
- Disease, Disability, and Social Problems
- Early Death
Developing Trauma Informed Schools

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Trauma Services Adaptation Center for Resilience Hope and Wellness in Schools and Communities
National Child Traumatic Stress Network
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A Startling Number of Students Are Exposed to Violence

- 2% Direct assault
- 6% No violence
- 48% Witness
- 27% No violence
- 23% Direct assault & witness
- 54% Violence not involving a weapon
- 40% Gun or knife violence

National Survey of Adolescents 1995

The LA Unified School District 6th-Grade Students, 2004
Decreased IQ and reading ability (Delaney-Black et al., 2003)

Lower grade point average (Hurt et al., 2001)

Decreased rates of high school graduation (Grogger, 1997)

More suspensions and expulsions (LAUSD survey, 2006)

More days absent from school (Hurt et al., 2001)
Lawsuit v. Compton Unified

- Class Action Suit
- Plaintiffs are students in High School
- Filed in Federal Court in May 2015
- Civil Rights Action
- Complaint: No 504 Accommodations for Students with Complex Trauma

Marleen Wong PhD University of Southern California
TraumaLearning.org
Screening and Linkage
Training All Staff to Recognize Possible Mental Health Symptoms

Spread the Word
Tips & Resources for District of Columbia

1. GET STARTED
   • Administrator guide (pdf, click to open)
   • Quick-start guide (pdf)
   • Best practices tip sheet (pdf)

2. ENGAGE

POWERPOINT PRESENTATIONS
   • Slides for use in meetings with educators and school personnel (ppt)

PROMOTIONAL FLYERS
   • At-Risk for High School Educators (pdf)
   • At-Risk for Middle School Educators (pdf)
   • At-Risk for Elementary School Educators (pdf)
   • Combination flyer (all three At-Risk) (pdf)

BANNERS & BUTTONS
   • Images for use on your website or in your newsletter (pdf)

VIDEO WALK THROUGH
   • 3-minute walk through of At-Risk for Middle School Educators (mp4)
   • 3-minute walk through of At-Risk for High School Educators (mp4)

EMAIL & NEWSLETTER TEXT
   • Template language to engage school personnel via email or on a website (doc)

DISCUSSION GUIDE
   • At-Risk for High School Educators (pdf)
   • At-Risk for Middle School Educators (pdf)
   • At-Risk for Elementary School Educators (pdf)

TIMING YOUR OUTREACH
   • Bullying Prevention Month resource packet (pdf)
   • Promotional calendar (pdf)

Nursing Credit (CNE) Available
   • Language to engage school nurses (doc)

OTHER
   • Research results
   • Related webinars (pdf)
   • Kognito fact sheet (pdf)

Access training at: www.supportdcyouth.com

These courses are made freely available to District educators by the District of Columbia Department of Behavioral Health.

Contact Us: 212.675.9234 | info@kognito.com | www.kognito.com
District of Columbia Public Schools
Trauma Sensitive Process

Early Childhood
• Identified via Gold Assessment

K-12th Grade
• Identified via Early Warning Indicators

9th Grade Repeaters
• Universal Screening

June 2015 Mental Health Screening Plan
### Early Warning Indicator System: Screening for MH and Trauma

<table>
<thead>
<tr>
<th>Early Warning Indicators</th>
<th>On-Track (Tier I)</th>
<th>Sliding (Tier II)</th>
<th>Off-Track (Tier III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEHAVIOR</td>
<td>No Office Discipline Referrals (ODR) or suspensions</td>
<td>2-3 ODRs and/or 1 suspension</td>
<td>3+ ODRs and/or 2+ suspensions</td>
</tr>
<tr>
<td>ATTENDANCE</td>
<td>missed &lt; 5% instructional days</td>
<td>missed ≥ 5-9% instructional days</td>
<td>≥ 10% instructional days</td>
</tr>
<tr>
<td>ACADEMICS: READING and Math</td>
<td>Above proficient or proficient on interim assessment</td>
<td>Below Proficient</td>
<td>Far below proficient</td>
</tr>
</tbody>
</table>

June 2015 Mental Health Screening Plan
Tier III - Intensive
Individualized intervention with community support for children who have active mental health symptoms or special education behavior support goals.

Tier II - Targeted Intervention
Early intervention for students who are identified as at risk for developing mental health, behavioral issues or educational issues.

Tier I - Universal Prevention
Social emotional learning programs to support ALL STUDENTS. Can be implemented by school social workers, teachers, counselors, nurses, etc.

June 2015 Mental Health Screening Plan
Tier One

Tier I: Universal Prevention/Consultation and Mental Health Promotion:

Social emotional support services at this tier are provided universally to the entire student body, school staff or parents/guardians. These services aim to prevent the development of serious mental health problems and to promote pro-social skill development among children and youth.

Examples of interventions at this tier include:
School-wide PBIS or classroom-based social emotional learning programs, including substance abuse and violence prevention programs (i.e., bullying prevention, good touch, bad touch, peer mediation, conflict resolution)
Staff professional development (i.e., mental health awareness, classroom management)
Mental health educational workshops for parents/guardians or students
Mental Health Consultation*

*During Tier One: Consultation is focused on increasing the general knowledge base of general education teachers regarding social emotional development, impairments, and the relationship to the curriculum and function in age-appropriate activities.

June 2015 Mental Health Screening Plan
Tier II: Targeted or early intervention/prevention:

Students who are at elevated risks for developing a mental health problem are offered various early intervention services to target specific risk factors. These interventions are delivered to children and youth who have social emotional challenges, behavioral symptoms and/or mental health needs that may not be severe enough to meet diagnostic criteria or eligibility for special education services.

Evidence-based interventions
- Cognitive Behavior Therapy (CBT-Elementary, Middle and High School)
- Child Centered Play Therapy (CCPT-Elementary School)
- Cognitive Behavioral Intervention For Trauma in Schools (CBITS-Middle and High School)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS-Middle and High School)
- Theatre Troupe/ Peer Education Project (TT/PEP-Middle and High School)
- Cannabis Youth Treatment (CYT-Middle and High School)

Additional interventions may include:
- Support groups (e.g., grief and loss, children of divorce, etc.)
- Focused skills training groups (social skills, anger management)
- Crisis management
- Interventions that target specific behaviors, such as aggression, withdrawal, sadness etc.
- Attendance interventions, dropout prevention programs, and training or consultation for families and teachers who work with identified children.
- Mental Health Consultation
- FBA and BIP-Level I

June 2015 Mental Health Screening Plan
Strengths and Difficulties Questionnaire (SDQ)
http://www.sdqinfo.com/a0.html

What is the SDQ?

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3-16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists. Each version includes between one and three of the following components:

A) 25 items on psychological attributes.

All versions of the SDQ ask about 25 attributes, some positive and others negative. These 25 items are divided between 5 scales:

1) emotional symptoms (5 items)
2) conduct problems (5 items)
3) hyperactivity/inattention (5 items)
4) peer relationship problems (5 items)
5) prosocial behaviour (5 items)

1) to 4) added together to generate a total difficulties score (based on 20 items)
Mental Health Screens
Global Appraisal of Individual Needs (GAIN)

Figure 1. GAIN Model of Emotional, Behavioral, Substance, Crime, and Violence Problems

- General Individual Severity Scale (GISS)
  - Internal Mental Distress Scale (IMDS)
    - Somatic Symptom Index (SSI)
    - Depression Symptom Scale (DSS)
    - Anxiety/Fear Symptom Scale (AFSS)
    - Traumatic Distress Scale (TDS)
    - Homicidal/Suicidal Thought Scale (HSTS)
  - Behavior Complexity Scale (BCS)
    - Inattentiveness Disorder Scale (IDS)
    - Hyperactivity-Impulsivity Scale (HIS)
    - Conduct Disorder Scale (CDS)*
  - Substance Problem Scale (SPS)
    - Substance Issues Index (SII)
    - Substance Abuse Index (SAI)
    - Substance Dependence Scale (SDS)
  - Crime/Violence Scale (CVS)*
    - General Conflict Tactic Scale (GCTS)
    - Drug Crime Scale (DCS)
    - Property Crime Scale (PCS)
    - Interpersonal Crime Scale (ICS)

* Conduct disorder cross-loads with the Crime/Violence Scale in statistical versions of this model.
Dennis, Chan, and Funk (2006)
Treatment of Anxiety and Depression
Treatment for Anxiety

Therapy
• Cognitive Behavioral Therapy (CBT)
• Family Therapy
• Acceptance and commitment therapy (ACT)

Medication
• Antidepressants; Benzodiazepines, and/or BetaBlockers

https://www.samhsa.gov/treatment/mental-disorders/anxiety-disorders#evidence-based-treatments
Treatment of Anxiety

Complementary Therapies and Activities

• Stress Management Techniques
• Mindfulness
• Progressive Muscle Relaxation
• Daily exercise, healthy nutrition, and adequate sleep
• Safe and Stable Living Situation
• Relationships and Social Networks
• Meaningful Daily Activities

https://www.samhsa.gov/treatment/mental-disorders/anxiety-disorders#evidence-based-treatments
Treatment for Depression

Therapy
- Cognitive Behavioral Therapy (CBT)
- Interpersonal Therapy

Medication
- Antidepressants
  - Variety and often takes multiple tries to find right match
  - Effects take up to 8 weeks

https://www.samhsa.gov/treatment/mental-disorders/depression#evidence-based
Treatment for Depression

Medications

NOTE:” In some cases, children, teenagers, and young adults (under age 25) may have more suicidal thoughts or actions when taking antidepressants. This is more likely in the first few weeks after starting a medication, or when the dose is changed. ”

https://www.samhsa.gov/treatment/mental-disorders/depression#evidence-based
Complementary Therapies and Activities

- A person with depression should create a **self-care plan**. The plan includes some of the following activities and approaches that can help improve symptoms:
  - Be active and exercise regularly
  - Make time to talk and interact with friends and family
  - Ask for help and let people
  - Do activities that were fun before the depressive symptoms started
  - Realize that depression improves over time, not immediately
  - Postpone making important life decisions until symptoms improve, or discuss a major decision with family and friends who can see things more objectively

• Yoga and Meditation
• Mind and Body Practices

https://www.samhsa.gov/treatment/mental-disorders/depression#evidence-based
TURN KNOWLEDGE INTO ACTION
Children’s Resilience Initiative

Three basic building blocks to success:
Adapted from the research of Dr. Margaret Blaustein

**Attachment** - feeling connected, loved, valued, a part of family, community, world

**Regulation** - learning about emotions and feelings and how to express them in a healthy way

**Competence** - acting rather than reacting, accepting oneself and making good choices
SKILL BUILDING

Think: lack of skill not intentional misbehavior
Think: building missing skills not shaming for lack of skills
Think: nurture not criticize
Think: teach not blame
Think: discipline not punishment
Attachment Skills (Connection)
EMPATHIC COMMUNICATION
REGULATION SKILLS
Mindfulness

- Practicing Mindfulness Activities
  - One thing exercise
  - Somatic experiences
    - (Observe, describe, participate)
  - Wise Mind
    - (breathing, self reflection)
  - Bi lateral movements
  - Mystery Game of Mindfulness
Recommended Times of Day

Beginning of the Day

Transitions

The Day Ends
3 Lessons

Lesson One: How are brain works

Lesson Two: Mindful Awareness

Lesson Three: Focused Awareness
Mind Up
Triggers and Trigger Mapping

- Incredible 5 point scale (Buron & Curtis, 2012)
  - 1-5 rating
  - Looks Like
  - Feels Like
  - Safe People can help me by ....

Practice !!
What is Competency?

- Mastery and Success across life domains
  - Social Connections
  - Community Involvement
  - Academic Engagement

- Building Resiliency
  - [www.resiliencetrumpsaces.org](http://www.resiliencetrumpsaces.org)

- Resilience Games

Adapted from Blaustein & Kinniburgh (2010) Treating Traumatic Stress in Children and Adolescents
Skill 2 : Competency

Self Development and Identity

- Seeing a sense of future
- Developing
  - Unique self
  - Positive Self
  - Coherent Self (before and after trauma)
  - Future Self

Adapted from Blaustein & Kinniburgh (2010) Treating Traumatic Stress in Children and Adolescents
Shame, Vulnerability and the Power of Connection

DR. BRENE BROWN’S WORK
Defining Shame

- Guilt = I did something bad
- Shame = I am bad
- Embarrassment = Fleeting, can laugh about it later
- Humiliation = “I didn’t deserve that”

12 Categories of Shame

- Appearance and body image
- Money and work
- Motherhood/fatherhood
- Family
- Parenting
- Mental and physical health
- Addiction
- Sex
- Aging
- Religion
- Surviving trauma
- Being stereotyped or labeled

WHAT IS SHAME AND WHY IS IT SO HARD TO TALK ABOUT IT?

1. We all have it. Shame is universal and one of the most primitive human emotions that we experience.

2. We’re all afraid to talk about shame.

3. The less we talk about shame, the more control it has over our lives

    ...shame is the fear of disconnection (68)

“It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errrs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat.”

THE MAN IN THE ARENA
Excerpt from the speech "Citizenship In Republic” delivered at the Sorbonne, in Paris, France on 23 April, 1910
Factors that Enhance Resilience

Sources:
Promote Virtuous Cycle of Health

Moderate ACE Effects, Improve Wellbeing Among Parenting Adults

Prevent High ACE Scores among Children

Mutually Reinforcing
Resilience at Work

- Interacting Cooperatively
- Maintaining Perspective
- Managing Stress
- Finding Your Calling
- Building Networks
- Living Authentically
Be a **F.O.R.S.E.** in your community

Image by Lincoln High student Brendon Gilman

Focus On Resilience & Social-Emotional
Resources

http://gucchdtacenter.georgetown.edu/TraumaInformedCare/index.html

https://www.youtube.com/watch?v=3axcjTzo58

https://www.youtube.com/watch?v=-HG8H4n2j9I

Thank You

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