WAYS TO BOLSTER RESILIENCE ACROSS THE LIFE-SPAN

DONALD MEICHENBAUM, PH.D.

Donald Meichenbaum, Ph.D.

Research Director of the Melissa Institute for Violence Prevention, Miami

www.melissainstitute.org

roadmaptoresilience.wordpress.com

Email address: dhmeich@aol.com

TABLE OF CONTENTS

RESILIENCE ACROSS THE LIFESPAN

Table 1

WHAT YOU NEED TO DO (AND NOT DO) TO DEVELOP CHRONIC POSTTRAUMATIC STRESS DISORDER (PTSD): A CONSTRUCTIVE NARRATIVE PERSPECTIVE

"We are all Homo Narrans or storytellers."
"We are lived by the stories we tell ourselves and that we tell others."

Engage in self-focused cognitions that have a "victim" theme.

1. See self as being continually vulnerable
2. See self as being mentally defeated
3. Dwell on negative implications with accompanying disgust, blame, shame, guilt, anger, hostility, depression.
4. Be preoccupied with how others view you
5. Imagine and ruminate about what might have happened ("Near Miss Experience")

Hold beliefs.

1. Changes are permanent and that you are a "burden" on others
2. World is unsafe, unpredictable, untrustworthy
3. Hold negative view of the future
4. Life has lost its meaning

Blame

1. Others with accompanying anger
2. Self with accompanying guilt, shame, humiliation

Engage in comparisons.

1. Self versus others
2. Before versus now
3. Now versus what might have been

Things to do.

1. Be continually hypervigilant
2. Be avoidant – cognitive level *(suppress unwanted thoughts, dissociate, engage in "undoing" behaviors)*
3. Be avoidant – behavioral level (*avoid reminders, use substances, withdraw, abandon normal routines, engage in avoidant safety behaviors)*
4. Ruminate and engage in contrafactual thinking ("Why me?", "Why now?", "Only if...", "Had I only...")
5. Engage in delaying change behaviors
6. Fail to resolve and share trauma story ("Keep secrets")
7. Put self at risk for revictimization

What *not* to do.

1. Not believe that anything positive could result from trauma experience.
2. Fail to retrieve, nor accept data of positive self-identity.
3. Fail to seek social supports.
4. Experience negative, unsupportive environments *(indifference, criticism, "moving on' statements).*
5. Fail to use faith and religion as a means of coping.
6. Fail to commit to a life worth living.

IN CONTRAST RESILIENT INDIVIDUALS TEND TO:

1. **Find and seek benefits that result from the trauma experience that may accrue to oneself and to others (benefit findings)"**

2. **Establish and maintain a future orientation.**

3. **Construct meaning (Use one's faith or spirituality).**

4. **Share their accounts with others and make a "gift" of their experience to others.**

5. **Undertake healing activities such as return to the site of the battle (Evidence courage and do "grief work" - - honoring those who were lost).**

6. **The mind likes to hang around in the past and be preoccupied with the uncertainty of the future. Any activity that reduces the likelihood of individuals engaging in negative rumination, such as mindfulness training, or that encourages individuals to alter the way they relate to their challenging thoughts and feelings, such as Acceptance and Commitment therapy, will bolster resilience. A key to bolstering resilience is challenging individuals to engage in "non-negative" thinking.**

7. **PTSD is essentially a disorder of non-recovery and reflects an autobiographical memory of a recent or distal victimizing and traumatic event. Brewin, Joseph and Meichenbaum have proposed that one does not "cure" individuals with PTSD, but rather therapists help clients retrieve positive autobiographical members in which they embed and reframe the landmark traumatic memories.**

Table 2

TREATMENT IMPLICATIONS AND PROCEDURES OF A CONSTRUCTIVE NARRATIVE PERSPECTIVE OF PERSISTENT POSTTRAUMATIC STRESS DISORDER (PTSD)

1. Develop a supportive, empowering *therapeutic alliance.*
2. Conduct *assessment interview* and use related measures. Provide constructive feedback.
3. Provide *rationale* for treatment plan.
4. Ensure *patient's safety* and *address disturbing symptoms.*
5. *Educate* patients and significant others.
6. *Teach* specific *coping skills* and *build-in generalization-enhancing procedures.*
7. Help patients *change beliefs about implications* of experiencing PTSD and associated symptoms.
8. Reconsider *anything positive* that resulted from the experience.
9. Address issues of guilt, shame, humiliation, anger, complicated grief.
10. "*Uncouple"* traumatic memories from disabling affect – use "Clock" metaphor.
11. Help patients *put into words* or into some other form of expression what happened and what they did to "survive" and cope.
12. Process and *transform emotional pain* – make a "gift" of their experience to others.
13. Help patients *distinguish* "then and there" from "here and now", not overgeneralize danger.
14. Help patients *retell their stories* and share the "*rest of their stories*". Retrieve "positive identities". (Use imaginal reliving procedure.)
15. Have patients *"spot triggers*" and *reduce unhelpful avoidant safety behaviors.*
16. Reduce maladaptive thought control strategies and consider the advantages (pros) and disadvantages (cons) of using each of these strategies (Metacognitive therapies).
17. Establish a strategy of detached mindfulness.
18. Have patients engage in graduated in vivo behavior exposure to places and activities that are safe, but that have been avoided. Have patients undertake safe exposure-based field trips.
19. Develop a plan that can guide thinking and behavior in future potential situations with trauma or reminders like anniversary effects.
20. *Reclaim* their *lives* and *former selves.*
21. Ensure patients *take credit* for changes – self-attributional efforts and self-mastery.
22. Avoid *revictimization.*
23. Build in *relapse prevention procedures.*
24. Put patients in a "*consultative"* role where they describe and discuss what they learned and what they can now teach others.

EVIDENCE OF RESILIENCE

"In spite of behaviors"
(***See Sherry Hamby You Tube "Trauma is everywhere, but so is resilience"***
"Good stuff is more important than bad stuff " Http://youtu..be/8tlVxVMygWXc)

Lessons from the research on Adverse Childhood Experiences
ACES versus PACES

Resilience is a positive adaptation despite adversity. Some facts about resilience.

1. Individuals can be resilient at one time in their lives, but not at other times. For example, the so-called "skin-deep" resilience in African American males.

2. Resilience is not an all or none phenomenon. Individuals can be resilient in one area of their lives, but not in other areas of their lives.

3. Resilience (positive emotions) and trauma reactions (negative emotions) can coexist, side-by-side.

4. Resilience does not come from rare, special or extraordinary qualities or processes. Resilience develops from the "everyday magic of ordinary resources." Resilience is not a sign of exceptional strengths, but a fundamental feature of everyday coping skills (Masten, 2014).

5. Resilience rests fundamentally on relationships. Attachment figures act as regulators of stress and provide a secure base. Bystanders provide "social capital", nurture an adaptive capacity, and provide a sense of security. They foster mastery motivation and a sense of self-efficacy.

6. Resilience-engendering behaviors and positive emotions such as optimism, gratitude, forgiveness, awe, and the like, can contribute to positive neurobiological changes (brain chemistry and structural alterations), and even impact gene expression.

7. Resilience is more accessible and available to some people than for others, but everyone can strengthen their level of resilience and "islands of competence".

POSSIBLE MEDIATING MECHANISMS

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

- 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.

THE NATURE OF RESILIENCE

Resilience and posttraumatic stress can coexist. Individuals may be resilient in one domain and not in others, or they may be resilient at one time period and not at other periods of their lives.

Such psychological processes as positive emotions, optimism, active coping, social supports and prosocial behaviors, meaning making, humor, and exercise can foster and support resilience and reduce the intensity and duration of stress responsivity. Such positive activities are associated with reduced HPA axis reactivity. The impact of positive emotions is cumulative; repeated positive emotional experiences over time prime the system for optimal response to negative stimuli by expanding physical, psychological, intellectual and social resources (Fredrickson, 2001). There is a protective capacity of positivity.

NEURO-PSYCHOLOGICAL MECHANISMS THAT NURTURE RESILIENCE

1. Reframing/Reappraisals is the ability to frame events in a relatively positive light. Functional MRI studies have shown increased activation in the lateral and medial prefrontal cortex regions and decreased amygdala activation during reappraisal. The increased activation in the lateral prefrontal cortex (the "executive" center) helps modulate the intensity of emotional responses and keeps the amygdala in check. Resilient individuals are better able to extinguish and contextualize traumatic emotional memories and can more readily retrieve positive memories.

2. Use of Humor is a way to engage in cognitive reappraisal and emotion regulation. A network of subcortical regions that constitute core elements of the dopaminergic reward system are activated during humor.

3. Exercise, Meditation, Mindfulness and Acceptance type activities have both neurological and psycho-social benefits, and bolster resilience.

4. Optimism is the inclination to adapt the most hopeful interpretation of the events which influences emotion regulation, contributes to life satisfaction, and increases psychological and physical health. An optimistic future-oriented outlook has been associated with increased activity in the amygdala and anterior cingulated cortex. For instance, optimists have lower rates of dying after cardiovascular disease over 15 years, compared to pessimists.

   As Southwick and Charney (2012, p. 25) observe, "optimism serves as the fuel that ignites resilience and provides energy to power the other resilience factors". But it is realistic optimism that works best, whereby individuals pay close attention to negative information, and not blind optimism that does not work.

5. Active goal-directed problem focused coping of taking direct actions when stressful life events are potentially changeable can increase neurotransmission in the mesolimbic dopaminergic pathways that increase pleasurable feelings and that stimulate reward

centers such as the ventral striatum. Dopamine release in the brain leads to "openness to experience", exploratory behaviors, and to the search for alternatives. A form of active coping is to engage in Behavioral Activation (physical exercise) which has positive effects on mood such as depression and that promotes resilience and neurogenesis. Exercise increases the level of serotonin, norepinephrine, dopamine and by stimulating the reward circuits in the brain. Exercise has also been shown to increase the size of the hippocampus and serum levels and increase brain volume (prefrontal cortex), especially among the elderly.

In some instances, when stressful events are not changeable, the use of emotional-palliative coping strategies such as acceptance, distraction, spirituality are the best ways to cope.

6. Prosocial behaviors and social supports and social competence, altruistic behaviors, helping others, and empathetic capacity facilitate resilience. The neuropeptides oxytocin, and vasopressin have been found to increase trust, compassion and enhance the reward value of social stimuli. Cortical "mirror neurons" have also been implicated in the regulation of positive emotions and can reshape the circuitry responsible for resilience. They play a role in facilitating social interactions by promoting shared understanding and empathy.

   For example, compassion contributes to an increase in the level of endorphins, endogenous cannabinoids, endogenous morphine, dopamine, vasopressin, nitric acid, and oxytocin. In addition, the stimulation of the Autonomic Nervous System (ANS) engenders compassion, as compared to negative emotional distress. Compassion also triggers an orientation response and accompanying heart rate deceleration tied to respiratory sinus arrhythmia, heart rate variability and reduced startle responses and skin conductance (vagus nerve response), as well as triggering "mirror neurons". Resilient individuals are better able to bond with others and attract social support.

   Low levels of social support have been linked to increased rates of depression, anxiety and PTSD. In a 9 year prospective study, individuals with no or few social supports had 1.9 to 3 times the risk of dying from a variety of illnesses, including cancer, cerebrovascular and cardiovascular diseases, as compared with those who had optimal social supports (Malta, 2012). Among the elderly, loneliness is a strong predictor of early morbidity and has the same predictive power of smoking and lack of exercise.

   Helping individuals increase their social supports and engaging in caregiving activities trigger the immune system to respond positively and stimulate the reward circuits along the medial forebrain bundle and engages dopaminergic neurons. Various hormones and neuropeptides like oxytocin and vasopressin facilitate social engagement and increase adaptation to stress by increasing empathy, eye contact, social cognition and problem-solving skills. Such positive attachment relationships buffer physiological stress responses.

7. Meaning-making is another strategy that can buffer against negative feelings and is associated with resilience. Having a role model who provides a "guiding light" and developing and following a personal "moral compass", holding spiritual beliefs, and engaging in religious faith-based practices bolster resilience and facilitate recovery. For example, consider the experiences of Jerry White (2008), who lost limbs to landmine explosions and who founded Landmine Survivors Network, which later became the Survivor's Corp. It is designed to foster a mindset of "Survivorship", which he defines as "choosing to live positively and dynamically in the face of death, disaster and disability; a form of meaning making. His approach is designed to combat the development of a "victim mentality" where individuals tend to pity themselves, resent their circumstances, live in the past and blame others. White believes that a victim-minded person is generally inflexible, stuck in his or her grievances, and is seemingly unable to let go, find hope, or move forward. Over time, a victim's intense focus is on their own personal suffering which can interfere with his or her ability to take positive action, relate to others in a healthy manner, or participate more fully in daily life.

   White proposes five steps to help trauma survivors to tap their innate resilience and grow stronger.

   1. Face facts: acknowledge and accept what has happened, the suffering and loss. Find a way to live with it and piece together a "personal story".

   2. Choose life: live for the future, not in the past.

   3. Reach out: connect to others who have "been there". Reach out to peers, friends and family.

   4. Get moving: set goals and take action for a healthy recovery. Develop an individual action plan and identify your life priorities. Each step engenders hope and builds self-confidence. Regularly evaluate your progress and when needed re-evaluate and change one's objectives. Such individual action plans are a contract of sorts with oneself and with others.

   5. Give back: be thankful for what you do have. Contribute to others and to your community. Express gratitude - - thanking people who have helped. Express generosity - - giving back more than taking. Move from being a beneficiary to a benefactor.

8. Hamby has highlighted three areas of resilience-engendering activities:

   a) Emotional regulation of both negative and positive emotions--- emotional awareness, distress tolerance, a positive Mindset, feelings of self -efficacy, and the ability to cheer oneself up after bad things have happened.

b) Interpersonal supports-- family support, able to share feelings, problems and family rituals/parent monitoring and investment in academic competence/ sense of belonging "mattering"/ support from prosocial peers/ at least two adults outside of the immediate family who have connected with the child/ teacher engagement and school connectedness/ feeling safe in school and in the community/community supports.

c) Meaning-making activities-- religion and spirituality/ dedicated to a cause, sense of purpose / belief in a better future / commitment to a specific role (student, worker, father, mother)/ adhere to code of honor or possess a "moral compass". As Viktor Frankl observed, "Anyone who has a WHY in their life can learn to handle any HOW."

In summary, the experience of positive-balanced emotions such as optimism, joy, pride, contentment, compassion, love, forgiveness, gratitude, humor have been associated with distinct neurobiological and psychological changes that provide a protective capacity. The positive emotion of awe, which reflects positive feelings of being in the presence of something vast that transcends our understanding of the world contributes to altruistic behaviors and to a sense of community. Awe helps shift one's focus from a narrow self-interest to the interests and well-being of a group to which individuals belong. Sights and sounds of nature, collective rituals, artistic events of music and dance elicit positive emotions that have behavioral and physiological sequelae. These neurobiological responses include:

> Increase of neurotransmitters like cortisol levels that facilitate pathway communication between Prefrontal Cortex (PFC) and subcortical systems like the amygdala. For instance, GABA (gamma amino butyric acid) which is an inhibiting neuropeptide made in the orbitomedium PFC (OBPFC) when released "turns down" the alarm system of the amygdala. The left PFC, a site associated with positive emotions such as happiness, is more activated during Compassion Meditation.

These positive emotions reduce physiological arousal and broaden and build an individual's focus of attention, allowing more creative inclusive, flexible, integrative perspective taking, engenders positive reappraisal of difficult situations, fosters problem-focused coping, and facilitates the infusion of ordinary events with meaning. Fredrickson et al. (2002, 2008), in her Broaden-and-Build Theory, highlights that the impact of positive emotions is cumulative. Repeated positive emotional responses to negative events expands and builds psychological and behavioral resources. (Also see Carl et al., 2013; Fava and Ruini 2003, Well-being therapy; James et al., 2013, McEwen, 2007; Ochner and Cross, 2008; Russo et al, 2012; Southwick et al., 2011).

IMPLICATIONS FOR CONDUCTING PSYCHOTHERAPY

The research on neurobiology of resilience underscores the value of conducting psychoeducation on neuroplasticity (the power of the human brain to change and repair itself) and the potential recovery from experiencing traumatic and victimizing experiences. The therapist can help clients learn a variety of skills and engage in activities that bolster positive emotions and improve resilience and health (Ray, 2012).

When discussing with clients the lingering impact of traumatic and victimizing experiences, the therapist can convey examples of how the body "keeps score" and the enduring impact on the clients brain and behavior. The good news, however, is that the brain is a remarkable resilient organ and clients have the potential ability to reverse this process. Clients can learn to capitalize and build upon what is called neuroplasticity, and moreover, even begin to "turn on" and "turn off" the genes in their body (neurogenesis).

The therapist can say: "***Let us begin by having you better appreciate the possible impact that traumatic and victimizing experiences may have on your brain and behavior. Traumatic events and losses can lead the lower part of your brain that is the emotional center to:***

> ***"hijack; overwhelm; flood; overshoot; ramp up; exceed; trigger action pathways; over activate and have a spiraling, cascading snowball effect; prime or kindle; shorten your fuse; and undermine and shut down the upper part of your brain, the frontal lobe executive control center."***

When conducting this psycho-education, the therapist should choose one or two of these illustrative verbs to describe the impact of traumatic and victimizing experiences and accompanying losses. Do not overwhelm the client. The therapist should then solicit personal examples from the client that reflects that activity.

> ***"Can you give me an example of how you did X?" (Choose one of the following).***

> ***"Magnified your fears; time slide back to your old ways of coping that once worked for you; went into a kind of autopilot mode of survival; engaged in safety behaviors; were hypervigilant and constantly on the lookout for possible threats; repeatedly conducted a kind of after action analysis in the form of ruminating; had difficulty sleeping; sought an adrenaline-rush by engaging in high-risk behaviors; used booze or drugs to self-medicate?"***

The therapist can convey to the client that he/she noticed, and wondered if the client also noticed, these behavioral patterns and "What is the impact, toll and price that resulted?" After discussing such consequences and how they may interfere with achieving the treatment goals, the therapist can convey that the therapy can help the client learn how to: (**Choose one**)

> ***"regulate, modulate, control, strengthen, regain, restore, reprogram, reshape, re-right myself, re-establish, re-define, mobilize, adapt, calibrate, blunt, improve their error detection skills; soothe, down-regulate, label and tame emotions, surmount your fears, orchestrate, get accustomed, accepted, organize your traumatic memories into a narrative account, develop coherent redemptive***

stories that have a beginning, middle and ending, note what you have done to survive, contextualize and put the landmark traumatic events into a larger autobiographical account."

The therapist can highlight that attention and increased awareness are the key first steps in the ability of the brain to repair itself. The client can learn how to "talk back" to the amygdala or the lower part of the brain and take charge once again. For instance, clients can learn emotion-regulation skills and they can come to tell themselves (and others):

"I can rewire my brain."

"I can talk to my amygdala (the alarm center) and train my emotional brain."

"Not allow my amygdala to hijack my frontal lobes."

"I can use the upstairs part of my brain to calm down the downstairs part of my brain."

"My positive emotions can Re-shape my brain."

"Positive relationships that I have can switch on and off different gene contributions and leave a positive chemical signature on my genes that affect my brain development."

"By being kind I can raise my level of oxytocin which curbs stress-induced rises in heart rate and blood pressure and that reduces feelings of depression. Being kind protects my heart."

"I can reduce my heart rate by 6 to 10 beats per minute by taking slow deep (diaphragmatic) breaths."

"I remind myself that my brain is not fixed, nor static. It is highly plastic and flexible. It can repair itself, with my help."

"As with other parts of my body, I need to use my brain or lose it."

"If I don't stimulate my brain, my brain cells will die and be pruned away."

"I have the capacity to bend, but not break."

"I can see the big picture and find the silver lining, and develop a new normal."

"I can get myself to do what I do not feel like doing and get myself out of my comfort zone."

INTERVENTION STRATEGIES THAT BOLSTER RESILIENCE

(See Meichenbaum's Roadmap to Resilience book for examples)

Use Physical exercise - - Behavioral Activation and use Active Coping Strategies (See McNally, 2007).

Use Emotional Regulation and Tolerance Skills and Increase the Protective Capacity of Positivity that Buffers Negative Feelings (See Kim & Humann, 2007).

Focus and savor positive emotions and past reminiscence and anticipate positive emotions (anticipating). Engage in goal setting and affective forecasting in the form of positive future-oriented imagery that nurtures hope. Avoid "dampening" or minimizing positive events ("*I don't deserve this*." "*This won't last"*).

Engage in Mindfulness Exercises - - pay attention in a particular way, on purpose in the present moment, and nonjudgmentally (See Chiesa et al., 2013; Salzberg, 2011).

Engage in Loving-kindness Meditation and engage in Acts of Kindness.

Engage in gratitude exercises ("Give back and pay forward").

Engage in Forgiveness exercises Toward others and Toward One-self - - Compassion is the awareness of the suffering of others and oneself, coupled with the wish and effort to alleviate it.

Engage in Meaning-making Activities and Cognitively Reappraisal ("Healing through meaning")

Use Spiritual-related Activities- - Use of One's Faith and engage in communal religious activities (See Meichenbaum "Trauma, spirituality and recovery" on Melissa Institute Website)

Increase Social Supports - - keep interpersonally fit by participating in positive activities; selectively choosing and altering situations, improving self-presentation (smiling, dressing up), improving communication skills and accessing social networks (See Uchina et al., 1996).

Use humor, Have fun and build-and-broaden Positive Emotions ("Bucket List Activities")

Each of these Activities will help <u>bolster resilience</u> by increasing the accompanying neurobiological processes. There is increasing data that a course of psychotherapy- even without medication- had measurable physical consequences in the brain.

THE CHALLENGES OF "HIGH RISK" CHILDREN AND THEIR FAMILIES CONFRONT

1. Exposure to Adverse Childhood Experiences (ACEs Studies). See the following resources

Adverse Childhood Experiences: Translating research into social action. American Psychologist, 2021, 76 ,2

www.iowa360.org Also, a Webinar from Dr. Kate Mclaughlin "Neurodevelopmental mechanisms linking childhood adversity with psychopathology http://youtube/n5hvdnR4xks and the TED talk by Dr. Nadine Burk Harris on the "Far reaching effects of adversity" (www.TED.com).

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.

CONFINED BY VIOLENCE

10 year Old Chicago Boy

I want to go outside and play, but I can't

Not because it is a rainy day

It is to avoid the gunshots that may come my way

I want to go outside and play, but I can't

Not because I have no bike to ride

It's because my mom fears

I'll be another victim of a senseless homicide

I want to go outside and play, but I can't

Not because it's after hours , or even that it 's way too dark

It's because of the gunshots that occur in my neighborhood park

I want to go outside and play , but I can't

Not because I have no friends

It's because of the violence that never ends

I want to go outside and play, but I can't

Not because I don't deserve it

There this thing called life and I am just trying to preserve it

- 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 educable 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 musculoskeletal 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 neurotrophic 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 non-abused 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.

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 TO BOLSTER RESILENCE

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.)

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, Cognitive behavioral intervention for trauma in schools. Longmont, CO: Sopris West, and Support for students exposed to trauma: The SSET Program by Lisa Jaycox, Audra Lanfley & Kristin Dean, 2009, Rand Corporation.)***

11. Implement a "strengths-based" program, identifying Islands of competence 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 helper role 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.

CLINICAL SETTINGS: 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 critical consumer 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 each one year cohort of high school dropouts. (See Belfield and Levin, The price we pay).

Home-school Liaison Programs

Community-based Interventions

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)

Technology-based Interventions

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

HOW TO BOLSTER RESILIENCE IN ADOLESCENTS

NEUROBIOLOGICAL AND COGNTIVE-AFFECTIVE-SOCIAL DEVELOPMENTAL CHANGES IN ADOLESCENTS: TREATMENT IMPLICATIONS

(See Steinberg,2001, Elkind, 2017, Skeen et al.2019 , Smetana et al., 2006)

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

A substantial amount of neural development occurs across the adolescent years, particularly the prefrontal cortex (PFC) regions of the brain that is responsible for higher order processing. Portions of the PFC do not fully mature until early 20s that are involved in such executive functioning as cognitive control, abstract and consequential thinking and self-regulation of feelings, thoughts and behaviors.

Prefrontal gray matter density peaks during early puberty (10 to 12) followed by synaptic pruning and dendritic arborization and projections from prefrontal regions in the brain become more well defined with development.

The contribution of neurological risk factors including impulsivity, a readily triggered arousal reward system, risk taking peer influences and peer pressure, and a deficient self -regulatory system contribute to adolescent behaviors. "The lower brain stem Amygdala can HIJACK the frontal lobes."

As Laurence Steinberg observes, teenagers are less mature than we might have thought, especially in the early stages of adolescence. They are like " starting an engine of a car without having a skilled driver."

Over the course of adolescence (ages 12 to 16) to 16 to 24, metacognitive skills develop as prefrontal regions mature, dopaminergic and brain communication changes.

In addition, adolescent hormonal changes are occurring rapidly. For example, the onset of puberty now happens earlier in development than in generations past, due partly to rising rates of childhood obesity. Gender differences have to be kept in mind. Female adolescents have more active and robust immune systems, but this also make them more susceptible to autoimmune disease (Hyde et al., 2020).

A parallel developmental change also occurs in the development of what Piaget called Formal Operational thinking processes and in the development of self-identity. David Elkind described these processes as a reflection of the adolescent " egocentrism" or marked self-centered beliefs.

Elkind described these processes as:

> IMAGINARY AUDIENCE -- the youth's belief and feelings that their behavior, appearance and activities are the main focus of other people's attention.

PERSONAL FABLE -- the youth's belief in their uniqueness and invulnerability ("Bad outcomes will NOT happen to me.")

These processes contribute to the youth's preoccupation and hypersensitivity to social media and peer acceptance and to the development of a sense of independence from parents.

Smetana et al. have noted that peer and neighborhood influences become more salient which dampens the relative influence and impact of family processes on youth's development.

TREATMENT MPLICATIONS

1. With regard to the neurological changes there is value in providing PROSTHETIC DEVICES (MPDs)-- executive organizers. Bathe the therapeutic social discourse with metacognitive verbs -- "notice, catch, plan and the like."

2. With regard to the cognitive affective developmental changes there is a need to focus on establishing and monitoring the therapeutic alliance using Feedback Informed Treatment on a session by session, as described below.

3.Parenting monitoring and open parent adolescent communication are critical. Parents' attitude and modeling of substance abuse are still key features of the youth's use of substances.

THE NATURE OF RESILIENCE: WAYS TO BOLSTER RESILIENCE IN YOUTH

See the following Website Resources:
www.melissainstitute.org Click on Resilience resources for the following papers.

"Important facts about resilience" and "Bolstering resilience: Benefits from lessons learned"

www.reachout.com A peer to peer teenage support website

"Today I am having a tough time because....."
"Today I can practice self-care by ....."

ccsp.org/wp-context/uploads/2018/08/youth-thrive

Center for the Study of Social Policy Youth Thrives Training by Jean Carpenter Williams

POSSIBLE RESILIENCE ENGENDERING ACTIVITIES FOR YOUTH

1. Stay active (exercise, dance, learn something new).

2. Practice relaxation, mindfulness, yoga, meditation. Keep safe, get a good night's sleep.

3. Make up a music playlist.

4. Reach out to supportive safe friends.

5. Enjoy nature, experience "awe".

6. Follow a routine-- recognize the value of regularity.

7. Establish mini-tasks that you can succeed at.

8. Take a break from your worries--less watching of the news and social media (Use worry time Apps).

9. Watch or read something uplifting.

10. Practice positive emotions like humor, gratitude, forgiveness and compassion toward others and toward yourself.

11. Use self-talk ("This too shall pass"). Answer the following questions:
"I can..." " I have....." "I am.... ".

12. Remember the SERENITY PRAYER

> "God grant me the SERENITY to accept the things I cannot change
> and the COURAGE to change the things I can change
> and the WISDOM to know the difference "

13. Engage in meaning-making activities

> Teens work on climate change See Bandura and Cherry, 2020
> https://www.youngvoicesfortheplanet.com
>
> Greta Thunberg, 16 year old Swedish girl
>
> Teens work on social justice issues such as Black Lives Matter
>
> Mimi Jones, a 17 year old African American who protested segregation using public Resistance
>
> Malala Yousifzai, a 17 year old who won the 2014 Nobel Peace Prize

WAYS TO BOLSTER RESILIENCE IN YOUTH BY ENGAGING THEIR FAMILIES

A number of culturally sensitive evidence-based parent training programs have been developed. Here area few illustrative examples.

Strong African American Families Program (Murry et al.,2007)

California Families Project for Latino Youth (Weissman et al. ,2015)

Family Check up Program (Dishion, et al., 2014)

Authentic Connections group for mothers (Luthar, in press)

Triple P Positive Parenting Program (Sanders)

Multi Systemic Training Program (Henggeler)

Functional Family Therapy Program (Alexander et al., 2013)

Most of these programs employ parallel training for youth and for parents and then conjoint sessions. They highlight the need for the avoidance of harsh discipline. Rather, use firm, but loving parenting and they highlight the importance of parent monitoring --the FOUR W's Where, When, What activities and With Whom.

They highlight the need for family shared activities such as the number of times that the family eats dinner together?

See below the discussion of how to address adolescent parent conflict.

THE CHALLENGES OF CONDUCTING PSYCHOTHERAPY WITH ADOLESCENTS

(See Bertolino,2003)

Issues to be addressed include motivation to change, establishing and maintaining the therapeutic alliance, developmental neurological and cognitive and affect, social changes, peer influences, engagement of parents, treatment nonadherence.

Assessment issues --the value of employing a Case Conceptualization Model (CCM) See Below.

Need to be culturally, gender (sex orientation issues) and racially sensitive when conducting therapy.

Focus on the role of the therapeutic alliance and establish and maintain trust.

Use the " Art of questioning " Use Motivational Interviewing procedures, address ambivalence, use Scaling procedures, evoke "change talk ". Small changes in language can open up possibilities for future behavioral changes (“As yet” "So far " "How" and "What" questions).

Use Feedback Informed Feedback. Use session-by-session client feedback and review this with the youth and his /her family (See Bertolino, 2017). The FIT rating scales include:

Relationships ("I feel heard, understood and respected")

Goals ("We worked on and talked about what I wanted to talk about")

Approach ("The therapist's approach is a good fit for me")

Overall ("Overall, today's session was right for me")

Implement the Core Tasks of Therapy See the Handout of Treating depressed and suicidal youth.

TREATMENT OF ADOLESCENTS WHO ARE DEPRESSED AND SUICIDAL

"I have nothing to live for."
"I miss my friends. I am alone and disconnected."
"I am sad and hopeless and don't see any future for me."
"I feel left behind."
"My whole life has been cancelled--prom, football, music performance."
"I have no control over anything in my life."
"I am flunking out and won't be able to ever catch up."
" My dad died of COVID. My dog died to."
" I just gave up."

These are statements offered by high school students who have expressed suicidal ideation and those who died by suicide. A New York Times lead article (Jan 24, 2021) on student suicide began with a report of 18 student suicides over 9 months in Clark County, Las Vegas with the youngest suicidal death being a 9 year old. Their school system had been closed to live classes for a year because of the pandemic. This pattern of increased adolescent suicide is consistent with a decade long increasing trend of adolescent suicide especially among Black youth and LGBTQ youth. These findings raise a number of specific questions.

1. How can "high-risk" students be identified?
2. What can be done to prevent suicide in adolescents?
3. What type of interventions should be offered to treat depressed and suicidal youth?
4. How can we bolster resilience in adolescents?

See the Treatment Manual on this topic on the Melissa Institute Website www.melissainstitute.org Click Resilience Resources and scroll to this Handout

"Child and adolescent depression and suicide"

"35 years of working with suicidal clients: Lessons learned"

"Core tasks of psychotherapy with families: Applications to children and youth with anxiety and depression "

Also see the following Websites for the Jed Foundation and Go Guardian Beacon.

TOPICS TO BE DISCUSSED

Assessment of depression and co-occurring disorders
Risk factors and warning signs for suicidal behaviors
See David Jobes CAMS -- Collaborative Assessment and Management of Suicide

Use peer nomination procedures.

Consider the role of co-occurring disorders and the impact of racial discrimination (microaggressions), history of victimization

Need to document, document, document.

Safety-based interventions See work by Joan Asarnow on the use of Emergency doctors.

Therapeutic Implications: CORE TASKS of PSYCHOTHERAPY.

Establish, maintain and monitor the quality of the therapeutic alliance, Use open -ended questions, reflective listening, nurture curiosity. Discuss issues of confidentiality.

Conduct psycho-education-- Use a CLOCK metaphor View suicide attempts as way of problem-solving and as an "escape from self ".

Nurture hope using Time lines Assess for "strengths and social capital. Identify "In spite of" behaviors and "Islands of competence" "Hidden treasures ", and engage the youth in collaborative goal-setting SMART goals-- Specific. Measurable, Attainable, Relevant, Timely.

Teach intra-and interpersonal skills Build in generalization guidelines See Handout on Melissa Institute for ways to enhance the generalization and maintenance of skills.

Address issue of treatment adherence, if medication has been prescribed.

Use Cognitive restructuring and Acceptance and mindfulness skills training.

Involve significant others (parents, school personnel) in treatment.

Conduct Active After Care Follow through and Booster sessions.

TREATMENT OF TARGET SPECIFIC ADOLESCENT GROUPS: VICITIMS OF ACE, HUMAN TRAFFICKING AND WAYS TO BOLSTER RESILIENCE IN LGBTQ YOUTH

(SEE THE FOLLOWING RESOURCES John Briere and Cheryl Lanktree Treatment Manual attc.usc.edu/ Walker et al. 2018 Treatment of victims of human trafficking / Papers on www.melissainstitute by Meichenbaum Click Resilience Resources)

These Treatment Manuals highlight the critical role of establishing ,maintaining and monitoring the quality of the therapeutic alliance, the need to conduct a comprehensive ongoing assessment to ensure the youth's safety and reduce of the likelihood of revictimization; the need to help the youth identify and build on his/her individual, social and organizational "strengths"; and where indicated, work on the acquisition of intra- and interpersonal coping skills such as emotional regulation, distress tolerance, cognitive and interpersonal skills including acceptance and mindfulness skills.

See the Handout on "Ways to increase the likelihood that the youth will apply, generalize and maintain these skills across settings and over time". DO NOT train and just HOPE for transfer of skills.

INTERVENTIONS WITH LGBTQ YOUTH: WAYS TO BOLSTER THEIR RESILIENCE

(See Handout on this topic on the Melissa Institute Website)

Comment on the suicide rate among gay and transgender youth.

Use the LGBTQ YOUTH EMPOWERMENT CHECKLIST that includes five areas:

Self-awareness / Connecting with others / Physical and emotional self-care / Being socially active/ Being flexible See how therapists, educators and parents can use this Checklist with youth/ How can schools create a supportive environment.

How to conduct therapy with LGBTQ youth and their families.

See Website Suicide, self-harm and LGBTQ youth: Tips for therapists

https://www.nctsn.org/resources/taking-care-of-yourself

TREATMENT OF ANGRY YOUTH: INTERVIEWING PROCEDURES TO HELP THEM BECOME RESPONSIBLE PROBLEM-SOLVERS

(See Larson, 2005 THINK FIRST Program and view a You Tube that demonstrates the interviewing procedure)

https:// www.youtube.com/watch?V=Lkz2Cgw0wic

The interview procedure has three phases: Preparation, Problem-solving and Implementation.

PREPARATION PHASE

- Focus on establishing a collaborative alliance through active listening, empathy and reframing
- Help de-escalate intense feelings
-Solicit the youth's view of the problem through developing a timeline

> "What happened before, during and after the anger incident?
> What did the youth and others do and say?
> How does the youth feel about what happened? "

- Review the story in highlights, emphasizing strengths and coping skills
- Nurture hopefulness and collaboration with positive "we" statements

PROBLEM-SOLVING PHASE

- Help the youth take the perspective of others.

> "Why do you think he/she said that?
> Could he/she have been thinking that you were....?
> How do you think he/she feels about what happened? "

- Help the youth generate as many alternative solutions as possible.
- Nurture a GOAL, PLAN, DO, CHECK approach.
- Help the youth identify both internal and external triggers to his/her anger.
- Use a CLOCK metaphor to have the youth better appreciate the interconnections between the ways he/she appraises internal and external events (12 O'clock), their accompanying feelings (3 O'clock), their thoughts (6 O'clock), and their behaviors and the reactions of others (9 O'clock).

IMPLEMENTATION PHASE

- Convey to the youth that this behavior change is a "challenge", bolster the youth's self - confidence.

> "It won't be easy to do what we have been talking about
> Maybe it is too early to ask you to do.....

This is going to take courage and street smarts. How will you begin?"

-Help the youth select an action plan to try and walk him/her through, both behaviorally and use imagery rehearsal.

"What will you have to watch out for?
What will you do when...? "

- Practice the action plan with the youth.

- Reinforce effort.

"I am impressed with your maturity and willingness to try a new way of handling.....
I give you a lot of credit for being able to (use meta cognitive verbs such as notice, Catch, interrupt, plan, make smart choices, and so forth) Give specific examples and ask the youth whether he/she agrees?

- Encourage the youth to explain how he/she will benefit from the new behaviors

These interventions can also be used on a group basis.

TREATMENT OF PARENT-ADOLESCENT CONFLICT

(See Alexander et al.2013; Bertolino, 2003; Dishion & Kavanaugh, 2003; Robin & Foster, 2002; Steinberg 2005)

Google parent -adolescent conflict for further references.

Fact sheet about parent-adolescent conflict.

Challenges deriving from COVID 19
Differential developmental changes in parent-adolescent conflict with mothers and fathers
The critical role of racial and ethnic differences
The benefits of Authoritative Parenting (AP)--warmth, involvement, firmness, consistency, nurturing adolescent independence
Factors that undermine AP

Assessment procedures: Art of questioning (See questions below that pull for "strengths")

Use self-report Scales For example, Conflict Questionnaire, Issues Checklist, Parent - teen Conflicts Tactics Scale (See Robin & Foster).

Core Tasks of Psychotherapy.

Ways to engage parents in treatment with the permission of the youth.

Establish and monitor the Therapeutic Alliance: See Bertolino 2017 for ways to use session-by session Feedback Informed Treatment procedures.

Provide ongoing psychoeducation Use Inductive curiosity open-ended inquiry.

Summary of sources of parental stressors: II CE HOPE.

I INTERRUPTION OF PLANS
I IMPLICATIONS FOR THE FUTURE

C CONCERNS ABOUT WELL-BEING
E VIOLATION OF EXPECTATIONS

H HISTORY REPEATS ITSELF
O OVERLOAD ON THE PARENTS AND THE ADOLESCENT
P PERSONAL PEEVES
E EMBARRASSMENT IN FRONT OF OTHERS

Nurture HOPE Use collaborative goal-setting, Use Time lines, Identify strengths.

Teach communication skills, parent monitoring, avoid harsh punishment and increase the ratio of positive to negative reinforcements, model appropriate attitudes and behavior with regard to substances, engage in family routines and rituals, demonstrate interest and support for academics.

Use wrap around services and ecologically-based interventions with high needs families (See Dykstra and work on Multi Systemic approaches.

Build in generalization guidelines --Self-attribution training ("Taking credit").

Conduct relapse prevention training.

Include follow through and Booster sessions.

ILLUSTRATIVE PARENT QUESTIONS

What are your notions (theories)about why your son/daughter is having these problems?
What do you think will happen if his/her problems get worse?
What would be different if his/her problems were solved?
When I get to know your son/daughter better, what will I see as his/her greatest strengths?
What impresses you most about your son/daughter?
Tell me about a time when things were even a little bit better?
What keeps you from "throwing in the towel"?
Are you willing to do whatever it takes to solve your son/daughter's problems?
Where do you think we should begin?

HOW TO BOLSTER RESILIENCE IN THE ELDERLY

KEYS TO AGING WELL: BUILDING BLOCKS FOR RESILIENCE

We will consider how to bolster fitness and resilience in SIX areas -- physical, interpersonal, emotional, cognitive, behavioral and spiritual.

The Role of Physical Fitness

(***See http://www.evanshealthlab.com/23-and-12-hours/***)

Physical activity has a very positive benefit on the health of older adults.

The greater one's life space (a measure of the extent and frequency of movement outside of one's home) the lower the rate of mortality (Mackey et al., 2014).

Some 80% of seniors (65+ years) do not meet the National physical activity standard of 150 minutes per week of moderate-to-vigorous physical activity (e.g., brisk walking).

Individuals who spend six hours per day watching television live on average five years less, as a result of developing chronic diseases.

The use of Pedometers that count the number of steps taken, have been found to increase physical activity when tied into individualized step goals.

Internet-delivered behavioral interventions have been used to increase physical activity. These programs usually involve several modules that include:

a) How to get started that discuss the benefits of physical activity and instructions on self-monitoring using pedometers that count the number of steps taken and ways to increase overall physical activity in one's daily life;

b) Planning for success that includes how to establish individualized goals and ratings of self-efficacy and confidence and the offering by the client of self-generated reasons for increasing physical activity. Set up a step count goal and monitor progress using a Goal Tracker program;

c) Beating the odds which examines the potential barriers and strategies for overcoming such barriers, as well as ways to develop social supports.

d) Sticking with it ways to maintain an active life-style and engaging in relapse prevention exercises.

These programs are supplemented with personal coaching where a positive supportive therapeutic alliance is critical in helping seniors develop a physically active lifestyle to the fullest extent possible (See Dlugonski et al., 2012; Tudor-Locke et al., 2011; Vandelanotte et al., 2007).

There is also a need to consider the REASONS seniors offer for not engaging in more physical activities. These Reasons fall into three categories, each requiring individually-tailored interventions.

Consider the barriers or reasons why seniors do not engage in physical activities.

Type I- Reasons that question the data on the relationship between physical activity (exercise) and the health benefits. Seniors may offer counter-examples.

Type II –Reasons that highlight barriers and fears. Cons outweigh the pros of exercising. Fear of falling, hurting oneself and being victimized.

Type III – Reasons that are personalogical and tied to belief system. Fatalistic beliefs, stubbornness, not wanting to be told what to do, reminder of limitations, and the like.

In addition to enhancing one's Life Space and becoming more physically active, there is a need to ensure that the senior's basic health related needs are being met (such as nutrition, sleep, adherence to prescribed medication, safe sex practices, regular medical and dental check-ups). There is a need to encourage and challenge clients to be as independent and active as much as possible.

Interpersonal Fitness

Social engagement with others outside of family members

Sense of belonging and social connectedness with others

Learn to ask for help

Help others, make a "gift" of one's experiences (volunteer work, altruistic activities)

Maintain social conduct with others using computer technology (Skype, Text, Email, Facebook, etc.)

Have a spouse who can act as a "Metacognitive Prosthetic Device (MPD) or as a "Surrogate Frontal Lobe (SFL), in a supportive manner. ("***Uh Oh***" example)

Able to engage in a therapeutic alliance

Keep in mind important gender differences in women versus men in the ways that they employ social support. Women are more likely to engage in and benefit from social relationships with other women, whereas men are more satisfied with solitary activities.

Emotional Fitness

Learn to bolster emotion regulation and distress tolerance skills.

Use acceptance strategies - - acknowledging that you are an older person with limitations, get on with things, rather than dwell (ruminate) and harbor regrets.

Memorialize those you have lost - -use restorative restorying.

Nurture hope by engaging in collaborative goal-setting (short-term, intermediate and long-term realistic and practical objectives).

Face fears and not engage in avoidance behaviors, nor magnifying one's fears.

Identify and label emotions. "Name them in order to tame them."

Learn to "talk back to the amygdala." Do not allow your emotions to "hijack" your thinking part of your brain (frontal lobe executive processes).

Increase positive emotions ("bucket list activities").

Build and broaden positive emotions of optimism, curiosity, empathy, forgiveness, gratitude.

Educate about what the experience of positive emotions does to the brain and body.

Cognitive Fitness

Hold a belief that one can learn and grow, no matter what your age.

Hold beliefs that life has a purpose and has meaning.

Engage in "generativity" behaviors of wanting to contribute to future generations.

Make a "gift" of one's life experiences and "wisdom" to others. Become a mentor.

Engage in direct action problem-solving coping where indicated for potentially changeable events and use palliative coping acceptance strategies for unchangeable stressors.

Let go of what one knows to be a current reality and embrace new thoughts and behaviors. Let go of what is familiar, when it is no longer working.

Conduct life reviews and identify both the positive and negative that come with life shifts.

Bend, bounce back, instead of resisting change.

Recognize that positive outcomes can arise from negative stressful events. Remember, people are not very good at affective forecasting or predicting the future.

Change the "story" you tell yourself and others. Bathe your story telling with "RE" verbs and executive metacognitive "change talk" (see Roadmap to resilience book, pages 127 and 136).

Behavioral Fitness

Maintain a behavioral routine.

Work to **REGAIN** independence.

Work on "Building Skills" that fall in the Zone of Potential Rehabilitation (ZPR) - - not too easy, but not too hard.

Engage in pleasurable activities.

Share your "story", highlighting strengths, survival skills, islands of competence. Be sure to tell the "rest of the story". In spite of behaviors.

Use expressive forms of disclosure (art, dance, gardening). Participate in group activities to combat isolation, withdrawal.

Volunteer, join clubs, church groups, social activities.

Maintain contact with others via the computer, smart phone and other devices.

Journaling, scrapbooking, and whatever other activities that encourage **RE**-storying, **RE**-authoring your life. Provide examples of your ability to adapt in response to change.

Spiritual Fitness

Use one's faith and religion.

Reflect on your ethnic, racial and cultural examples of intergenerational resilience ("What and how did they survive and flourish?")

If you are a veteran, reflect on evidence of resilience, "Band of Brothers", evidence of courage, live for a purpose.

Identify personal values, a "moral compass", life priorities. ("What is really important and how can you incorporate these values into your life"?)

Use positive religious coping responses.

PSYCHOTHERAPY WITH SENIORS

There is an adage that "***One cannot teach old dogs, new tricks***". This does not apply in the case of elderly individuals who have various forms of psychiatric disorders such as depression and anxiety. Research indicates that seniors benefit as much, or even more than middle-aged individuals from cognitive behavior therapies and interpersonal therapies. (Google Psychotherapy with the elderly).

There is a need, however to adjust psychotherapeutic interventions in an age-appropriate fashion. Here are a few examples of ways to conduct psychotherapy with the elderly.

1. As in psychotherapy with all age groups, the establishment, maintenance and monitoring of the therapeutic alliance (TA) is critical. Use treatment-outcome feedback on an ongoing basis to assess the quality of the TA.

2. Address any potential therapy-interfering behaviors, practical barriers such as transportation, timing (conduct early morning meetings), consider financial costs, and the like. Consider practical barriers like fatalistic beliefs, level of hopelessness, client's implicit theories about the ability to change, and the like.

3. Maintain continuity of care and be culturally-sensitive.

4. Conduct a risk assessment for suicidal behaviors.

5. Engage in Collaborative goal-setting that nurtures hope in establishing SMART goals - - Specific, Measurable, Attainable, Relevant and Timely behavioral objectives in each specific resilience domains.

6. When conducting sessions use Advance Organizers (provide an overview) of what will be covered in the sessions and why - - how the content relates to the client's specific goals. Use discovery-oriented Socratic questioning and intermittent summaries.

7. Conduct simple psycho-education. Do not lecture the client. Use **CLOCK** Metaphor to educate about the interrelationships between thoughts, feelings and behaviors. The **CLOCK** metaphor entails:

   12 o'clock - - external and internal triggers

   3 o'clock - - primary and secondary emotions. Treat emotions as a "commodity". "What did you do with your feelings?"

   6 o'clock - -automatic thoughts and images- self-talk….

   9 o'clock – behavior (what the client did and resultant consequences)

   Convey the notion of a "vicious cycle"- the interdependence of thoughts, feelings, behaviors and resultant consequences. Consider "How the client can break this vicious

cycle?" "What have he/she tried in the past to break the cycle?" "What else could the client do to break the cycle and become more resilient?"

8. Teach slowly, build in reminders (Simple Acronyms, use Handouts). Schedule extra sessions, use phone calls, texting, emails as reminders (with the client's permission). Address memory limitations.

9. Build on client's "strengths". Use Time Lines. Reawaken old skills. Build in generalization guidelines and put the client in a "consultative mode" - - explaining, teaching, demonstrating skills. Involve significant others as Metacognative Prosthetic Devices (MPDs), when available.

10. Tailor skills training in an age-appropriate fashion. For example, conduct relaxation training, but be aware of possible impact of the client's having arthritis. Solicit feedback regularly.

11. When conducting cognitive restructuring procedures, keep in mind the findings that with age, seniors put less effort into remembering negative life events, and are more prone to highlight positive life events (Charles et al., 2003). Life Review interventions that help seniors to attend to "positive" life experiences (Time Line 2 and in spite of behaviors). Seniors often use social comparisons to others to view their situation in a more positive manner (Frieswijk et al., 2004). Also, probe about the notion of "generativity" - - of how the client can make a "gift" of his/her experience and "wisdom" to the next generation and to peers.

12. Build in relapse prevention procedures, self-attribution training ("taking credit" for changes), use the Client Checklist like the Strategies for Coping with Grief.

13. Build in active follow-up, booster sessions. Conduct group-based interventions and nurture a supportive environment to sustain behavioral changes.

14. Have fun with clients.

WAYS TO BOLSTER RESILIENCE IN TRAUMA THERAPISTS AND HEALTH CARE WORKERS

(See the Handout by Don Meichenbaum on the Melissa Institute Website CLICK on Resilience Resources)

AT THE INDIVIDUAL LEVEL

Increase your self-awareness. Assessment issues Evidence of "Vicarious resilience" in therapists

Increase self-care-emotional regulation procedures and RE-plenish activities

Learn to leave work at work Develop a transition ritual

Use Your Cognitive Abilities--Alter expectations and redefine your role

Engage in Behavioral Activities Balance Case Load Be gentle with yourself

PEER AND COLLEGIAL LEVEL

Access social support --material, informational, emotional

Use group supervision and coaching --debriefing (For example, suicide of a patient)

"Love yourself as a person, but doubt yourself as a therapist"

When indicated, seek treatment

ORGANIZTIONAL AND AGENCY LEVEL

Provide supports --mentoring, supervision, emotional checkups

Provide ongoing training and engage in mission -oriented activities

Provide Stress Inoculation Training