A Center Quick Training Aid ....

School Interventions to Prevent and Respond to Affect and Mood Problems

This document is a hardcopy version of a resource that can be downloaded at no cost from the center's website http://smhp.psych.ucla.edu.

The center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 Phone: (310) 825-3634.

Quick Training Aids

School Interventions to Prevent and Respond to Affect and Mood

Periodically, windows of opportunities arise for providing inservice at schools about mental health and psychosocial concerns, When such opportunities appear, it may be helpful to access one of more of our Center's *Quick Training Aids*.

Each of these offer a brief set of resources to guide those providing an inservice session. (They also are a form of quick self-tutorial and group discussion.)

Most encompass

- •key talking points for a short training session
- •a brief overview of the topic
- •facts sheets
- •tools
- •a sampling of other related information and resources

In compiling resource material, the Center tries to identify those that represent "best practice" standards, If you know of better material, please **let us know** *so that we can make improvements.*

This set of training aids was designed for free online access and interactive learning. It can be used online and/or downloaded at http://smhp.psych.ucla.edu - go to Quick Find and scroll down in the list of "Center Responses to Specific Requests" to Depression**.** Besides this Quick Training Aid, you also will find a wealth of other resources on this topic.

Guide for Suggested Talking Points

III. Tools/Handouts

IV. Intervention Strategies / Model Programs

V. Additional Resources

VI. Originals for Overheads

This material provided by:	UCLA Center for Mental Health in Schools/Los Angeles, CA 90095-1563 (310) 825-3634/ Fax: (310) 206-8716/ Email: smhp@ucla.edu

Note: Documents in PDF format (identified with a) require Adobe Reader 3.0 or higher to view. If you don't have this program, you can download it for free from Adobe.

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I. Brief Overview
A. Keeping Affect and Mood Problems in Broad Perspective

Affect and related problems are often key factors interfering with school learning and performance. As a result, considerable attention has been given to interventions to address such problems. A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environ-mental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the person (P)
E (E<--->p)	E<--->P	(e<--->P) P
Type I problems	Type II problems	Type III problems
•caused primarily by environments and systems that are deficient and/or hostile	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)	•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive	•problems are mild to moderately severe and pervasive	•problems are moderate to profoundly severe and moderate to broadly pervasive

I. Brief Overview

B. How school environments could support mental health and reduce problems

Excerpt from: ***Practices and Conditions that Lead to a Sense of Community in Middle Schools***
by Susan J. Belenardo, In **National Association of Secondary School Principals**
Bulletin, October 2001, Vol. 85 No. 627

In this era of educational accountability, school success is measured by students' performance on standardized assessments. It is often forgotten that student effort——as well as teacher and parent effort——may depend greatly on the underlying climate and culture of the school. When parents, teachers, and students all feel surrounded by a caring and supportive school environment, they are more likely to respond favorably to schoolwide challenges such as the pressure for students to perform well on tests (Beck and Murphy 1996; Driscoll 1989; Rosenholtz 1991; Rutter et al. 1979)....

Defining a Sense of Community This study used the term "community" to refer to a shared psychological sense of coherence at a school. A sense of community is the presence of beliefs, feelings, and relationships that connect members of a school community to each other; it provides a sense of belonging to something that transcends the situational relationships in an organization (Goodlad 1981; Haberman 1992; Sergiovanni 1994). Even though much rhetoric has been devoted to the importance of a sense of community in schools, a clear understanding of the organizational elements that contribute to its presence does not exist (Driscoll 1989; Sergiovanni 1994)...

Dimensions of a Sense of Community

Shared values. A cohesive, reinforcing school program is built on a core of common beliefs and expectations. These shared values underlie the school vision and provide a uniform direction for the development of the instructional program and for behavioral expectations. A school program developed from a system of shared values eliminates the uncertainty and frustration that occurs if there is a lack of clear direction. Administrators, teachers, and parents have common goals for student learning and behavior. They share a common belief in the kind of people students are capable of becoming, and express that belief in the day-to-day activities of the school. Indicators of shared values include agreements on instructional expectations and practices, the enforcement of schoolwide discipline standards, high academic standards for all students, and explicit achievement goals. These values are communicated to students through stated performance expectations and modeled in the behaviors and conversations of the adults in the school (Bryk and Driscoll 1988; Driscoll 1995; Rossi and Stringfield 1995; Sarason 1974; Smrekar 1996).

Commitment. According to Beck and Murphy (1996), commitment is one of the imperatives of a successful school. Commitment is evidenced by a willingness to go beyond expected participation. A strong connection to the school eliminates distractions caused by competing demands for attention. To a large extent, membership in the group reinforces and satisfies the needs of the individual. Thus, the effort and attention given to creating a successful organization contributes to each participant's feelings of success.

A feeling of belonging. In schools where there is a sense of community, there is a shared emotional connection that provides participants with a sense of being part of something that has a past, present, and future. This feeling of belonging is created by school programs that recognize the positive performance and contributions of individual members; a common agenda of activities and similar experiences that link students, families, teachers, and administrators to the school's traditions; and the acceptance of all members into the group regardless of their individual differences (Beck 1998; McMillan and Chavis 1986). A strong consistent academic program and the frequency with which teachers participate in activities that involve parents are examples of a common agenda of activities. Respect for individual differences is evidenced by parents' reports that their children feel accepted by teachers, and teachers' indicating they feel accepted as a colleague by other teachers. These shared rituals, recognitions, and experiences unite the members of the organization and create feelings of connection to the institution——of belonging to something of value. This sense of belonging, in turn, binds members to the past and sets a direction for the future (Bryk, Lee, and Holland 1993).

Caring. Caring connects members of the group and results in mutual respect, support, and interest. In schools, caring is evident in the actions of teachers as they extend themselves to work with students beyond what is required, and in the presence of programs that are available to meet the needs of all students. A feeling of cooperation rather than competition is demonstrated through the willingness of adults (i.e., educators and parents) to help each other, as well as to help students. Stakeholders emphasize the development of relationships and the development of individuals who care and are cared for in return (Noddings 1995).

Within caring communities, there is a spirit of service that assures that the needs of individual members are met. In schools, examples of caring include special programs that help students who are having difficulty; teachers who take a personal interest in all of their students; and parents who perceive that their children would get help if they were having problems in class. Caring interactions among teachers, students, and parents often make the difference between a positive and a frustrating school experience (Noddings 1995).

Interdependence. Schools with a strong sense of community are defined by more cooperative forms of social interaction. A recognized interrelationship exists among individuals, as well as an understanding that all actions occur in relation to others rather than in isolation (Beck 1998). Teachers coordinate curriculum and exchange and share ideas. They regard one another as sources of help with individual problems. This cooperation results in ongoing, mutually beneficial skill development and contributes to the collegiality of the school. This collegiality is reflected in organizational strength that far surpasses the strength of the individual.

Collaborative schools are marked by strong, reciprocal, social, and academic relationships among colleagues (Rosenholtz 1991). Indicators of interdependence include teachers working together to plan lessons and observing one another's instructional practice, and teachers and parents working together to improve school programs. This interaction provides a supportive framework as teachers, students, and parents recognize others' strengths that complement their own.

Regular contact. In schools that have a sense of community, importance is placed on providing opportunities for all members to meet and communicate. School communities are identified by the presence of regularly scheduled activities that provide ample opportunities for teachers to interact with one another, develop relationships, and celebrate their membership in the organization (Smrekar 1996). Such schools also provide regular opportunities for teachers to interact with students and parents in

informal activities that promote relationships that go beyond the academically oriented relationships of the classroom. Established procedures ensure that all members are kept informed of school programs and activities.

Regular contact includes parents who participate in school activities and who call other parents if they have a question about the school. Among teachers, regular contact includes engaging in personal and professional conversations with other teachers. The combination of shared values, commitment, a feeling of belonging, caring, interdependence, and regular contact defines the strength of a school's sense of community. Although each dimension is manifested in a myriad of activities, a sense of community is defined as the integration of all these elements.

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[11] This article summarizes findings from a larger study. For the detailed report, see Belenardo (2000). The author acknowledges and thanks Professor Henry "Hank" Becker at the University of California, Irvine, for his contributions to the preparation of this article. Thanks are also extended to all of the schools that participated in the study for their willingness to contribute to this project.

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I. Brief Overview
C. Identifying problems and responding appropriately

Excerpt from: ***Mood Disorders in Children and Adolescents***
by Anne Brown, In **NARSAD Research Newsletter**, Winter 1996.

Many researchers believe that mood disorders in children and adolescents represent one of the most under diagnosed group of illnesses in psychiatry. This is due to several factors:

(1) children are not always able to express how they feel,
(2) the symptoms of mood disorders take on different forms in children than in adults,
(3) mood disorders are often accompanied by other psychiatric disorders which can mask depressive symptoms, and
(4) many physicians tend to think of depression and bipolar disorder as illnesses of adulthood.

Not surprisingly, it was only in the 1980's that mood disorders in children were included in the category of diagnosed psychiatric illnesses.

How Prevalent are Mood Disorders in Children and Adolescents?

7-14% of children will experience an episode of major depression before the age of 15.
20-30% of adult bipolar patients report having their first episode before the age of 20.
Out of 100,000 adolescents, two to three thousand will have mood disorders out of which 8-10 will commit suicide.

Depression

There is emerging evidence that major depression can develop in prepubertal children and that it is a significant clinical occurrence among adolescents. Recent epidemiologic studies have shown that a large proportion of adults experience the onset of major depression during adolescence and early adulthood...

The essential features of mood disorders are the same in children as in adults, although children exhibit the symptoms differently. Unlike adults, children may not have the vocabulary to accurately describe how they feel and, therefore may express their problems through behavior. The following behaviors may be associated with mood disorders in children:...

- *In Elementary School-Aged Children and Adolescence*:

Disruptive behavior, possible academic difficulties, and peer problems. Increased irritability and aggression, suicidal threats, and worsening school performance. Parents often say that nothing pleases the children, that they hate themselves and everything around them.

Bipolar Disorder

There has been a great deal of diagnostic uncertainty surrounding bipolar disorder in children. This may be caused by a major difference in the way mania is expressed in bipolar children versus adults. A look back at the histories of adults with bipolar symptoms often shows that mood swings began around puberty, however there is a frequent 5-to-10 year lag between the onset of symptoms and display of the disorder serious enough to be recognized and require treatment, resulting in the under diagnosis of bipolar disorder.

Unlike adult bipolar patients, manic children are seldom characterized by euphoric mood. Rather, the most common mood disturbance in manic children may be better described as irritable, with "affective storms" or prolonged and aggressive temper outbursts...

Other aspects that make diagnosing bipolar disorder in children difficult is the frequency with which bipolar disorder is mistaken for attention-deficit hyperactivity disorder (ADHD), conduct disorder (which includes symptoms of socially unacceptable, violent or criminal behavior), or schizophrenia.

Bipolar Disorder vs. Other Childhood Disorders

ADHD and bipolar disorder have many overlapping features which include: distractibility, inattention, impulsivity, and hyperactivity. However, bipolar disorder has several differentiating features, which include: psychosis, depression, aggression, excitability, rapid mood swings, inappropriate affect and disregard for feelings of others.

Conduct disorder overlaps with bipolar disorder on symptoms such as: impulsivity, shoplifting, substance abuse, difficulties with the law and aggressiveness . However, in bipolar disorder, some distinguishing factors include: antisocial behavior with elevated or irritable mood and lack of peer group influence...

Treatments

It is important for children suffering from mood disorders to receive prompt treatment because early onset places children at a greater risk for multiple episodes of depression throughout their life span. Children who experience their first episode of depression before the age of 15 have a worse prognosis when compared with patients who had a later onset of the disorder.

At the present time, there is no definitive treatment for the spectrum of mood disorders in children, although some researchers believe that children respond well to treatment because they readily adapt and their symptoms are not yet entrenched. Treatment consists of a combination of interventions. Medications can be useful for cases of major depression or childhood onset mania, and psychotherapy can help children express their feelings and develop ways of coping with the illness. Some other helpful interventions that may be used are educational and family therapy.

Children suspected of mood disorders should be evaluated by a child psychiatrist, or if one is not available an adult psychiatrist who has experience in treating children. It is important that the clinician has had special training in speaking with children, utilizing play therapy, and can treat children in context of a family unit...

I. Brief Overview
D. Why this problem is important to schools

Excerpt from: ***Consequences and Correlates of Adolescent Depression***
by Sherry Glied, PhD; Daniel S. Pine, MD
In **Archives of Pediatrics & Adolescent Medicine,** Vol. 156 No. 10, October 2002
http://archpedi.ama-assn.org/issues/v156n10/rfull/poa10284.html

...Depression may lead girls and boys to miss school or to fall behind in school. Education is a critical determinant of adult earnings, so if school attendance and performance are substantially affected by depression, adolescents may lose earnings in the future. Depression may inhibit school performance of children and adolescents, just as such symptoms reduce work performance among adults.[3-5] Second, depression may affect other aspects of well-being. Such effects could occur through a connection between depression and dangerous behaviors, such as alcohol and drug use, bingeing, and smoking. Children with emotional and behavioral disorders in general are significantly more likely to experience substance use and are at higher risk of involvement with the juvenile justice system.[6, 7] ...

It is difficult to assess the consequences of depressive symptoms because depression in adolescents is often associated with many other factors that also raise the risk of undesirable behaviors and outcomes. Mental health problems in adolescents tend to be concentrated in the most disadvantaged groupschildren from minority groups, from single-parent families, and from low-income families. Furthermore, family studies suggest that the prevalence of depression is higher among adolescents from families that include a parent with depression, and these children may be at risk for other poor outcomes as well.[12]

Adolescent depression may also be associated with environmental adversity. The relationship between depression and extreme stress has been demonstrated in children subjected to natural disasters, children who are homeless, and children subjected to physical or sexual abuse.[13-15] While these studies consistently note associations between depression and extreme adversity, the findings are limited by the nature of the generally nonrepresentative samples in most studies...

Depressed adolescents are at much higher risk of poor performance at school, of using drugs and alcohol, and of bingeing. Together, these findings suggest that depression is an especially serious problem among children who live in risky environments and that depression is, in turn, associated with other serious risks.

The results of this study show that school attendance, smoking, bingeing, and suicidal ideation are significantly correlated with depression. Information about these indicators and behaviors as well as the presence of traumatic life events could be powerful tools for physicians in the difficult task of identifying adolescent depression and initiating treatment. Overall, studies show that about 1 in 20 adolescents currently suffers from depression, suggesting that routine screening for depression has considerable merit. In this study, among adolescents who missed more than 10 days of school in the preceding month, smoked, engaged in bingeing, or had suicidal thoughts, rates of elevated depressive symptoms were more than twice as high. Thorough screening for depression in this group is critical.

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II. Fact Sheets/Practice Notes

A. Children's Mental Health
Excerpt from: *What every Child Needs for Good Mental Health*

B. General Guidelines for Prevention

C. The Depressed Child

D. Adolescent Depression: Helping Depressed Teens

E. Concerns about Children and Adolescents
Excerpts from: *The Classification of Child and Adolescent Mental Diagnosis in Primary Care*

1. Developmental Variations

2. Problems

3. Disorders

A. Children's Mental Health:
What Every Child Needs for Good Mental Health

Excerpted from National Mental Health Association
http://www.nmha.org/infoctr/factsheets/72.cfm

It is easy for parents to identify their child's **physical** needs: nutritious food, warm clothes when it's cold, bedtime at a reasonable hour. However, a child's **mental** and **emotional** needs may not be as obvious. Good mental health allows children to think clearly, develop socially and learn new skills. Additionally, good friends and encouraging words from adults are all important for helping children develop self confidence, high self-esteem, and a healthy emotional outlook on life.

A child's physical and mental health are *both* important.

Basics for a child's good physical health:
- nutritious food
- adequate shelter and sleep exercise
- immunizations
- healthy living environment

Basics for a child's good <u>mental</u> health:
- unconditional love from family
- self-confidence and high self-esteem
- the opportunity to play with other children
- encouraging teachers and supportive caretakers
- safe and secure surroundings
- appropriate guidance and discipline

Give children unconditional love.

Love, security and acceptance should be at the heart of family life. Children need to know that your love does not depend on his or her accomplishments.

Mistakes and/or defeats should be expected and accepted. Confidence grows in a home that is full of unconditional love and affection.

Nurture children's confidence and self-esteem.

· **Praise Them -** Encouraging children's first steps or their ability to learn a new game helps them develop a desire to explore and learn about their surroundings. Allow children to explore and play in a safe area where they cannot get hurt. Assure them by smiling and talking to them often. Be an active participant in their activities. Your attention helps build their self-confidence and self-esteem.

· **Set Realistic Goals -** Young children need realistic goals that match their ambitions with their abilities. With your help, older children can choose activities that test their abilities and increase their self-confidence.

· **Be Honest** - Do not hide your failures from your children. It is important for them to know that we all make mistakes. It can be very re-assuring to know that adults are not perfect.

· **Avoid Sarcastic Remarks -** If a child loses a game or fails a test, find out how he or she feels about the situation. Children may get discouraged and need a pep talk. Later, when they are ready, talk and offer assurance.

· **Encourage children -** To not only strive to do their best, but also to enjoy the process. Trying new activities teaches children about teamwork, self-esteem and new skills.

Make Time for play!

Encourage Children to Play

To children, play is just fun. However, playtime is as important to their development as food and good care. Playtime helps children be creative, learn problem-solving skills and learn self-control. Good, hardy play, which includes running and yelling, is not only fun, but helps children to be physically and mentally healthy.

Children Need Playmates

Sometimes it is important for children to have time with their peers. By playing with others, children discover their strengths and weaknesses, develop a sense of belonging, and learn how to get along with others. Consider finding a good children's program through neighbors, local community centers, schools, or your local park and recreation department...

School should be fun!

Starting school is a big event for children. "Playing school" can be a positive way to give them a glimpse of school life.
Try to enroll them in a pre-school, Head Start, or similar community program which provides an opportunity to be with other kids and make new friends. Children can also learn academic basics as well as how to make decisions and cope with problems.

Provide appropriate guidance and instructive discipline

Children need the opportunity to explore and develop new skills and independence. At the same time, children need to learn that certain behaviors are unacceptable and that they are responsible for the consequences of their actions.
As members of a family, children need to learn the rules of the family unit. Offer guidance and discipline that is fair and consistent. They will take these social skills and rules of conduct to school and eventually to the workplace.

Suggestions on guidance and discipline

Be firm, but kind and realistic with your expectations.
Children's development depends on your love and encouragement.

Set a good example.
You cannot expect self-control and self-discipline from a child if *you* do not practice this behavior.

Criticize the behavior, *not* the child.
It is best to say, "That was a bad thing you did," rather than "You are a bad boy or girl."

Avoid nagging, threats and bribery.
Children will learn to ignore nagging, and threats and bribes are seldom effective.
Give children the reasons "why" you are disciplining them and what the potential consequences of their actions might be.

Talk about your feelings.
We all lose our temper from time to time. If you do "blow your top," it is important to talk about what happened and why you are angry. A*pologize* if you were wrong!

Remember, the goal is not to control the child, but for him or her to learn self-control.

Provide a safe and secure home.

It's okay for children to feel afraid sometimes. Everyone is afraid of something at some point in their life. Fear and anxiety grow out of experiences that we do not understand.

If your children have fears that will not go away and affect his or her behavior, the first step is to find out what is frightening them. Be loving, patient and reassuring, not critical. Remember: the fear may be very real to the child.

Signs of Fear

Nervous mannerisms, shyness, withdrawal and aggressive behavior may be signs of childhood fears. A change in normal eating and sleeping patterns may also signal an unhealthy fear. Children who "play sick" or feel anxious regularly may have some problems that need attention.

Fear of school can occur following a stressful event such as moving to a new neighborhood, changing schools, or after a bad incident at school.

Children may not want to go to school after a period of being at home because of an illness.

When to seek help.

Parents and family members are usually the first to notice if a child has problems with emotions or behavior. Your observations with those of teachers and other caregivers may lead you to seek help for your child. If you suspect a problem or have questions, consult your pediatrician or contact a mental health professional.

Warning Signs

The following signs may indicate the need for professional assistance or evaluation:

- decline in school performance
- poor grades despite strong efforts
- regular worry or anxiety
- repeated refusal to go to school or take part in normal children's activities
- hyperactivity or fidgeting
- persistent nightmares
- persistent disobedience or aggression
- frequent temper tantrums
- depression, sadness or irritability

Where to seek help

Information and referrals regarding the types of services that are available for children may be obtained from:

- mental health organizations, hotlines and libraries
- other professionals such as the child's pediatrician or school counselor
- other families in the community
- family network organizations
- community-based psychiatric care
- crisis outreach teams
- education or special education services
- family resource centers and support groups
- health services
- protection and advocacy groups and organizations
- self-help and support groups

B. General Guidelines for Prevention

From *Addressing Barriers to Learning*
UCLA Center for Mental Health in Schools, Vol. 4, (3), Summer, 1999

Various efforts have been made to outline guidelines for both primary and secondary (indicated) prevention. A general synthesis might include:

- Systemic changes designed to both minimize threats to and enhance feelings of competence, connectedness, and self-determination (e.g., emphasizing a caring and supportive climate in class and school-wide, personalizing instruction). Such changes seem easier to accomplish when smaller groupings of students are created by establishing smaller schools within larger ones and small cooperative groups in classrooms.
- Ensure a program is integrated into a comprehensive, multifaceted continuum of interventions.
- Build school, family, and community capacity for participation.
- Begin in the primary grades and maintain the whole continuum through high school.
- Adopt strategies to match the diversity of the consumers and interveners (e.g., age, socio economic status, ethnicity, gender, disabilities, motivation).
- Develop social, emotional, and cognitive assets and compensatory strategies for coping with deficit areas.
- Enhance efforts to clarify and communicate norms about appropriate and inappropriate behavior (e.g., clarity about rules, appropriate rule enforcement, positive "reinforcement" of appropriate behavior; campaigns against inappropriate behavior).

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

C. THE DEPRESSED CHILD

From American Academy of Child & Adolescent Psychiatry,
Facts for Families No. 4 (10/92) (Updated 8/98)
http://www.aacap.org/publications/factsfam/depressd.htm

Not only adults become depressed. Children and teenagers also may have depression, which is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent''s ability to function.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their youngsters.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Hopelessness
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

A child who used to play often with friends may now spend most of the time alone and without interests. Things that were once fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way to feel better.

Children and adolescents who cause trouble at home or at school may actually be depressed but not know it. Because the youngster may not always seem sad, parents and teachers may not realize that troublesome behavior is a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

Early diagnosis and medical treatment are essential for depressed children. This is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. It may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat depression in children and teenagers.

D. Adolescent Depression: Helping Depressed Teens

Excerpted from National Mental Health Association

http://www.mentalhealthamerica.net/go/information/get-info/depression/depression-in-teens

It's not unusual for young people to experience "the blues" or feel "down in the dumps" occasionally. Adolescence is always an unsettling time, with the many physical, emotional, psychological and social changes that accompany this stage of life.

Unrealistic academic, social, or family expectations can create a strong sense of rejection and can lead to deep disappointment. When things go wrong at school or at home, teens often overreact. Many young people feel that life is not fair or that things "never go their way." They feel "stressed out" and confused. To make matters worse, teens are bombarded by conflicting messages from parents, friends and society. Today''s teens see more of what life has to offer —— both good and bad —— on television, at school, in magazines and on the Internet. They are also forced to learn about the threat of AIDS, even if they are not sexually active or using drugs.

Teens need adult guidance more than ever to understand all the emotional and physical changes they are experiencing. When teens'' moods disrupt their ability to function on a day-to-day basis, it may indicate a serious emotional or mental disorder that needs attention —— adolescent depression. Parents or caregivers must take action.

Dealing With Adolescent Pressures

When teens feel down, there are ways they can cope with these feelings to avoid serious depression. All of these suggestions help develop a sense of acceptance and belonging that is so important to adolescents.

- **Try to make new friends.** Healthy relationships with peers are central to teens'' self-esteem and provide an important social outlet.
- **Participate in sports, job, school activities or hobbies.** Staying busy helps teens focus on positive activities rather than negative feelings or behaviors.
- **Join organizations that offer programs for young people.** Special programs geared to the needs of adolescents help develop additional interests.
- **Ask a trusted adult for help.** When problems are too much to handle alone, teens should not be afraid to ask for help.

But sometimes, despite everyone''s best efforts, teens become depressed. Many factors can contribute to depression. Studies show that some depressed people have too much or too little of certain brain chemicals. Also, a family history of depression may increase the risk for developing depression. Other factors that can contribute to depression are difficult life events (such as death or divorce), side-effects from some medications and negative thought patterns.

Recognizing Adolescent Depression
Adolescent depression is increasing at an alarming rate. Recent surveys indicate that as many as one in five teens suffers from clinical depression. This is a serious problem that calls for prompt, appropriate treatment. Depression can take several forms, including bipolar disorder (formally called manic-depression), which is a condition that alternates between periods of euphoria and depression.

Depression can be difficult to diagnose in teens because adults may expect teens to act moody. Also, adolescents do not always understand or express their feelings very well. They may not be aware of the symptoms of depression and may not seek help.

These symptoms may indicate depression, particularly when they last for more than two weeks:

- Poor performance in school
- Withdrawal from friends and activities
- Sadness and hopelessness
- Lack of enthusiasm, energy or motivation
- Anger and rage
- Overreaction to criticism
- Feelings of being unable to satisfy ideals
- Poor self-esteem or guilt
- Indecision, lack of concentration or forgetfulness
- Restlessness and agitation
- Changes in eating or sleeping patterns
- Substance abuse
- Problems with authority
- Suicidal thoughts or actions

Teens may experiment with drugs or alcohol or become sexually promiscuous to avoid feelings of depression. Teens also may express their depression through hostile, aggressive, risk-taking behavior. But such behaviors only lead to new problems, deeper levels of depression and destroyed relationships with friends, family, law enforcement or school officials.

Treating Adolescent Depression
It is extremely important that depressed teens receive prompt, professional treatment. Depression is serious and, if left untreated, can worsen to the point of becoming life-threatening. If depressed teens refuse treatment, it may be necessary for family members or other concerned adults to seek professional advice.

Therapy can help teens understand why they are depressed and learn how to cope with stressful situations. Depending on the situation, treatment may consist of individual, group or family counseling. Medications that can be prescribed by a psychiatrist may be necessary to help teens feel better.

Some of the most common and effective ways to treat depression in adolescents are:

- **Psychotherapy** provides teens an opportunity to explore events and feelings that are painful or troubling to them. Psychotherapy also teaches them coping skills.
- **Cognitive-behavioral therapy** helps teens change negative patterns of thinking and behaving.
- **Interpersonal therapy** focuses on how to develop healthier relationships at home and at school.
- **Medication** relieves some symptoms of depression and is often prescribed along with therapy.

When depressed adolescents recognize the need for help, they have taken a major step toward recovery. However, remember that few adolescents seek help on their own. They may need encouragement from their friends and support from concerned adults to seek help and follow treatment recommendations.

Facing The Danger Of Teen Suicide
Sometimes teens feel so depressed that they consider ending their lives. Each year, almost 5,000 young people, ages 15 to 24, kill themselves. The rate of suicide for this age group has nearly tripled since 1960, making it the third leading cause of death in adolescents and the second leading cause of death among college-age youth.

Studies show that suicide attempts among young people may be based on long-standing problems triggered by a specific event. Suicidal adolescents may view a temporary situation as a permanent condition. Feelings of anger and resentment combined with exaggerated guilt can lead to impulsive, self-destructive acts.

Recognizing The Warning Signs

Four out of five teens who attempt suicide have given clear warnings. Pay attention to these warning signs:

- Suicide threats, direct and indirect
- Obsession with death
- Poems, essays and drawings that refer to death
- Dramatic change in personality or appearance
- Irrational, bizarre behavior
- Overwhelming sense of guilt, shame or rejection
- Changed eating or sleeping patterns
- Severe drop in school performance
- Giving away belongings

REMEMBER!!! These warning signs should be taken seriously. Obtain help immediately. Caring and support can save a young life.

Helping Suicidal Teens

- **Offer help and listen.** Encourage depressed teens to talk about their feelings. Listen, don't lecture.
- **Trust your instincts.** If it seems that the situation may be serious, seek prompt help. Break a confidence if necessary, in order to save a life.
- **Pay attention to talk about suicide.** Ask direct questions and don't be afraid of frank discussions. Silence is deadly!
- **Seek professional help.** It is essential to seek expert advice from a mental health professional who has experience helping depressed teens. Also, alert key adults in the teen's life —— family, friends and teachers.

Looking To The Future

When adolescents are depressed, they have a tough time believing that their outlook can improve. But professional treatment can have a dramatic impact on their lives. It can put them back on track and bring them hope for the future.

E. Classifying Concerns about Children and Adolescents

Deciding how to label a problem, especially related to children and adolescents, is a difficult and controversial matter.

The current scheme that dominates practice is the Diagnostic and Statistical Manual published by the American Psychiatric Association.

To counter the tendency toward turning common states manifested by young people into pathology, the American Academy of Pediatrics has developed The Classification of Child and Adolescent Mental Diagnosis in Primary Care (DSM-PC). It provides a perspective on what are simply developmental variations as contrasted to common problems and real disorders.

Excerpted on the following pages the sections of the DSM-PC that focus on mood and affect.

1. Developmental Variations

2. Problems

3. Disorders

1. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATIONS	COMMON DEVELOPMENTAL PRESENTATIONS
Sadness Variation Transient depressive responses or mood changes to stress are normal in otherwise healthy populations.	**Early Childhood** The child may have transient withdrawal and sad affect that may occur over losses and usually experiences bereavement due to the death of a parent or the loss of a pet or treasured object.
Bereavement Sadness related to a major loss that typically persists for less than 2 months after the loss...	**Middle Childhood** The child feels transient loss of self-esteem aver experiencing failure and feels sadness with losses as in early childhood. **Adolescence** The adolescent's developmental presentations are similar to those of middle childhood but may also include fleeting thoughts of death. Bereavement includes loss of a boyfriend or girlfriend, friend, or best friend.
Thoughts of Death Variation Anxiety about death in early childhood. Focus on death in middle childhood or adolescence.	**Early Childhood** In early childhood anxiety about dying may be present **Middle Childhood** Anxiety about dying may occur in middle childhood, especially after a death in the family. **Adolescence** Some interest with death and morbid ideation may be manifest by a preference for black clothing and an interest in the occult. If this becomes increased to a point of preoccupation, a problem or a serious ideation should be considered.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics
Notes: Dots (...) indicate that the original text has a reference to another section of the document.

2. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM	COMMON DEVELOPMENTAL PRESENTATIONS

Sadness Problem
Sadness or irritability that begins to include some symptoms of major depressive disorders in mild form.

- depressed/irritable mood
- diminished interest or pleasure
- weight loss/gain, or failure to make expected weight gains
- insomnia/hypersomnia
- psychomotor agitation/retardation
- fatigue or energy loss
- feelings of worthlessness or excessive or inappropriate guilt
- diminished ability to think/concentrate

However, the behaviors are not sufficiently intense to qualify for a depressive disorder.

These symptoms should be more than transient and have a mild impact on the child's functioning. Bereavement that continues beyond 2 months may also be a problem.

Early Childhood
The child may experience similar symptoms as in infancy, b sad affect may be more apparent. In addition, temper tantrums may increase in number and severity, and physical symptoms such as constipation, secondary enuresis (...), encopresis (...), and nightmares may be present.

Middle Childhood
The child may experience some sadness that results in brief suicidal ideation with no clear plan of suicide, some apathy, boredom, low self-esteem, and unexplained physical symptoms such as headaches and abdominal pain (...).

Adolescence
Some disinterest in school work, decrease in motivation, and day-dreaming in class may begin to lead to deterioration of school work. Hesitancy in attending school, apathy, and boredom may occur.

SPECIAL INFORMATION

Sadness is experienced by some children beyond the level of a normal developmental variation when the emotional or physiologic symptoms begin to interfere with effective social interactions, family functioning, or school performance. These periods of sadness may be brief or prolonged depending on the precipitating event and temperament of the child. Reassurance and monitoring is often needed at thisevel. If the sad behaviors are more severe, consider major depressive disorders.

The potential for suicide in grieving children is higher. Evaluation of suicidal risk should be part of a grief workup for all patients expressing profound sadness or confusion or demonstrating destructive behaviors toward themselves or others.

Behavioral symptoms resulting from bereavement that persist beyond 2 months after the loss require evaluation and intervention. Depressed parents or a strong family history of depression or alcoholism (...) puts youth at very high risk for depressive problems and disorders. Family and marital discord, ... exacerbates risk. Suicidal ideation should be assessed (see Suicidal Thoughts or Behaviors cluster).

Lying, stealing, suicidal thoughts (see Suicidal Thoughts or Behaviors cluster), and promiscuity may be present. Physical symptoms may include recurrent headaches, chronic fatigue, and abdominal pain (...).

Thoughts of Death Problem
The child has thoughts of or a preoccupation with his or her own death.

If the child has thoughts of suicide, consider suicidal ideation and attempts (...).

Early and Middle Childhood
The child may express a wish to die through discussion or play. This often follows significant punishment or disappointment.

Adolescence
The adolescent may express nonspecific ideation related to suicide.

SPECIAL INFORMATION

Between 12% and 25% of primary school and high school children have some form of suicidal ideation. Those with a specific plan or specific risk factors should be considered at most risk.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in primary Care*. (1996) American Academy of Pediatrics
Notes: Dots (...) indicate that the original text has a reference to another section of the document.

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric

DISORDERS

Major Depressive Disorder
Significant distress or impairment is manifested by five of the nine criteria listed below, occurring nearly every day for 2 weeks.

These symptoms must represent a change from previous functioning and that either depressed or irritable mood or diminished interest or pleasure must be present to make the diagnosis.

- depressed/irritable
- diminished interest or pleasure
- weight loss/gain
- insomnia/hypersomnia
- psychomotor agitation/retardation
- fatigue or energy loss
- feelings of worthlessness
- diminished ability to think/concentrate
- recurrent thoughts of death and suicidal ideation

(see *DSM-IV* Criteria ...)

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
True major depressive disorders are difficult to diagnose in infancy. However, the reaction of some infants in response to the environmental cause is characterized by persistent apathy, despondency (often associated with the loss of a caregiver or an unavailable [e.g., severely depressed] caregiver), nonorganic failure-to-thrive (often associated with apathy, excessive withdrawal), and sleep difficulties. These reactions, in contrast to the "problem" level, require significant interventions.

Early Childhood
This situation in early childhood is similar to infancy.

Middle Childhood
The child frequently experiences chronic fatigue, irritability, depressed mood, guilt, somatic complaints, and is socially withdrawn (...). Psychotic symptoms (hallucinations or delusions) may be present.

Adolescence
The adolescent may display psychomotor retardation or have hypersomnia. Delusions or hallucinations are not uncommon (but not part of the specific symptoms of the disorder).

SPECIAL INFORMATION

Depressed parents or a strong family history of depression or alcoholism puts youth at very high risk for depressive disorder (...). Risk is increased by family and marital discord (...), substance abuse by the patient (...), and a history of depressive episodes. Suicidal ideation should be routinely assessed.

Sex distribution of the disorder is equivalent until adolescence, when females are twice as likely as males to have a depressive disorder.

Culture can influence the experience and communication of symptoms of depression, (e.g., in some cultures, depression tends to be expressed largely in somatic terms rather than with sadness or guilt). Complaints of "nerves" and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or "imbalance" (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being heartbroken (among Hopis) may express the depressive experience.

Subsequent depressive episodes are common. Bereavement typically improves steadily without specific treatment. If significant impairment or distress is still present aver 2 months following the acute loss or death of a loved one, or if certain symptoms that are not characteristic of a "normal" grief reaction are present (e.g., marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation), consider diagnosis and treatment of major depressive disorder.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in primary Care*. (1996) American Academy of Pediatrics
Notes: Dots (...) indicate that the original text has a reference to another section of the document.

DISORDER

Dysthymic Disorder
The symptoms of dysthymic disorder are less severe or disabling than those of major depressive disorder but more persistent.

Depressed/irritable mood for most of the day, for more days than not (either by subjective account or observations of others) for at least 1 year.

Also the presence, while depressed/ irritable, of two (or more) of the following:

- poor appetite/overeating
- insomnia/hypersomnia
- low energy or fatigue
- poor concentration/difficulty making de-cisions
- feelings of hopelessness

(see *DSM-IV* Criteria ...)

Adjustment Disorder With Depressed Mood

(see DSM-IV Criteria ...)

Depressive Disorder, Not Otherwise Specified

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not diagnosed.

Early Childhood
Rarely diagnosed.

Middle Childhood and Adolescence
Commonly experience feelings of inadequacy, loss of Interest/pleasure, social withdrawal, guilt, brooding, irritability or excessive anger, decreased activity/productivity. May experience sleep/ appetite/weight changes and psychomotor symptoms. Low self-esteem is common.

SPECIAL INFORMATION

Because of the chronic nature of the disorder, the child may not develop adequate social skills.

The child is at risk for episodes of major depression.

DISORDER

Bipolar I Disorder, With Single Manic Episode

(see DSM-IV CRITERIA...)

Bipolar II Disorder, Recurrent Major Depressive Episodes With Hypomanic Episodes

Includes presence (or history) of one or more major depressive episodes, presence of at least one hypomanic episode, there has never been a manic episode (similar to manic episodes but only need to be present for 4 or more days and are not severe enough to cause marked impairment in function) or a mixed episode. The symptoms are not better accounted for by schizoaffective disorder, schizophrenia, delusional disorder, or psychotic disorder. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not diagnosed.

Early Childhood
Rarely diagnosed.

Middle Childhood
The beginning symptoms as described for adolescents start to appear.

Adolescence
During manic episodes, adolescents may wear flamboyant clothing, distribute gifts or money, and drive recklessly. They display inflated self-esteem, a decreased need for sleep, pressure to keep talking, flights of ideas, distractibility, unrestrained buying sprees, sexual indiscretion, school truancy and failure, antisocial behavior, and illicit drug experimentation.

SPECIAL INFORMATION

Substance abuse is commonly associated with bipolar disorder (...).

Stimulant abuse and certain symptoms of attention-deficit/ hyperactivity disorder may mimic a manic episode (see Hyperactive/ Impulsive Behaviors cluster).

Manic episodes in children and adolescents can include psychotic features and may be associated with school truancy, antisocial behavior (...), school failure, or illicit drug experimentation. Long-standing behavior problems often precede the first manic episode.

One or more manic episodes (a distinct period of an abnormally and persistently elevated and expansive or irritable mood lasting at least 1 week if not treated) frequently occur with one or more major depressive episodes. The symptoms are not better accounted for by other severe mental disorders (e.g., schizoaffective, schizophrenegenic, delusional, or psychotic disorders). The symptoms cause mild impairment in functioning in usual social activities and relationships with others.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in primary Care*. (1996) American Academy of Pediatrics
Notes: Dots (...) indicate that the original text has a reference to another section of the document.

DISORDER	COMMON DEVELOPMENTAL PRESENTATIONS

Suicidal Ideation and Attempts
The child has thoughts about causing intentional self-harm acts that cause intentional self-harm or death.

This code represents an unspecified mental disorder. It is to be used when no other condition is identified.

Infancy
Unable to assess.

Early Childhood
The child expresses a wish and intent to die either verbally or by actions.

Middle Childhood
The child plans and enacts self-injurious acts with a variety of potentially lethal methods.

Adolescence
The adolescent frequently shows a strong wish to die and may carefully plan and carry out a suicide.

SPECIAL INFORMATION

A youngster's understanding that death is final is not an essential ingredient in considering a child or adolescent to be suicidal. How-ever, very young children, such as preschoolers who do not appreciate the finality of death, can be considered to be suicidal if they wish to carry out a self-destructive act with the goal of causing death. Such behavior in preschoolers is often associated with physical or sexual abuse (...).

Prepubertal children may be protected against suicide by their cognitive immaturity and limited access to more lethal methods that may prevent them from planning and executing a lethal suicide attempt despite suicidal impulses.

The suicide rate and rate of attempted suicide increase with age and with the presence of alcohol and other drug use. Psychotic symptoms, including hallucinations, increase risk as well.

Because of societal pressures, some homosexual youth are at increased risk for suicide attempts (...).

In cases of attempted suicide that are carefully planned, adolescents may leave a note, choose a clearly lethal method, and state their intent prior to the actual suicide. In contrast, most suicide attempts in adolescence are impulsive, sometimes with little threat to the patient's life. The motivation for most attempts appears to be a wish to gain attention and/or help, escape a difficult situation, or express anger or love. However, irrespective of motivation, all suicide attempts require careful evaluation and all patients with active intent to harm themselves should have a thorough psychiatric evaluation.

Although suicidal ideation and attempts is not a disorder diagnosis, more extensive evaluation may identify other mental conditions (e.g., major depressive disorder).

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in primary Care*. (1996) American Academy of Pediatrics
Notes: Dots (...) indicate that the original text has a reference to another section of the document.

III. Tools/Handouts

A. Two Guides on Environmental Stressors and Common Responses

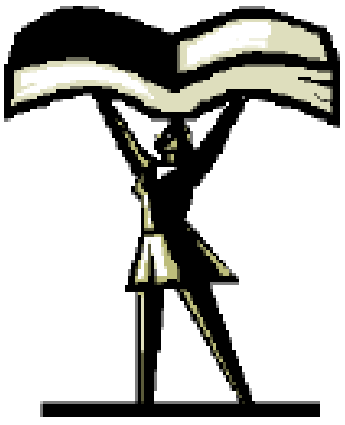
1. Environmental Situations and Potentially Stressful Events

2. Common Behavior Responses

B. Enhancing Coping and Building Resilience

1. Enhancing Resilience and Protective Factors

2. Embracing Resilience in an At-Risk World



A. Two Guides on Environmental Stressors and Common Responses

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of exhibits that give an overview of such events and responses.

Guide 1
Environmental Situations and Potentially Stressful Events Checklist

Challenges to Primary Support Group
- Challenges to Attachment Relationship
- Death of a Parent or Other Family Member
- Marital Discord
- Divorce
- Domestic Violence
- Other Family Relationship Problems
- Parent-Child Separation

Changes in Caregiving
- Foster Care/Adoption/Institutional Care
- Substance-Abusing Parents
- Physical Abuse
- Sexual Abuse
- Quality of Nurture Problem
- Neglect
- Mental Disorder of Parent
- Physical Illness of Parent
- Physical Illness of Sibling
- Mental or Behavioral disorder of Sibling

Other Functional Change in Family
- Addition of Sibling
- Change in Parental Caregiver

Community of Social Challenges
- Acculturation
- Social Discrimination and/or Family Isolation

Educational Challenges
- Illiteracy of Parent
- Inadequate School Facilities
- Discord with Peers/Teachers

Parent or Adolescent Occupational Challenges
- Unemployment
- Loss of Job
- Adverse Effect of Work Environment

Housing Challenges
- Homelessness
- Inadequate Housing
- Unsafe Neighborhood
- Dislocation

Economic Challenges
- Poverty
- Inadequate Financial Status

Legal System or Crime Problems

Other Environmental Situations
- Natural Disaster
- Witness of Violence

Health-Related Situations
- Chronic Health Conditions
- Acute Health Conditions

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics.

Guide 2
Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

EARLY CHILDHOOD (3-5Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- N/A

Emotions and Moods
- Generally sad
- Self-destructive behaviors

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- High activity level

Negative/Antisocial Behaviors
- Tantrums
- Negativism
- Aggression
- Uncontrolled, noncompliant

Feeding, Eating, Elimination Behaviors
- Change in eating
- Fecal soiling
- Bedwetting

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Regression or delay in developmental attainments

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Ambivalence toward independence
- Socially withdrawn, isolated
- Excessive clinging
- Separation fears
- Fear of being alone

MIDDLE CHILDHOOD (6-12Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- Transient physical complaints

Emotions and Moods
- Sadness
- Anxiety
- Changes in mood
- Preoccupation with stressful situations
- Self -destructive
- Fear of specific situations
- Decreased self-esteem

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- High activity level
- Impulsivity

Negative/Antisocial Behaviors
- Aggression
- Noncompliant
- Negativistic

Feeding, Eating, Elimination Behaviors
- Change in eating
- Transient enuresis, encopresis

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Decrease in academic performance

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Change in school activities
- Change in social interaction such as withdrawal
- Separation fear
- Fear of being alone

Substance Use/Abuse...

ADOLESCENCE (13-21Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- Transient physical complaints

Emotions and Moods
- Sadness
- Self-destructive
- Anxiety
- Preoccupation with stress
- Decreased self-esteem
- Change in mood

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- Impulsivity
- High activity level

Negative/Antisocial Behaviors
- Aggression
- Antisocial behavior

Feeding, Eating, Elimination Behaviors
- Change in appetite
- Inadequate eating habits

Somatic and Sleep Behaviors
- Inadequate sleeping habits
- Oversleeping

Developmental Competency
- Decrease in academic achievement

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Change in school activities
- School absences
- Change in social interaction such as withdrawal

Substance Use/Abuse...

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

III. Tools/Handouts (cont.)

B. Enhancing Coping & Building Resiliency

Exhibit 1
Enhancing Resilience and Protective Factors

Anyone working with children and youth is familiar with words like strength, assets, and resilience. This reflects the progress made in moving beyond a deficit or problem focused bias to incorporate approaches that build on motivation and promote resilience.

Enhancing resilience is a good thing; but what does it mean and how do we do it?

Research indicates that external factors (related to neighborhood, family, school, and/or peers) are primary causes for youngsters' learning, behavior, and emotional problems. Protective factors act as buffers to risk producing conditions. Resilience refers to an individual's ability to cope with risk factors.

"Resilient children are children who remain competent despite exposure to misfortune or to stressful events... Characteristics of resilient children include:

- A sense of self-esteem and self-efficacy, which allows the child to cope successfully with challenges
- An active stance toward an obstacle or difficulty
- The ability to see a difficulty as a problem that can be worked on, overcome, changed, endured, or resolved in some way
- Reasonable persistence, with an ability to know when "enough is enough"
- A capacity to develop a range of strategies and skills to bear on the problem, which can be used in a flexible way..."

From "Fostering Resiliency"
Northwest Regional Educational Laboratory
http://www.nwrel.org/pirc/hot9.html

While efforts to reduce risks and enhance protection can help minimize problems, a focus on promoting healthy development goes a step further by focusing on establishing systems that foster full development, well-being, and a value-based life. Safe, stable schools and neighborhoods that provide enriched opportunities to promote student development, learning, and a sense of community go well beyond just strengthening resilience.

School-based interventions can strengthen resilience, prevent problems, and promote healthy development. Positive outcomes have been found that last well into adulthood. For example, a report in the May 2002 issue of the *Archives of Pediatrics & Adolescent Medicine* indicates that an elementary school social development program designed to promote social competence, bonding to school, and academic success also contributed to a reduction in risky sexual practices and adverse health consequences in early adulthood. The program, the *Seattle Social*

Development Project, is only one of many that appear on the proliferating lists of evidence-based programs. (See online journal *Prevention & Treatment* for a composite review of positive youth development programs - http://journals.apa.org/prevention/volume5/pre0050015a.html).

Staff from the Prevention Research center for the Promotion of Human Development at Pennsylvania State University have reviewed and extrapolated the ingredients of effective programs.

(http://journals.apa.org/prevention/volume4/pre0040001a.html).

Their conclusions are that:

- Multi-year programs are more likely to foster enduring benefits
- preventive interventions may effectively operate throughout childhood when developmentally-appropriate risk and protective factors are targeted. However, interventions may need to begin at preschool for serious conduct problems.
- Preventive interventions are best directed at risk and protective factors rather than at categorical problem behavior. It is both feasible and cost-effective to target multiple negative outcomes in the context of a coordinated set of programs.
- Interventions should be aimed at multiple domains, changing institutions and environments as well as individuals.
- Prevention programs that focus independently on the child are not as effective as those that simultaneously "educate" the child and instill positive changes across both the school and home environments.
- There is no single program component that can prevent multiple high-risk behavior. A package of coordinated, collaborative strategies and programs is required in each community.
- Prevention programs need to be integrated with systems of treatment to enhance linkages and sustainability.

Finally, they express surprise that so few comprehensive interventions (combining school-wide primary prevention together with secondary prevention and treatment) have been developed and evaluated. They stress that schools, in coordination with community providers, are potential settings for the creation of such fully-integrated models.

School based health center staff are in a unique position to work with school students supporting staff and the community to create the type of integrated system that builds on strengths and fosters resilience.

"Kids can walk around in trouble if there is some place to walk to and someone to walk with" Tito, quoted in McLaughlin, Irby and Langman, 1993

For links to materials on resilience see http://smhp.psych.ucla.edu/qf/resilience.html

III. Tools/Handouts (cont.)

B. Enhancing Coping & Building Resiliency

Exhibit 2

Embracing Resilience in an At-Risk World Discussion Guide

http://www.neahin.org/programs/mentalhealth/resiliency101.htm

Resiliency 101

Resilience is an inherent trait that exists in every person, school and community. People, schools and communities, however, all have their own, unique identities, situations, strengths and weaknesses, assets and deficits. Your understanding of resilience and how you put that into practice in your everyday life is, therefore, unique. So, while resilience exists in everyone and everywhere, there is no one-size fits all program or product that is granted to make resilience happen...

- What's your own, personal definition of resilience?
- Brainstorm. On your own and with your colleagues, a definition of resilience for your school.
- Resilience applies to everyone at school. Identify at least one protective factor that exists for school staff. How can faculty and administration maximize the benefit of that protective factor to enhance your own resilience?
- Identify at least one protective factor that presently exists for students at your school. How, in your role at school, can you use that protective factor to enhance resilience for yourself and among your students and colleagues?...

IV. Intervention Strategies /Model Programs

A. The Prevention of Depression

B. Do Kids Need Friends?

C. Programs to Combat Bullying

D. What to do when a Friend is Depressed

IV. Intervention Strategies/Model Programs

A. The Prevention of Depression in Youth

by William R. Beardslee, M.D., and Tracy R. G. Gladstone, Ph.D.

...A review of these prevention programs and our experience developing and implementing a family-based preventive intervention program reveal six key points that we believe may prove helpful in treating children at risk for depression.

Resilience

Resilience refers to competence despite adversity (Luthar et al., in press) and provides an important foundation for the treatment of children with depression. Treatment of children at risk for depression must focus on identifying children's strengths and resources and on encouraging the development of factors that may protect children from the onset of illness. Our work with at-risk pre-adolescents has indicated that resilient children remained active in school and social activities outside of the home, maintained a view of themselves as separate from their parents' illness, and developed relationships with adults outside of the family (Beardslee and Podorefsky, 1988). Treatment with mildly depressed or at-risk children must focus on enhancing these characteristics.

Psychoeducation

In our work with families with parental depression, we found that adults knew little about this disorder and that children frequently did not have a name for their parent's depressed mood or irritability. Providing at-risk children with information about depression, identifying symptoms as an illness rather than as difficult behavior, and defining depression as a highly treatable mental illness will help reduce children's feelings of guilt or fear about their parents' or their own symptoms. In addition, providing children with information about causes, symptoms and risk factors for depression may assist them in identifying their own symptoms and seeking help when necessary.

Family-based Approach

Depression influences marital and family functioning (Keitner and Miller, 1990), and family members reinforce depressive behaviors in each other (Kaslow and Racusin, 1994), thus supporting the use of a family-centered approach in preventing the onset of depression in children at risk for depression. Parental involvement in treating at-risk children is crucial to successful prevention in this population, as parents may provide support and encourage resilience so that children are better able to negotiate developmental challenges successfully.

We have found that families with parental depression are characterized by poor cross-generational communication, poor understanding of disorder by children and feelings of guilt among children for any role they may have played in their parent's illness (Beardslee et al., 1997). Family meetings and family involvement in treatment may address these concerns and promote understanding and communication in families with depression. The principles of family-based prevention recently have been presented in a format that families themselves can use (Beardslee, 2002).

Developmental Perspective

Intervention for children at risk for depression must attend to developmental issues as well as emotional concerns. In fact, the risks for depression, and the valence of those risks, shift over the life span, and the expression of symptoms of depression varies developmentally. Thus, an intervention approach that is appropriate for a 4-year-old may be quite different from one that is appropriate for a 14-year-old. For example, parental involvement in intervention is appropriate for early adolescents, but a peer focus group may be more useful with young adults as they make the transition from home to college or the work force.

Address All Risks

Research tells us that depression in parents or children often signals a constellation of risk factors that, when considered together, puts children at risk for poor outcomes. In fact, social adversity predicts poor mental health outcomes in children, even beyond the effects of parental mood disorder (Rutter, 1986 as cited in Beardslee et al., 1996). Thus, comprehensive concern for the prevention of childhood depression must be based on all the risks a child faces, and treatment must attend to the range of risks present in any child, particularly in children who face social disadvantage.

Treatment

Although primary prevention programs aim to reach youth before they are ill, an essential precondition for prevention involves competent treatment for all those who experience illness. It is crucial that adequate treatment for children and adults who already suffer from illness be incorporated into any prevention approach. In fact, illness cannot be prevented in children at risk for depression until their parents who suffer from mental illness receive appropriate treatment services.

Conclusions

Successful preventive interventions offer great benefit to families because they can relieve the enormous burden of suffering caused by mental illness. The study of prevention requires new, nontraditional ways of thinking, however; and scientific advances in neuroscience and developmental epidemiology have provided an empirical knowledge base from which to mount prevention efforts.

In addition, prevention programs targeting children at risk for disorder must consider the plasticity of development and the multiple influences on children's development. Current research in neuroscience emphasizes the capacity of individuals to change and grow. Knowledge of what influences plasticity at the molecular, individual and familial levels, even in the face of significant adversity, is needed to guide the development of preventive interventions across the life span.

Finally, advocates for the study of the prevention of depression must recognize the need for comprehensive programs to prevent risk factors for depression, including exposure to violence, social isolation and discrimination. Indeed, from a public health point of view, those concerned about the prevention of depression can find common ground with others in advocating for adequate health care for all children and all caregivers.

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IV. Intervention Strategies/Model Programs

B. Do Kids Need Friends?

by Anita Gurian, Ph.D. and Alice Pope, Ph.D.
Excerpted from: http://www.aboutourkids.org/articles/do_kids_need_friends

...What are friends for?

Friendships are important in helping children develop emotionally and socially. They provide a training ground for trying out different ways of relating to others. Through interacting with friends, children learn the give and take of social behavior in general. They learn how to set up rules, how to weigh alternatives and make decisions when faced with dilemmas. They experience fear, anger, aggression and rejection. They learn how to win, how to lose, what's appropriate, what's not. They learn about social standing and power - who's in, who's out, how to lead and how to follow, what's fair and what's not. They learn that different people and different situations call for different behaviors and they come to understand the viewpoints of other people. Friends provide companionship and stimulation for each other, and they find out who they are by comparing themselves to other children - who's bigger, faster, who can add better, who can catch better. They learn that they're both similar to and different from others. Through friendships and belonging to a group children improve their sense of self-esteem. The solace and support of friends help children cope with troubling times and through transition times - moving up to a new school, entering adolescence, dealing with family stresses, facing disappointments.

Friendships are not just a luxury; they are a necessity for healthy psychological development. Research shows that children with friends have a greater sense of well-being, better self-esteem and fewer social problems as adults than individuals without friends. On the other hand, children with friendship problems are more likely than other children to feel lonely, to be victimized by peers, to have problems adjusting to school, and to engage in deviant behaviors...[1]

Friends and school achievement

It seems logical that having friends at school would enhance a child's academic progress. Schools can provide a network of rewarding experiences and represent natural communities of reinforcement. Friends can help each other with class assignments and homework; they can fill in what's missed during absences, and most importantly, friends make school more fun. Research confirms these impressions. Longitudinal studies show that children entering first grade have better school attitudes if they already have friends and are successful in keeping the old friends as well as in making new ones. [3] Similarly teens who have friends experience fewer psychological problems than friendless teens when school changes or transitions occur. [4]

When friendships are not helpful - the downside of friendship

The quality of friendship is important. The well known "peer pressure" effect which starts in early adolescence, although positive for many, can also have negative consequences. Children who align themselves with friends who engage in antisocial behavior are at risk for also engaging in this type of behavior. Antisocial friends are not good role models. Especially during adolescence, teenagers who have a history of difficult behavior and poor peer relationships can engage in delinquent behavior. In contrast, adolescents who have a history of positive peer relationships and are socially mature are more resilient and better able to deal with life changes and stress. [5] Learning to deal with peer pressure, competition and difference is a necessary part of development. Helping children deal with pressure from friends is more important than protecting them from it.

Encouraging children's friendships

What Schools Can Do

For children who require individual help several different formats are presently in use:

- Children are taught social skills individually by an adult coach or counselor and then they practice the new strategies.
- Peer pairing therapy; two children with difficulties interact while they receive feedback from an adult coach. In some instances a shy child is matched with a more outgoing child.

For group interventions in the classroom:

- Conflict resolution programs teach children alternate ways of handling problems through peer counselors or adult-supervised techniques.
- Collaborative learning, cooperative assignments and games or "buddy systems" may foster alliances and encourage positive peer interactions.
- Reinforcement of appropriate social skills may enhance a socially reluctant child's social interaction.

What Parents Can Do

- Let your child know that you feel friendships are important and worth the effort.
- Respect your child's social style; some children do best with a host of friends, and some do best with a few close friends. Some make friends quickly, and some warm up to friends slowly.
- Find practical ways you can help your child make room in his/her life for being with other children. This is especially important if your child is shy or reluctant about peer interactions. For example, be flexible about family schedules so that your child can find time to be with friends. Offer your home or offer to accompany children on outings. You might also make arrangements for your family to spend time with another family that has a similar-age child.

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IV. Intervention Strategies/Model Programs

C. Programs to Combat Bullying

Northwest Regional Educational Laboratory, Fact Sheet Number 4, Winter 1999
101 SW Main, Suite 500, Portland, OR 97204
Telephone: 1-800-547-6339 ext. 477 | Fax: (503) 275-0444
Excerpted from: http://www.nwrel.org/request/dec01/schoolwide.html

Bullying occurs throughout the school, though teachers and parents are generally unaware of its extent. Making the situation worse, adults often believe that bullying is "part of growing up" and that they should not intervene. In one study, 71 percent of students reported that adults in the classroom ignored bullying. When asked, students uniformly said that they wanted teachers to intervene to stop bullying and teasing. Faced with adult indifference, children are either reluctant to get involved or do not know how to obtain help. Adults in schools must intervene to stop bullies.

Bullying must be fought throughout the school community, using a "whole-school" approach. Effective interventions focus on more than the perpetrators and victims. Schoolwide bullying policies need to include curricular measures such as teaching conflict resolution and assertiveness training, peer and professional counseling, and improvement of the physical school environment, allowing easier adult supervision...

A number of principles can be worked into the regular curriculum:

- Discuss how kids are different and how they are the same
- Examine the meaning of courage and lead students beyond the "superhero" image of bravery
- Promote friendship between students who are different from each other
- Promote friendship between boys and girls
- Talk about teasing and bullying throughout the year, not just following an incident

Listen to Your Child About Bullying

If your children are being bullied, it is vital to listen to what they tell you. Parents should make it clear that bullying is not the victim's fault, and that children do not have to face bullying on their own. Ask how they have been dealing with bullies, and talk about other ways to deal with them...

IV. Intervention Strategies/Model Programs

D. What to do When a Friend is Depressed: Guide for Students

National Institute of Mental Health, 2000
http://www.pueblo.gsa.gov/cic_text/health/friend-depressed/friend.pdf

You know that these school years can be complicated and demanding. Deep down, you are not quite sure of who you are, what you want to be, or whether the choices you make from day to day are the best decisions.

Sometimes the many changes and pressures you are facing threaten to overwhelm you. So, it isn't surprising that from time to time you or one of your friends feels "down" or discouraged.

But what about those times when a friend's activity and outlook on life stay "down" for weeks and begin to affect your relationship? If you know someone like this, your friend might be suffering from depression. As a friend, you can help.

……Find Out More About Depression

What is depression?

Depression is more than the blues or the blahs; it is more than the normal, everyday ups and downs.

When that "down" mood, along with other symptoms, lasts for *more than a couple of weeks*, the condition may be clinical depression. Clinical depression is a serious health problem that affects the total person. In addition to feelings, it can change behavior, physical health and appearance, academic performance, social activity and the ability to handle everyday decisions and pressures.

What causes clinical depression?

We do not yet know all the causes of depression, but there seem to be biological and emotional factors that may increase the likelihood that an individual will develop a depressive disorder...

...Be Able To Tell Fact From Fiction

Myths about depression often separate people from the effective treatments now available. Friends need to know the **facts.** Some of the most common myths are these:

Myth: It's normal for teenagers to be moody; Teens don''t suffer from "real" depression.

Fact: Depression can affect people at any age or of any race, ethnic, or economic group.

Myth: Teens who claim to be depressed are weak and just need to pull themselves together. There''s nothing anyone else can do to help.

Fact: Depression is not a weakness, but a serious health disorder. Both young people and adults who are depressed need professional treatment. A trained therapist or counselor can help them learn more positive ways to think about themselves, change behavior, cope with problems, or handle relationships. A physician can prescribe medications to help relieve the symptoms of depression. For many people, a combination of psychotherapy and medication is beneficial.

Myth: Talking about depression only makes it worse.

Fact: Talking through feelings may help a friend recognize the need for professional help. By showing friendship and concern and giving uncritical support, you can encourage your friend to talk to his or her parents or another trusted adult, like a teacher or coach, about getting treatment. If your friend is reluctant to ask for help, you can talk to an adult -- that''s what a real friend will do.

Myth: Telling an adult that a friend might be depressed is betraying a trust. If someone wants help, he or she will get it.

Fact: Depression, which saps energy and self-esteem, interferes with a person''s ability or wish to get help. And many parents may not understand the seriousness of depression or of thoughts of death or suicide. It is an act of true friendship to share your concerns with a school guidance counselor, a favorite teacher, your own parents, or another trusted adult.

...Know the Symptoms

The first step toward defeating depression is to define it. But people who are depressed often have a hard time thinking clearly or recognizing their own symptoms. They may need your help. Check the following to see if a friend or friends have had any of these symptoms persisting longer than two weeks.

Do they express feelings of

- Sadness or "emptiness"?
- Hopelessness, pessimism, or guilt?
- Helplessness or worthlessness?

Do they seem

- Unable to make decisions?
- Unable to concentrate and remember?
- To have lost interest or pleasure in ordinary activities -- like sports or band or talking on the phone?
- To have more problems with school and family?

Do they complain of

- Loss of energy and drive -- so they seem "slowed down"?
- Trouble falling asleep, staying asleep, or getting up?
- Appetite problems; are they losing or gaining weight?
- Headaches, stomach aches, or backaches?
- Chronic aches and pains in joints and muscles?

Has their behavior changed suddenly so that

- They are restless or more irritable?
- They want to be alone most of the time?
- They've started cutting classes or dropped hobbies and activities?
- You think they may be drinking heavily or taking drugs?

Have they talked about

- Death?
- Suicide - or have they attempted suicide?

...Find Someone Who Can Help

If you answered yes to several of the items, a friend may need help. Don''t assume that someone else is taking care of the problem. Negative thinking, inappropriate behavior or physical changes need to be reversed as quickly as possible. Not only does treatment lessen the severity of depression, treatment also may reduce the length of time (duration) your friend is depressed and may prevent additional bouts of depression.

If a friend shows many symptoms of depression, you can listen and encourage him or her to ask a parent or teacher about treatments. If your friend doesn't seek help quickly, talk to an adult you trust and respect -- especially if your friend mentions death or suicide.

There are many places in the community where people with depressive disorders can be diagnosed and treated. Help is available from family doctors, mental health specialists in community mental health centers or private clinics, and from other health professionals...

V. Additional Resources

A. Annotated "Lists" of Empirically Supported/ Evidence Based Interventions for School-Aged Children and Adolescents

B. Quick Find Contents

1. Environments that Support Learning
2. Peer Relationships and Peer Counseling
3. Resilience/ Assets
4. Childhood and Adolescent Depression

ANNOTATED "LISTS" OF EMPIRICALLY SUPPORTED/EVIDENCE BASED INTERVENTIONS FOR SCHOOL-AGED CHILDREN AND ADOLESCENTS

The following table provides a list of lists, with indications of what each list covers, how it was developed, what it contains, and how to access it.

I. Universal Focus on Promoting Healthy Development

A. ***Safe and Sound. An Educational Leader's Guide to Evidence-Based Social & Emotional Learning Programs*** (2002). The Collaborative for Academic, Social, and Emotional Learning (CASEL).

1. *How it was developed:* Contacts with researchers and literature search yielded 250 programs for screening; 81 programs were identified that met the criteria of being a multiyear program with at least 8 lessons in one program year, designed for regular ed classrooms, and nationally available.

2. *What the list contains:* Descriptions (purpose, features, results) of the 81 programs.

3. *How to access:* CASEL (http://www.casel.org)

B. ***Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs*** *(2002).* Social Develop. Res. Group, Univ. of Wash.

1. *How it was developed:* 77 programs that sought to achieve positive youth development objectives were reviewed. Criteria used: research designs employed control or comparison group and had measured youth behavior outcomes.

2. *What the list contains:* 25 programs designated as effective based on available evidence.

3. *How to access:* Online journal *Prevention & Treatment* (http://journals.apa.org/prevention/volume5/pre0050015a.html)

II. Prevention of Problems; Promotion of Protective Factors

A. ***Blueprints for Violence Prevention*** (1998). Center for the Study and Prevention of Violence, Institute of Behavioral Science, University Colorado, Boulder.

1. *How it was developed:* Review of over 450 delinquency, drug, and violence prevention programs based on a criteria of a strong research design, evidence of significant deterrence effects, multiple site replication, sustained effects.

2. *What the list contains: 10* model programs and 15 promising programs.

3. *How to access:* Center for the Study and Prevention of Violence (http://www.colorado.edu/cspvblueprints/model/navigate.htm)

B. ***Exemplary Substance Abuse Prevention Programs*** (2001). Center for Substance Abuse Prevention (SAMHSA).

1. *How it was developed:* (a) Model Programs: implemented under scientifically rigorous conditions and demonstrating consistently positive results. These science-based programs underwent an expert consensus review of published and unpublished materials on 15 criteria (theory, fidelity, evaluation, sampling, attrition, outcome measures, missing data, outcome data, analysis, threats to validity, integrity, utility, replications, dissemination, cultural/age appropriateness. (b) Promising Programs: those that have positive initial results but have yet to verify outcomes scientifically.

2. *What the list contains*: 30 substance abuse prevention programs that may be adapted and replicated by communities.

3. *How to access:* SAMHSA (http://www.modelprograms.samhsa.gov)

C. ***Preventing Drug Use Among Children & Adolescents. Research Based Guide*** (1997). National Institute on Drug Abuse (NIDA).

1. *How it was developed:* NIDA and the scientists who conducted the research developed research protocols. Each was tested in a family/school/community setting for a reasonable period with positive results.

2. *What the list contains:* 10 programs that are universal, selective, or indicated.

3. *How to access:* NIDA (www.nida.nih.gov/prevention/prevopen.html)

D. ***Safe, Disciplined, and Drug-Free Schools Expert Panel Exemplary Programs*** (2001). U.S. Dept. of Educ. Safe & Drug Free Schools

1. *How it was developed:* Review of *132* programs submitted to the panel. Each program reviewed in terms of quality, usefulness to others, and educational significance.

2. *What the list contains:* 9 exemplary and *33* promising programs focusing on violence, alcohol, tobacco, and drug prevention.

3. *How to access*: U.S. Dept. of Education – (http://www.ed.gov/offices/OERI/ORAD/KAD/expert_panel/drug-free.html)

III. Early Intervention: Targeted Focus on Specific Problems or at Risk Groups

A. ***The Prevention of Mental Disorders in School-Aged Children: Current State of the Field*** (2001). Prevention Research Center for the Promotion of Human Development, Pennsylvania State University.

1. *How it was developed:* Review of scores of primary prevention programs to identify those with quasi-experimental or randomized trials and been found to reduce symptoms of psychopathology or factors commonly associated with an increased risk for later mental disorders.

2. *What the list contains:* 34 universal and targeted interventions that have demonstrated positive outcomes under rigorous evaluation and the common characteristics of these programs.

3. *How to access:* Online journal *Prevention & Treatment* http://journals.apa.org/prevention/volume4/pre0040001a.html

IV. Treatment for Problems

A. ***The American Psychological Association, Division of Child Clinical Psychology, Ad Hoc Committee on Evidence-Based Assessment and Treatment of Childhood Disorders,*** published it's initial work as a special section of the *Journal of Clinical Child Psychology* in 1998.

1. *How it was developed:* Reviewed outcomes studies in each of the above areas and examined how well a study conforms to the guidelines of the Task Force on Promotion and Dissemination of Psychological Procedures (1996).

2. *What it contains:* reviews of anxiety, depression, conduct disorders, ADHD, broad spectrum Autism interventions, as well as more global review of the field. For example:

   >*Depression:* results of this analysis indicate only 2 series of studies meet criteria for probably efficacious interventions and no studies meet criteria for well-established treatment.
   >*Conduct disorder:* Two interventions meet criteria for well established treatments: videotape modeling parent training programs (Webster-Stratton) and parent training program based on Living with Children (Patterson and Guillion). Twenty additional studies identified as probably efficacious.
   >Attention Deficit Hyperactivity Disorder: behavioral parent training and behavioral interventions in the classroom meet criteria for well established treatments. Cognitive interventions do not meet criteria for well-established or probably efficacious treatments.
   >Phobia and Anxiety: for phobias participant modeling and reinforced practice are well established; filmed modeling, live modeling, and cognitive behavioral interventions that use self instruction training are probably efficacious. For anxiety disorders, only cognitive-behavioral procedures with and without family anxiety management were found to be probably efficacious.

   Caution: Reviewers stress the importance of devising developmentally and culturally sensitive interventions targeted to the unique needs of each child; need for research that is informed by clinical practice.

3. *How it can be accessed*: APA (http://www.psy.fsu.edu/~clinicalchild/taskfor.htm) and *Journal of Clinical Child Psychology* (1998) v.27, pp. 156-205.

V. Review/Consensus Statements/ Compendia of Evidence Based Treatments

A. ***School-Based Prevention Programs for Children & Adolescents*** (1995). J.A. Durlak. Sage: Thousand Oaks, CA. Reports results from 130 controlled outcome studies that support "a secondary prevention model emphasizing timely intervention for subclinical problems detected early.... In general, best results are obtained for cognitive-behavioral and behavioral treatments & interventions targeting externalizing problems."

B. ***Mental Health and Mass Violence:*** Evidence-based early psychological intervention for victims/ survivors of mass violence. A workshop to reach consensus on best practices (U.S. Departments of HHS, Defense, Veterans Affairs, Justice, and American Red Cross). Available at: (http://www.nimh.nih.gov/research/massviolence/pdf)

C. ***Society of Pediatric Psychology,*** Division 54, American Psychological Association, *Journal of Pediatric Psychology.* Articles on empirically supported treatments in pediatric psychology related to obesity, feeding problems, headaches, pain, bedtime refusal, enuresis, encopresis, and symptoms of asthma, diabetes, and cancer.

D. ***Preventing Crime: What works, what doesn't, what's promising. A Report to the United States Congress*** (1997) by L.W. Sherman, Denise Gottfredson, et al. Washington, DC: U.S. Dept. of Justice. Reviews programs funded by the OJP for crime, delinquency and substance use. (http://www.ncjrs.org/pdffiles/171676.pdf). Also see Denise Gottfredson's book: *Schools and delinquency* (2001). New York: Cambridge Press.

E. School Violence Prevention Initiative Matrix of Evidence-Based Prevention Interventions (1999). Center for Mental Health Services SAMHSA. Provides a synthesis of several lists cited above to highlight examples of programs which meet some criteria for a designation of evidence based for violence prevention and substance abuse prevention. (i.e., Synthesizes lists from the Center for the Study and Prevention of Violence, Center for Substance Abuse Prevention, Communities that Care, Dept. of Education, Department of Justice, Health Resources and Services Administration, National Assoc. of School Psychologists) (http://modelprograms.samhsa.gov/matrix_all.cfm)

BUT THE NEEDS OF SCHOOLS ARE MORE COMPLEX!

Currently, there are about 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of behavior, emotional, and learning, problems in mind. School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth – though relatively few resources usually are allocated for such activity.

There is a large body of research supporting the promise of specific facets of this activity. However, no one has yet designed a study to evaluate the impact of the type of comprehensive, multifaceted approach needed to deal with the complex range of problems confronting schools.

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It is either naive or irresponsible to ignore the connection between children's performance in school and their experiences with malnutrition, homelessness, lack of medical care, inadequate housing, racial and cultural discrimination, and other burdens . . . .

Harold Howe II

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. . . consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved – their values, their character, their personal failings – rather than asking whether something about the system in which these students find themselves might also need to be addressed.

Alfie Kohn, 1999

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What the best and wisest parent wants for (her)/his own child that must the community want for all of its children. Any other idea . . . is narrow and unlovely.

John Dewey

****

Quick Find On-line Clearinghouse
(http://smhp.psych.ucla.edu/qf/environments.htm)

TOPIC: Classroom Climate/Culture and School Climate/Culture and Environments that Support Learning

The following represents a sample of information to get you started and is not meant to be exhaustive. (Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

Center Developed Documents, Resources, and Tools

Books/Articles

- H.S. Adelman, & L. Taylor (2005). **Classroom Climate** in S.W. Lee, P.A. Lowe, & E. Robinson (Eds.), *Encyclopedia of School Psychology*, Thousand Oaks, CA: Sage
- L. Taylor & H.S. Adelman (1999). **Personalizing Classroom Instruction to Account for Motivational and Developmental Differences.** *Reading & Writing Quarterly*, 15(4), 255-276.
- **The Implementation Guide to Student Learning Supports in the Classroom and Schoolwide**

A Center Practice Brief

- **Schools as Caring, Learning Communities (Center Practice Brief)**

Continuing Education Module

- **Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom-Focused Enabling (Continuing Education Module)**

Guides to Practice

- **What Schools Can Do to Welcome and Meet the Needs of All Students and Families (Guides to Practice)**

Information Sheet

- **About School Engagement and Re-Engagement (Information Sheet)**

Introductory Packet

- **Transitions: Turning Risks into Opportunities for Student Support (Introductory Packet)**

Newsletters

- **Easing the Impact of Student Mobility: Welcoming & Social Support (Newsletter, Fall, '97)**
- **Schools as Caring, Learning Communities (Newsletter, Spring, '01)**
- **Re-engaging Students in Learning at School (Newsletter, Winter, '02)**
- **Concerns = Opportunities: Addressing Student Disengagement, Acting Out, and Dropouts by Moving in New Directions (Newsletter, Spring '06)**

Practice Notes

- About Motivation (Practice Notes)
- Natural Opportunities to Promote Social-Emotional Learning and MH (Practice Notes)
- Supporting Successful Transition to Ninth Grade (Practice Notes)
- Welcoming Strategies for Newly Arrived Students and Their Families (Practice Notes)

Quick Training Aids

- Re-engaging Students in Learning (Quick Training Aids)

Resource Aid Packet

- Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What It Needs (Resource Aid Packet)

Technical Aid Packet

- Volunteers to Help Teachers and Schools Address Barriers to Learning (Technical Aid Packet)
- After-School programs and Addressing Barriers to Learning (Technical Aid Packet)
- Welcoming and Involving New Students and Families (Technical Aid Packet)

Training Tutorials

- Classroom Changes to Enhance and Re-engage Students in Learning (Training Tutorial)
- Support for Transitions to Address Barriers to Learning (Training Tutorial)

Tools For Practice

- Classroom-based Approaches to Enable and Re-engage Students in Classroom Learning: A Self-Study Survey (Tools for Practice)
- Support for Transitions: A Self-Study Survey (Tools for Practice)

Net Exchange

- School Climate

Relevant Documents, Resources, and Tools on the Internet

Class Size

- "Are Small Schools and Private Schools Better for Adolescents' Emotional Adjustment?" (2003) American Sociological Association
- Breaking Up Large High Schools: Five Common (and Understandable) Errors of Execution
- Classroom Environment Scale
- Class Size Reduction: Lessons Learned from Experience
- Dollars and Sense: The Cost Effectiveness of Small Schools**(PDF document)**
- Guideposts for Smaller High Schools: Lessons from Inside and Outside the School Walls (2002)
- "School Size, Violence, Cost, and Achievement" (2003) A report to the NJ Commission on Business Efficiency of Public Schools

Learning Environment

- A Framework for Success for All Students**(PDF)**
- All Together Now: Sharing Responsibility for the Child. (2006)**(PDF)**
- Block Scheduling: The Key to Quality Learning Time

- Center for Social Organization of Schools
- Creating an Effective Physical Classroom Environment
- Creating a Personalized and Orderly Learning Environment in High School
- Flexible School Facilities
- Health and Academics
- Impact of Facilities on Learning (National Clearinghouse for Educational Facilities)
- In Our Backyard: How 3 L.A. Neighborhoods Affect Kids' Lives (2002)
- Instructional Approaches: A Framework for Professional Practice
- The Learning Partnerships Specialist: Building the New and Needed Web of Learning Support
- Making Schools Places Where Everyone Succeeds: Belonging is Necessary for Learning
- Meeting Five Critical Challenges of High School Reform: Lessons from Research on Three Reform Models (2006) J. Quinn.
- National Center for School Engagement
- National Clearinghouse for Comprehensive School Reform
- National Dignity in Schools Campaign
- New Century Schoolhouse
- Problem-Based Learning
- School As A Caring Community Profile—II (SCCP-II)
- Social and School Connectedness in Early Secondary School as Predictors of Late Teenage Substance Use, Mental Health, and Academic Outcomes (2007) **L. Bond, et al., Journal of Adolescent Health, 40(4) 357-66**
- Some Simple and Yet Overlooked Common Sense Tips For A More Effective Classroom Environment
- Student Context, Student Attitudes and Behavior, and Academic Achievement
- Years of Promise: A Comprehensive Learning Strategy for America's Children

Classroom/School Climate

- "Altering the Structure and Culture of American Public Schools" (2003)
- Annenberg Institute for School Reform
- California Healthy Kids Survey
- Climate and Diversity of Educational Institutions
- Developing school connectedness in diverse youth through extracurricular programming
- Examining School Climate: Defining Factors and Educational Influences
- Kettering Scale of School Climate
- Positive School Climate
- Research Brief School Climate
- School Climate
- School Climate Research Summary
- School Climate Predictors of School Disorder: Results from a National Study of Delinquency Prevention in Schools (2005) **G. Gottfredson et al, *Journal of Research in Crime and Delinquency***
- School Size, School Climate, and Student Performance
- The School Climate Challenge Narrowing the Gap Between School Climate Research and School Climate Policy, Practice Guidelines and Teacher Education Policy
- The School Environment and Adolescent well-being: Beyond Academics
- Where We Learn: The CUBE Survey of Urban School Climate **(PDF)**

Related Agencies and Websites

- **Center for School Safety, School Climate and Classroom Management**
- **Coalition for Community Schools**
- **The Collaborative for Academic, Social, and Emotional Learning (CASEL)**
- **National Clearinghouse for Educational Facilities**
- **Urban Educational Facilities for the 21st Century (UEF 21)**

Relevant Publications That Can Be Obtained Through Libraries

- **"Classroom social climate and student absences and grades" by Moos, R., & Moos, B. (1978). In: *Journal of Educational Psychology*, 70, 263-269.**
- **"Context and coping: Toward a unifying conceptual framework" by Moos R (1984). In: *American Journal of Community Psychology*, 12: 5-25.**
- **"Evaluating and changing class room settings" by Moos, R., & David, T. (1981). In J. Epstein (Ed.), *The quality of school life* (pp. 59-80). Lexington, MA: D. C. Heath.**
- **"Evaluating classroom learning environments" by Moos R (1980). In: *Studies in Educational Evaluation*, 6: 239-252.**
- ***Evaluating educational environments: Procedures, methods, findings and policy implications* by Moos R (1979). San Francisco, CA: Jossey-Bass.**
- **"Learning environments in context: Links between school, work, and family settings" by Moos R (1987). In: Fraser B (Ed.), *The Study of Learning Environments* (Volume 2, p 1-16). Perth, Australia: Curtin University of Technology.**
- ***Living an idea: Empowerment and the evolution of an inner city alternative public school* by Trickett, E. J. (1991). Cambridge, MA.: Brookline Books.**
- **"Natural experiments and the educational context: The environment and effects of an alternative inner city public school on adolescents" by Trickett, E. J., McConahay, J. B., Phillips, D., & Ginter, M. A. (1985). In: *American Journal of Community Psychology*, 13, 617-643.**
- **"Personal correlates of contrasting environments: Student satisfaction in high school classrooms" by Trickett, E., & Moos, R. (1974). In: *American Journal of Community Psychology*, 2,1-12.**
- **"Person-environment congruence in work, school, and health care settings" by Moos, RH (1987). In: *Journal of Vocational Behavior*, 31: 231-247.**
- **"Safe & Caring Schools Grades 6-8: Hundreds of Ways to Improve Academic Success and School Climate" by Katia Petersen (2008). Free Spirit Publishing.**
- **"A School for Each Student: Personalization in a Climate of High Expectations (Paperback)" by Nelson Beaudoin (2008). Pub: Eye on Education.**
- **"The perceived environment of special education classrooms for adolescents: A revision of the Classroom Environment Scale" by Trickett, E. J., Leone, P. E., Fink, C. M., & Braaten, S. L. (1993). In: *Exceptional Children*, 59(5), 411-420.**
- ***The Social Climate Scales: A user's guide* by Moos, R. (1994). Palo Alto, CA: Consulting Psychologists Press.**
- **"The social environments of junior high and high school classrooms" by Trickett, E., & Moos, R. (1973). In: *Journal of Educational Psychology*, 65, 93-102.**
- **"Three domains of classroom environment: An alternative analysis of the Classroom Environment Scale" by Trickett, E., & Quinlan, D. (1979). In: *American Journal of Community Psychology*, 7, 279-291.**
- **"Towards a social-ecological conception of adolescent socialization: Normative data on contrasting types of public schools" by Trickett, E. (1978). In: *Child Development*, 49, 408-414.**
- **"Two decades of classroom environment research" by Fraser B (1991). In: Fraser B &**

Walberg HJ, *Educational Environments: Evaluation, Antecedents, and Consequences*. (pp. 3-27). Oxford, England: Pergamon Press, Inc.

- **"A Typology of Junior High and High School Classrooms" by Moos R (1978). In: *American Educational Research Journal*, 15: 53-66.**
- **"Understanding environments: the key to improving social processes and program outcomes" by Moos RH (1996). In: *American Journal of Community Psychology*, 24(1): 193-201.**
- **"Understanding the social ecology of classrooms for adolescents with behavioral disorders: A preliminary study of differences in perceived environments" by Leone PE, Luttig PG, Zlotlow S, & Trickett EJ (1990). In: *Behavioral Disorders*, 16(1): 55-65.**
- **"Using individual or group scores on perceived environment scales: Classroom Environment Scale as example" by Trickett, E., & Wilkinson, L. (1979). In: *American Journal of Community Psychology*, 7, 497-502.**
- **"Violence Prevention for Adolescents: A Cognitive-Behavioral Program for Creating a Positive School Climate: Leaders Manual (Paperback)" by Diane De Anda (2007). Research Press.**

We hope these resources met your needs. If not, feel free to contact us for further assistance. For additional resources related to this topic, use our search page to find people, organizations, websites and documents. You may also go to our technical assistance page for more specific technical assistance requests.

If you haven't done so, you may want to contact our sister center, the Center for School Mental Health at the University of Maryland at Baltimore.

If our website has been helpful, we are pleased and encourage you to use our site or contact our Center in the future. At the same time, you can do your own technical assistance with "The fine Art of Fishing" which we have developed as an aid for do-it-yourself technical assistance.

Quick Find On-line Clearinghouse
(http://smhp.psych.ucla.edu/qf/peersupport.htm)

TOPIC: Peer Relationships and Peer Counseling

The following represents a sample of information to get you started and is not meant to be exhaustive. (Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one.)

Center Developed Documents, Resources and Tools

Center Practice Brief
- **Schools as Caring, Learning Communities**

Introductory Packet
- **Social and Interpersonal Problems Related to School Aged Youth**
- **Transitions: Turning Risks into Opportunities for Student Support**

Newsletter
- **Promoting Youth Development and Addressing Barriers**

Practice Notes
- **Natural Opportunities to Promote Social-Emotional Learning and MH**
- **Supporting Successful Transition to Ninth Grade**
- **Welcoming Strategies for Newly Arrived Students and Their Families**

Resiliency
- **Protective Factors (Technical Assistance Sampler)**

Quickfinds
- **Social Skills**
- **Tutoring**
- **Mentoring**
- **Bullying**

Technical Aid Packet
- **After-School Program and Addressing Barriers to Learning**
- **School-Based Mutual Support Groups**
- **Volunteers to Help Teachers and Schools Address Barriers to Learning**
- **Welcoming and Involving New Students and Families**

Net Exchange
- **Peer Programs**

Relevant Documents, Resources, Tools on the Internet

- **Assessing the Quality of Youth Peer Education Programmes**

- **Bully-Proof: A Teachers' Guide on Teasing and Bullying for use with Fourth and Fifth Grade Students**
- **Classwide Peer Tutoring**
- **Cross-Age Teaching**
- **Early Adolescence: A Review of the Literature (please refer to the chapter on social development) (pdf document):**
- **Deviant Peer Influences in Intervention and Public Policy for Youth**
- **Loneliness in Young Children**
- **Peer-Assisted Learning**
- **Peer Initiation Strategies for Students with Autism**
- **Peer Mentoring Network**
- **Peer Support: An Elementary Approach**
- **Peer Support/Peer Provided Services: Underlying Processes, Benefits, and Critical Ingredients**
- **School-Wide Peer Helping: Peer Helping Changes School Climate**
- **Structuring for Success: Link Crew**
- **The Performance of At-Risk Youth As Tutors**
- **Teenagers as Teachers Programs**
- **What Works Clearinghouse: Peer-assisted Learning**

Related Agencies and Websites

- **About Our Kids (New York University, Child Study Center)**
- **The National Peer Helpers Association**
- **Peer Resources Document Archive**

Relevant Publications That Can Be Obtained through Libraries

- **"Poor Social Skills Are a Vulnerability Factor in the Development of Psychosocial Problems" by Chris Segrin & Jeanne Flora (2000). In: *Human Communication Research*, 26 (3): 489-514.**
- **"Second Step: Preventing Aggression by Promoting Social Competence" by Karin Frey, Miriam Hirschstein, & Barbar Guzzo (2000). In: *Journal of Emotional and Behavioral Disorders*, 8(2): 102-12**
- **"Social Interactions and Peer Support for Problem Behavior" by Thomas Farmer & Thomas Cadwallader (2000). In: *Preventing School Failure*, 44(3): 105-09.**
- **"The relationships of peer norms, ethnic identity, and peer support to school engagement in urban youth: An article from: Professional School Counseling" by Richard Shin, Bryan Daly & Elizabeth Vera (2007). In: *Professional School Counseling* , 44(3): 10(4) 379-389.**
- **"Youth Helping Youth: A Handbook for Training Peer Facilitators (Paperback)" by Robert D. Myrick & Tom Erney (2004). In: *Educational Media***

We hope these resources met your needs. If not, feel free to contact us for further assistance.For additional resources related to this topic, use our search page to find people, organizations, websites and documents. You may also go to our technical assistance page for more specific technical assistance requests.

If you haven't done so, you may want to contact our sister center, the Center for School Mental

Quick Find On-line Clearinghouse
(http://smhp.psych.ucla.edu/qf/resilience.html)

TOPIC: Resilience/Protective Factors

The following represents a sample of information to get you started and is not meant to be exhaustive. (Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one.)

Center Developed Documents, Resources and Tools

Technical Assistance Sampler
- **Protective Factors/Resiliency**

Newsletters
- **Enabling Learning in the Classroom: A Primary Mental Health Concern** (Spring '98)
- **Easing the Impact of Student Mobility: Welcoming & Social Support.** (Fall, '97)
- **Promoting Youth Development and Addressing Barriers.** (Fall, '99)

Informational Sheets
- **About School Engagement and Re-Engagement**
- **About Positive Psychology**

Technical Aid Packets
- **After-School Programs and Addressing Barriers to Learning**
- **School-Based Mutual Support Groups (For Parents, Staff, Older Students)**
- **Volunteers to Help Teachers and School Address Barriers to Learning**
- **Welcoming and Involving New Students and Families**

Practice Notes
- **About Motivation**
- **Natural Opportunities to Promote Social-Emotional Learning and MH**

Other Resources
- **Guides to Practice: What Schools Can Do to Welcome and Meet the Needs of All Students and Families**
- **A Center Brief: Early Development and School Readiness from the Perspective of Addressing Barriers to Learning (November, 2001)**
- **Introductory Packet: Early Development and Learning from the Perspective of Addressing Barriers**
- **Continuing Education Module: Addressing Barriers to Learning: New Directions for Mental Health in Schools**
- **Quick Training Aid: Re-engaging Students in Learning**
- **Transitions: Turning Risks into Opportunities for Student Support**

Other Relevant Documents, Resources, and Tools on the Internet

Facts, Statistics

- **Developmental Assets: An Overview**
- **Mapping Community Capacity**
- **Protective Factors in Individuals, Families, and Schools**
- **Resilience fact sheets geared toward specific populations(e.g., children, people of color, military families, primary-care providers, mental health workers, first responders, and others)**
- **Validation of the risk and resiliency assessment tool for juveniles in the Los Angeles County probation system (2005) S. Turner, et al, Rand**

General

- **"American Psychological Association Resilience for Kids & Teens Campaign"**
- **Fostering Resilience in Children**
- **"From Risk to Resiliency"**
- **Healthy Communities- Healthy Youth**
- **Healthy Youth, CDC, DASH**
- **Promoting Positive and Healthy Behavior in Children**
- **Race, genetics, and health disparities: A community resilience approach to reducing ethnic and racial disparities in health**
- **Resilience in African American Children and Adolescents: A Vision for Optimal Development**
- **"Resiliency in an at Risk World" NEA Health Information Network**
- **Resiliency is not enough: Young children and the rebuilding of New Orleans**
- **Resilience for Kids & Teens**
- **"Resiliency: What we have learned" (2004) B. Bernard, WestEd**
- **THRIVE: Tool for health and resilience in vulnerable environments**
- **Beyond Individual Resilience**

Programs, Guides

- **Building Assets for Youth**
- **Building Assets: What Parents Can Do**
- **Fostering Resilience in Children- from the Clearinghouse on Elementary and Early Childhood Education**
- **Growing Resilience: Creating Opportunities for Resilience to Thrive**
- **Promoting Resilience: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform**
- **Resilient children: Literature Review and Evidence from the HOPE VI Panel Study**
- **Turning It Around for All Youth: From Risk to Resilience**

Studies

- **A friend in need: The role of friendship quality as a protective factor in peer victimization and bullying**
- **Data Trends: The Effectiveness of Strength-Based Treatment for Youth with Emotional or Behavioral Disorders (March 2007)**
- **Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community**
- **Good Kids in Bad Circumstances: A Longitudinal Analysis of Resilient Youth**
- **Resilient children in distressed neighborhoods (2005) M. Eeiseman, et al, Urban Institute**
- **Resiliency Research: Implications for Schools and Policy (PDF document)**
- **Risk and promotive factors in families schools, and communities: a contextual model of positive youth development in adolescence (Pediatrics)**

- **Student health risks, resilience, and academic performance in California: Year 2 Longitudinal Analysis (2003)**

Related Agencies and Websites

- **Assets Project- Special Education Service Agency**
- **Building Up Strengths In Youth (B.U.S.Y.)**
- **Center for Educational Research and Development**
- **Center for Research on the Education of Students Placed at Risk**
- **Connecticut Assets Network on Education, Diversity, and Excellence**
- **CYFERNet- Children, Youth, Families Education and Research Network**
- **National Youth Development Information Center**
- **Resilience Project**
- **Resiliency in Action**
- **ResilienceNet**
- **Search Institute**

Relevant Publications That Can Be Obtained through Libraries

- **"The contribution of developmental assets to the prediction of thriving outcomes among adolescents." Scales, P.C., Benson, P.L., Leffert, N., & Blyth, D.A. (2000). *Applied Developmental Science, 4,* 27-46.**
- ***Coping with divorce, single parenting, and remarriage: A risk and resiliency perspective.* Hetherington, E. Mavis (Ed.). (1999). Mahwah, NJ: Erlbaum.**
- ***Helping Teens Handle Tough Experiences Strategies to Foster Resilience*. By Nelson, Jill R. & Kjos, Sarah. (2008). Search Institute Press. Minneapolis, MN.**
- ***How to Make Friends: Building Resilience and Supportive Peer Groups*. By Macconville, Ruth M. (2008). Sage Publications Ltd. London, UK.**
- **"Mobilizing communities to promote developmental assets: A promising strategy for the prevention of high-risk behaviors." By Benson, P.L. (1998). *Family Science Review,11,* 220-238.**
- ***Promoting Resilience in the Classroom: A Guide to Developing Pupils' Emotional and Cognitive Skills*. By Cefai, Carmel. (2008). Jessica Kingsley Publishers, London, UK.**
- ***Resilience in Action: Working with Youth Across Cultures and Contexts*. by Liebenberg, Linda Ungar, Michael (Eds.). (2008). University of Toronto Press. Toronto, ON, Canada.**
- ***Resiliency in families: Vol. 4. The dynamics of resilient families.* McCubbin, Hamilton I.; & Thompson, Elizabeth A. (Eds.). (1999). Thousand Oaks, CA: Sage.**
- **"The role of family support programs in building developmental assets among young adolescents: A national survey of services and staff training needs." By Scales, P.C. (1997). *Child Welfare, 76(5),* 611-635.**
- ***Stress, coping, and resiliency in children and families.* Hetherington, E. Mavis; & Blechman, Elaine A. (Eds.). (1996). Mahwah, NJ: Erlbaum.**

We hope these resources met your needs. If not, feel free to contact us for further assistance. For additional resources related to this topic, use our search page to find people, organizations, websites and documents. You may also go to our technical assistance page for more specific technical assistance requests.

Quick Find On-line Clearinghouse

(http://smhp.psych.ucla.edu/qf/depression.htm)

TOPIC: Childhood and Adolescent Depression

The following represents a sample of information to get you started and is not meant to be exhaustive. (Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one.)

Center Developed Documents, Resources and Tools

Introductory Packet
- **Assessing to Address Barriers to Learning**
- **Affect and Mood Problems related to School Aged Youth**

Newsletter
- **Youth Suicide/Depression/Violence (Summer, '99)**

Quick Training Aid
- **Suicide Prevention**
- **School Interventions to Prevent and Respond to Adolescent Affect and Mood Problems**

Practice Notes
- **Grief and Loss**
- **When a Student Seems Dangerous to Self or Others**
- **Countering the Over-Pathologizing of Students' Feelings & Behavior: A Growing Concern Related to MH in Schools**

Resource Aid Packets
- **Screening/Assessing Students: Indicators and Tools**
- **Student Psychotropic Medication: The School's Role**
- **School Helping Students Deal With Loss**

Policy & Program Reports & Briefs
- **Suicide Prevention in Schools**

Continuing Education
- **Addressing Barriers to Learning: New Directions for Mental Health in Schools**

Other Relevant Documents, Resources, and Tools on the Internet

General Depression
- **Behaviors May Indicate Risk of Adolescent Depression**
- **Brighter Futures: Improvements in Depression Care Pay for Themselves**
- **Cost-effectiveness of an intervention to prevent depression in at-risk teens**
- **The Depressed Child**
- **Depression**

- **Depression and the Initiation of Alcohol and Other Drug Use among Youths Aged 12 to 17** (from the National Survey on Drug Use and health)
- **Depression in Children and Adolescents**
- **Difference in Early Childhood Risk Factors for Juvenile- and Adult-onset Depression**
- **Emergency Treatment of Young People Following Deliberate Self-harm (2005) M. Olfson, et al, *Archives of General Psychiatry, 62*:1122-1128.**
- **FDA Public Health Advisory on Antidepressant Medications**
- **General and Specific Childhood Risk Factors for Depression and Drug Disorders by Early Adulthood**
- **The Hopelessness Theory of Depression: A Test of the Diathesis--Stress and Causal Mediation Components in Third and Seventh Grade Children [1].(Statistical Data Included)**
- **Major depressive episodes among youths aged 12 to 17 in the United States: 2004-2006**
- **Major Depression in Children and Adolescents**
- **Mental Health, Education, and Social role outcomes of Adolescents with Depression**
- **Mood Disorders (including Bipolar) (Schoolbehavior.com)**
- **National Trends in Outpatient Treatment of Depression (pdf document)**
- **Negative Behavior Can be a Depression Smokescreen (from NASBHC)**
- **Obesity, shame and depression in school-aged children: A population-based study**
- **Prevalence of depression by race/ethnicity: Findings from the National Health and Nutrition Examination Survey III**
- **QuickStats: Rate of hospitalization for depression among persons aged 5-19 years, by sex- United States, 1990-1992 and 2002-2004. Morbidity and Mortality Weekly Review, 55(26) 731.**
- **Reporting on Suicide: Recommendations for the Media**
- **Screening for Depression: Recommendations and Rationale**
- **State estimates of depression, 2004 & 2005**
- **Teen Homicide, Suicide, and Firearm Death**
- **Toward Guidelines for Evidence-Based Assessment of Depression in Children and Adolescents, 2005**
- **"The Treatment for Adolescents with Depression Study Team" (2003) Journal of the American Academy of Child and Adolescent Psychiatry, 42(5), 531-542**
- **What to do When a Friend is Depressed: A Guide for Students**

Bipolar

- **A Story of Bipolar Disorder**
- **"Educator's Guide to Receiving Bipolar Students After Hospitalization"**
- **Treatment of Bipolar Disorder: A Guide for Patients and Families**
- **Toward an Evidence-Based Assessment of Pediatric Bipolar Disorder, 2005**

Related Agencies and Websites

- **American Academy of Child and Adolescent Psychiatry**
- **Bipolar Disorder (NIMH)**
- **The Center for Mental Health Services**
- **The Child & Adolescent Bipolar Foundation**
- **Depression (NIMH)**
- **International Foundation for Research and Education on Depression**
- **Mental Health America**
- **The National Association of School Psychologists**
- **National Foundation for Depressive Illnesses**

- **SAVE: Suicide Awareness**
- **Suicide Prevention Resource Center**
- **Teens-Depression and Suicide Prevention**

Relevant Publications That Can Be Obtained through Libraries

- **A review of pharmacotherapy of major depression in children and adolescents. Ambrosini, Paul J. Psychiatric Services. 2000 May. 51 (5): p. 627-633.**
- **A developmental psychopathology perspective on the cognitive components of child and adolescent depression. Kaslow, Nadine J.; Adamson, Lauren B.; Collins, Marietta H. In: Arnold J. Sameroff, Ed; Michael Lewis, Ed; et al. Handbook of developmental psychopathology (2nd ed.). Kluwer Academic/Plenum Publishers: New York, NY, US, 2000. p. 491-510 of xxxi, 813pp.**
- **Assessment and treatment of adolescent depression and suicidality. Stanard, Rebecca; Powell, Ed . Journal of Mental Health Counseling. 2000 Jul. 22 (3): p. 204-217.**
- **Childhood and adolescent predictors of major depression in the transition to adulthood. Reinherz, H.Z. et al. (2003). *the American Journal of Psychiatry* December 2003 160:2141-2147**
- **Development and depression. Garber, Judy. In: Arnold J. Sameroff, Ed; Michael Lewis, Ed; et al. Handbook of developmental psychopathology (2nd ed.).. Kluwer Academic/Plenum Publishers: New York, NY, US, 2000. p. 467-490 of xxxi, 813pp.**
- **Evidence-Based Psychosocial Treatments for Child and Adolescent Depression. Corinne David-Ferdon and Nadine J. Kaslow.(2008). *Journal of Clinical Child and Adolescent Psychology, Vol 37, No. 1***
- **Preventing depression: A review of cognitive-behavioral and family interventions. Gillham, Jane E.; Shatte, Andrew J.; Freres, Derek R. Applied & Preventive Psychology. 2000 Spr. 9 (2): p. 63-88.**
- **Scale-based protocols for the detection and management of depression. Lynch, S. Clarkson, P. Blenkiron, P. & Fraser, J. (2003). *LibraPharm, Primary Care Psychiatry,* 8(3):77084**
- **Should we screen for depression? Caveats and potential pitfalls. Coyne, J.C. et al. (2002). *Applied & Preventive Psychology, 9,* 101-121**
- **Social skills deficits associated with depression. Segrin, Chris. Clinical Psychology Review. 2000 Apr. 20 (3): p. 379-403.**
- **The treatment for adolescents with depression study team. (2003). *Journal of the American Academy of Child and Adolescent Psychiatry,* 42(5), 531-542.**
- **Treating adolescent depression: A review of intervention approaches. Finn, Cindy A. International Journal of Adolescence & Youth. A B Academic Publishers: United Kingdom, 2000. 8 (4): p. 253-269.**

We hope these resources met your needs. If not, feel free to contact us for further assistance.For additional resources related to this topic, use our search page to find people, organizations, websites and documents. You may also go to our technical assistance page for more specific technical assistance requests.

If you haven't done so, you may want to contact our sister center, the Center for School Mental Health at the University of Maryland at Baltimore.

If our website has been helpful, we are pleased and encourage you to use our site or contact our Center in the future. At the same time, you can do your own technical assistance with "The fine

IV. Originals for Overheads

The following can be copied to overhead transparencies to assist in presenting this material.

A. Continuum of Causes

B. General Guidelines for Prevention

C. Preventing Problems by Strengthening Supportive Environment

D. What To Do

E. Embracing Resilience

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the person (P)
E (E<--->p)	E<--->P (e<--->P)	P
Type I problems	Type II problems	Type III problems
•caused primarily by environments and systems that are deficient and/or hostile •problems are mild to moderately severe and narrow to moderately pervasive	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology) •problems are mild to moderately severe and pervasive	•caused primarily by person factors of a pathological nature •problems are moderate to profoundly severe and moderate to broadly pervasive

In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

- **Type I: Problems caused by Environmental / Systems factors**
- **Type II: Problems caused by an interaction between Environmental factors and Personal factors**
- **Type III: Problems caused by factors in the Person / Biological or Psychological factors**

General Guidelines for Prevention

- Enhance feelings of
    - competence
    - connectedness
    - self-determination
- Provide a continuum of interventions
- Enhance participation in school, family, and community
- Provide supports Kindergarten through 12th grade
- “Culturally” appropriate interventions
- Focus on Assets
- Make expectations clear

Preventing Problems by Strengthening Supportive Environments

Creating a Sense of Community

Dimensions of a Sense of Community

Shared Values

Commitment

A feeling of belonging

Caring

Interdependence

Regular Contact

All provided in a context that maximizes feelings of

- Competence
- Self-determination (real options and choices)
- Positive interpersonal connections at school and at home

and minimizes threats to such feelings

What Anyone Can Do When They Think Someone is Depressed

- *Offer help and listen*
- *Talk about feelings*
- *Know the symptoms (hopeless, helpless)*
- *Find someone who can help (parent, teacher, professional)*
- *Stay connected*

What School Professionals Can Do

- *Assess severity*
- *Look for causes that can be addressed*
- *Mobilize support system (family)*
- *Refer to MH Services, if needed*
- *Monitor to support improvements*

From National Education Association
Health Information Network

Embracing Resilience in an At-Risk World

Discussion Guide:

- What's your own, personal definition of resilience?

- Brainstorm, on your own and with your colleagues, a definition of resilience for your school

- Identify at least one protective factor that exists for school staff

- Identify at least one protective factor that presently exists for students at your school

- How can you use that protective factor to enhance resilience for yourself and among your students and colleagues?