

Critical Mental Health Issues in International Schools: Impact and Strategies for Intervention



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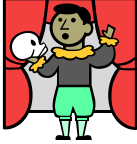
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Mary Sean O'Halloran, PhD

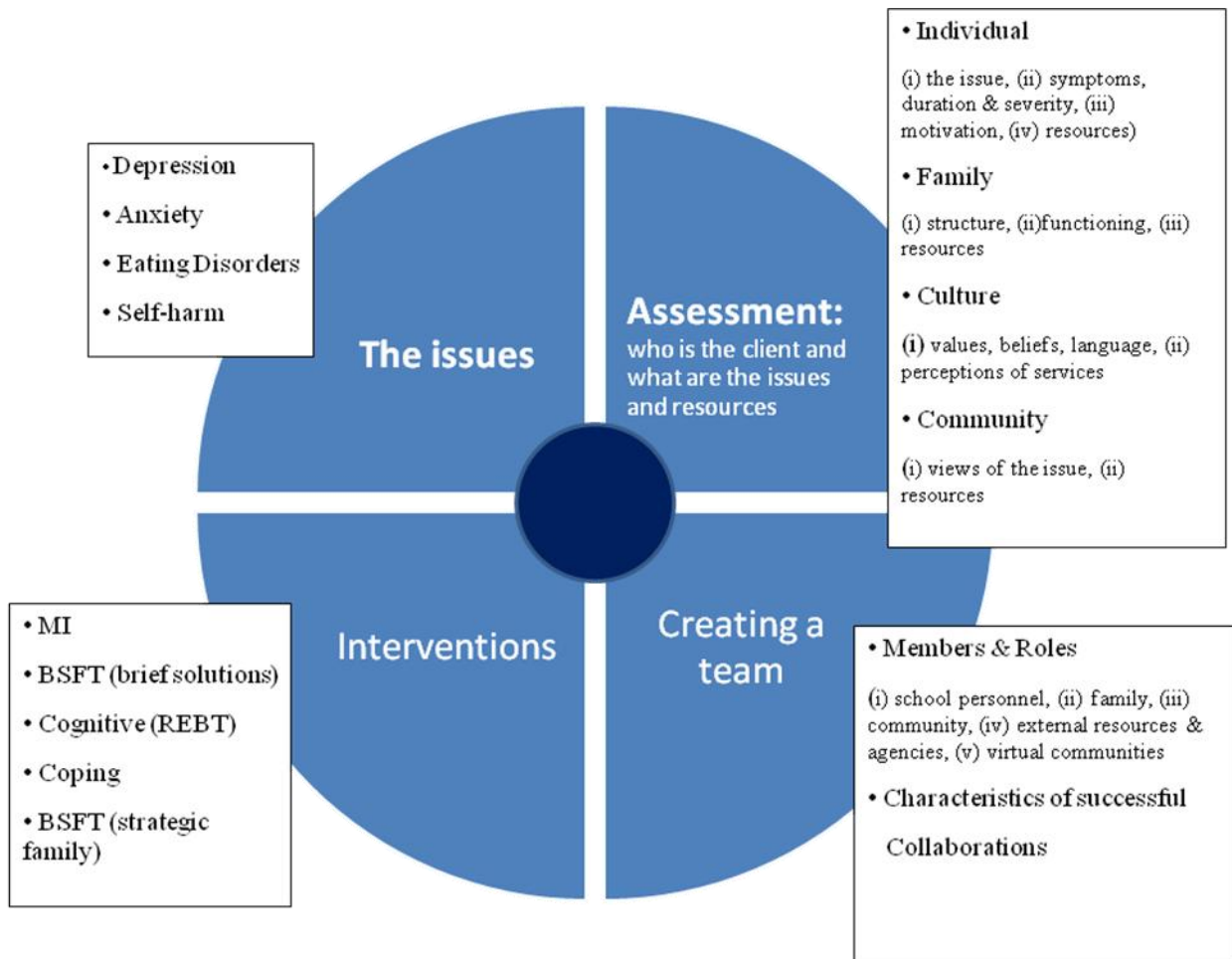
Eating disorders, depression, anxiety, and self-harming behaviors pose considerable health issues for students and their families, and are present in many schools and countries. This workshop focuses on creating intervention teams within schools to focus on these issues. Topics include basic assessment, interventions, and developing resources and referral networks. Demonstrations will be conducted and there be time to share experiences, resources, discuss sample cases, and create plans to build a school team.

One of the most important pieces of information I learned at a recent training is how little we traditionally learn in lectures.

We learn and remember:

- ❖ 10% of what we read 
- ❖ 20% of what we hear. 
- ❖ 30% of what we see. 
- ❖ 50% of what we see and hear.  and 
- ❖ 80% of what we say. 
- ❖ 90% of what we say and we act.  and 

Thus you might remember between 10-50% of this talk if I gave you this information through a traditional lecture, depending on the amount of didactic discussion and questions raised by the group. But you and I would like it be higher. Therefore, principles from Participant Centered Learning are incorporated to increase retention.



CULTURAL CONSIDERATIONS

Understanding important aspects of World View

Cultural Competency:

- Self awareness of our biases that allows us to be culturally humble responders and researchers.
- Obtaining knowledge about specific people and groups of people.
- Integrating and transforming knowledge into specific standards, policies, practices, and attitudes
- Using these tools to increase the quality of services and produce better outcomes Davis (1997).

Cultural Humility:

The cultural humility approach enhances services by effectively weaving an attitude of learning about cultural differences into individual encounters. Additionally, this approach cultivates self-awareness by encouraging providers to acknowledge the belief systems and cultural values they bring to individual and community encounters. Tervalon & Murray-Garcia (1998).

Worldview:

- Worldview is a construct concerned with how people view themselves, others, and the world.
- Worldview influences perceptions, feelings, values, beliefs and behaviors of a group.

Our demographic characteristics (gender, race/ethnicity, age, class) as well as cultural group identity, individual identity, beliefs, values, history, language, and contextual factors contribute to a construction of reality determining perceptions of the world.

Worldview influences perceptions of counselors/teachers/administrators. Worldview influences how services such as counseling or education are delivered, the assessment instruments used to determine strengths or deficits. Even the setting where services are offered is influenced by worldview.

Components of worldview

Group Identity: the collective awareness / understanding based on history of the group and the development of a shared culture. Group identity includes acceptance of group sanctioned behaviors and beliefs, such as: definitions of success and failure, perceptions of health and illness, role of parents and children, differential expectations for different age or gender groups, etc.

Individual identity includes cultural constructions of "self concept". Historically psychology has conducted research on self concept by examining middle class White Americans. This "self" is egocentric, characterized by personal control and individuality, and it has often excluded others. Until

recent years, the mental health profession assumed that this was the self concept of all peoples. Other cultures were seen as deficient and lacking in self-esteem as defined by traditional personality measures.

It is important to consider extended or sociocentric perceptions of self. This self is obligated to others who affect the individual's actions and are considered central in problem solving and taking action.

It is also important to consider to what degree a person identifies with the group identity. Typically four possibilities are discussed: traditional, nontraditional, bicultural, marginal.

Value dimensions

The anthropologist, Florence Kluckhohn, conducted research in the 1950's. In studying diverse cultures she found that these dimensions contain perceptions that influence behavior. Kluckhohn, F.R. and Strodtbeck, F.L. (1961) *Variations in Value Orientations*, Row Peterson and Co., Evanston, IL.

- Human Nature: understood as good, evil, or a mixture of both.
- Relationship with Nature: Subjugation to-, harmony with-, mastery over -nature.
- Time (temporal) focus: ways of doing things and acceptance or rejection of change. a) present, b) past (traditions & beliefs), and c) future oriented (planning ahead, replacing what was past).
- Human Relations Orientations: a) Collaterality: emphasis on consensus within laterally extended groups (communal, sharing), b) Linearity-emphasis on hierarchical principles and deferring to higher authorities or authorities within the group (authority via age, generation, or cultural traditions that define relationships). c) Individualism: emphasis on individuals or individual families with the group who make decisions independently from the others .
- Human activity orientation: The locus of meaning for self-expression. a) Doing (accomplishing something, external to the individual, emphasis on activity valued by the self and sanctioned by others; b) Being-In-Becoming (emphasis on personal development), or c) Being –internal to the individual with an emphasis on activity sanctioned by the self but not necessarily by others.

Beliefs

Identity (within group and individual) is derived from shared values, life experiences, etc. These beliefs concern the nature of health/illness and beliefs about etiology, for example, is physical or psychological illness due to biological factors, germs, spirits, magic, or forces in nature over which one has little control. Some cultures do not distinguish between mental and physical health. Health may be more than simply the absence of disease.

Language

Means of communicating shared experiences. Language allows examination of idiosyncratic patterns of thought that demonstrate important characteristics of particular world views. Language affects thought and imposes perceptions of reality.

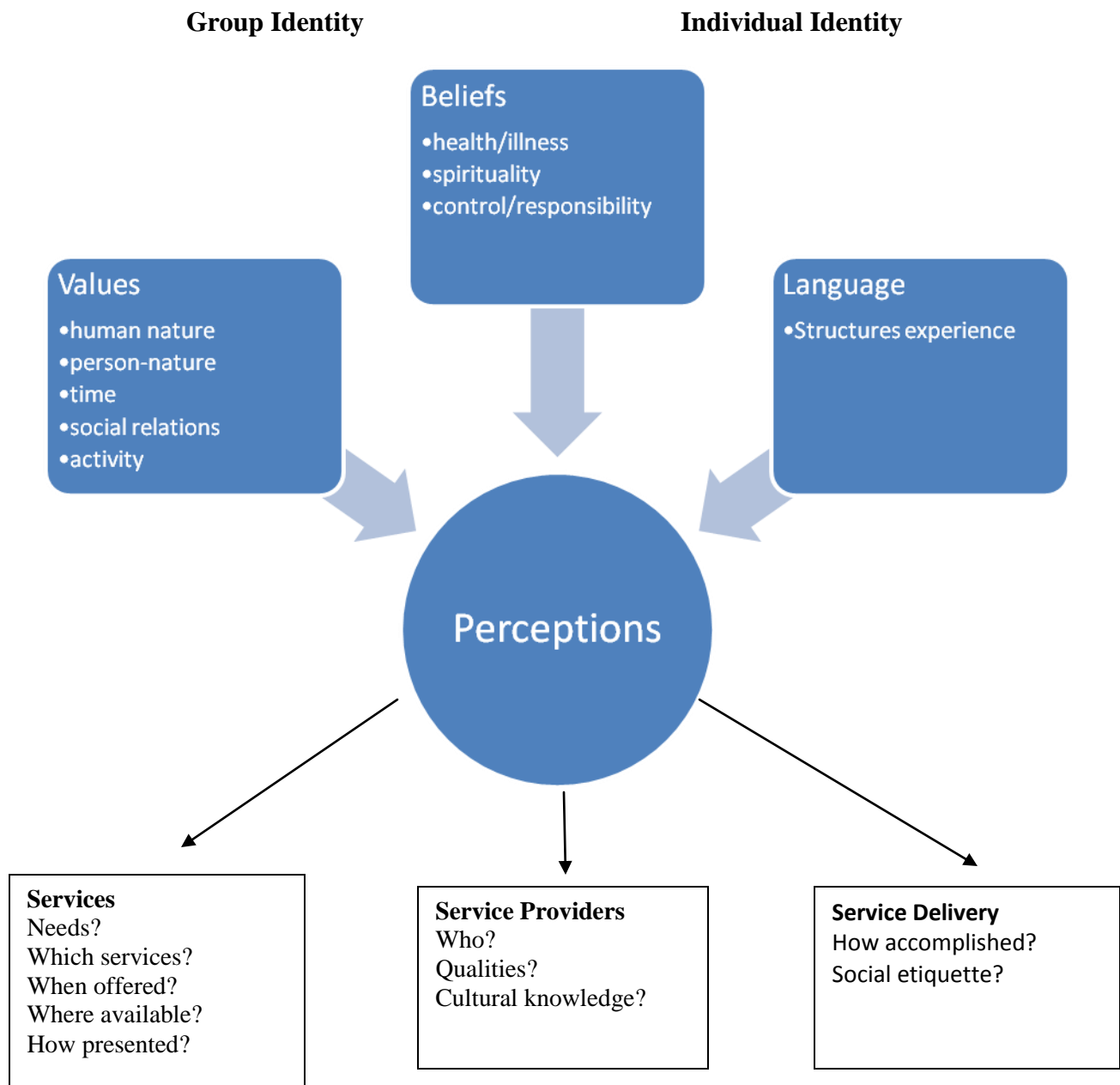
How Worldview affects Service Utilization

SERVICES: *What* kinds of services are available? Are they relevant? What needs to they fill?

Who? What are the characteristics, backgrounds, education, etc of people offering services? Do they understand our culture?

How? How are services offered? How are role differences acknowledged? What is the social etiquette? Do adults or children speak first? Where? In an office, at school, at home?

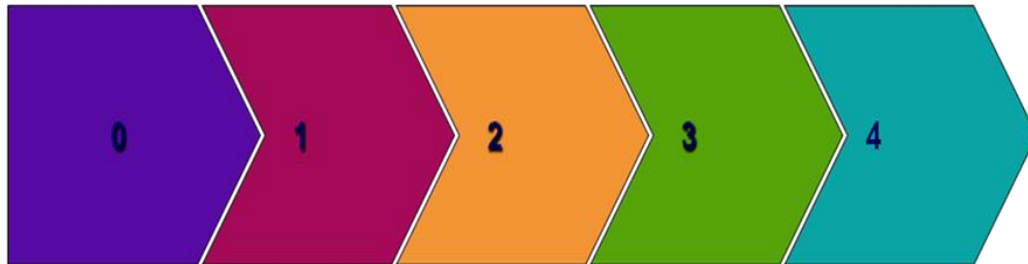
Components of World View



The RESPECTFUL Model	
For Yourself	For Your Student/Client
R – Religious and Spiritual Orientation	
E – Economic Class Standing &* Profession	
S – Sexual Identity and Orientation	
*P – Physical Characteristics	
E – Ethnic/Cultural/Racial Background, *Values, *Time	
C –Chronological Status & Challenges	
T – Threats to Personal Wellness & Sources of Social Support	
F – Family History and Influence	
U – Unique Physical Characteristics	
L – Location of Residence	

*Adapted slightly from original. Adopted from: D’Andrea, M., & Daniels, J. (2001). RESPECTFUL counseling: An integrative model for counselors. In D. Pope-Davis & H. Coleman (Eds.), *The interface of class, culture and gender in counseling* (pp. 417-66). Thousand Oaks, CA: Sage

Different Levels of Cultural Competence



- 0: Little to no awareness of cultural differences - Approaching each individual the same way with no regard for culture, ethnicity, and background
- 1: Awareness of cultural differences, but little variation in the way in which individuals from different groups are approached
- 2: Awareness of cultural differences, approaching individuals from different groups in more culture-specific ways
- 3: Beginning to take note of individuals' ethno-cultural environments and take this into account when modifying the way in which you approach them
- 4: Taking cultural differences into account when conceptualizing an intervention/study, forming collaborations, choosing instruments to be used, approaching individuals in the study in culturally-specific ways, etc.

Norris & Alegria, 2005; Jones, Hadder, Carvajal, Chapman, Alexander, 2006

Descriptions of selected psychological concerns and useful resources

Anxiety disorders

A chronic condition characterized by an excessive and persistent sense of apprehension with physical symptoms such as sweating, [palpitations](#), and feelings of [stress](#). Anxiety disorders have biological and environmental causes. <http://www.medterms.com/script/main/art.asp?articlekey=9948>

There are six major types of anxiety disorders, each with their own distinct symptom profile: generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, post-traumatic stress disorder, and social anxiety disorder. www.helpguide.org/mental/anxiety_types_symptoms_treatment

It's normal to worry and feel tense or scared when under pressure or facing a stressful situation. Anxiety is the body's natural response to danger, an automatic alarm that goes off when we feel threatened.

Although it may be unpleasant, anxiety isn't always a bad thing. In fact, anxiety can help us stay alert and focused, spur us to action, and motivate us to solve problems. But when anxiety is constant or overwhelming, and interferes with your relationships and activities—that's when you've crossed the line from normal anxiety into the territory of anxiety disorders

(http://www.helpguide.org/mental/anxiety_types_symptoms_treatment.htm)

Depression

Depression presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850 000 thousand lives annually.http://www.who.int/mental_health/management/depression/definition/en/

Feeling down from time to time is a normal part of life. But when sadness takes hold and won't go away, it may be depression. More than just the temporary "blues," the lows of depression make it tough to function and enjoy life like you once did. A person with severe depression has little or no interest in work or hobbies, and may even have trouble getting out of bed. With treatment and help, you can feel better. Learning how to understand depression – including its signs, symptoms, and causes – is the first step to overcoming the problem. (http://www.helpguide.org/mental/depression_signs_types_diagnosis_treatment.htm)

Eating Disorders

There are three major types of eating disorders. People with anorexia nervosa have a distorted body image that causes them to see themselves as overweight even when they're dangerously thin. Often refusing to eat, exercising compulsively, and developing unusual habits such as refusing to eat in front of others, they lose large amounts of weight and may even starve to death.

Individuals with bulimia nervosa eat excessive quantities of food, then purge their bodies of the food and calories they fear by using laxatives, enemas, or diuretics, vomiting and/or exercising. Often acting in secrecy, they feel disgusted and ashamed as they binge, yet relieved of tension and negative emotions once their stomachs are empty again.

Like people with bulimia, those with binge eating disorder experience frequent episodes of out-of-control eating. The difference is that binge eaters don't purge their bodies of excess calories. (From APA Help Center - <http://www.apahelpcenter.org/articles/article.php?id=9>)

Self-Harm

Self-mutilation or self-injury is any form of self-harm inflicted on your body without the intent to commit suicide. Self-mutilation is a compulsive act that may be performed to release emotional pain, anger, or anxiety; to rebel against authority; to flirt with risk-taking; or to feel in control. (From NYU Langone Medical Center - <http://www.med.nyu.edu/patientcare/library/article.html?ChunkIID=11569>)

Information about Specific Concerns

Anxiety Disorders

Anxiety Disorders <http://www.nimh.nih.gov/health/publications/anxiety-disorders/complete-publication.shtml>)

What are panic attacks? How do they relate to obsessions and phobias? What are the best ways to treat these anxieties? The National Institute of Mental Health gives you the scientific lowdown.

Healthfinder.gov has resources on a wide range of health topics selected from over 1,600 government and non-profit organizations to bring you the best, most reliable health information on the Internet.

Healthfinder.gov – Anxiety Disorders <http://www.healthfinder.gov/scripts/SearchContext.asp?topic=56>

American Psychological Association –Anxiety <http://www.apahelpcenter.org/articles/article.php?id=46>. APA's Help Center is your online resource for brochures, tips and articles on the psychological issues that affect your physical and emotional well-being, as well as information about referrals.

Eating Disorders

Body Positive: looks at ways we can feel good in the bodies we have. This site offers resources for accepting your body at whatever weight you are. <http://www.bodypositive.com/>

Dying to be Thin. This companion site to the film "Dying to be Thin" includes information on minority women and eating disorders, personal stories, resources, and frequently asked questions answered by an experienced psychologist. <http://www.pbs.org/wgbh/nova/thin/>.

National Eating Disorders Association (NEDA), the biggest U.S. non-profit organization dedicated to the prevention and treatment of eating disorders, has a site offering information on how to recognize and how to get treatment for anorexia, bulimia and binge eating disorder as well as advice to people with body image and weight issues. http://www.nationaleatingdisorders.org/p.asp?WebPage_ID=337

This particular link is very helpful for educators and coaches:

<http://www.nationaleatingdisorders.org/information-resources/educators-and-coaches.php>

Grurze books and bulimia.com (or gurze.com) useful website with topics related to eating disorders, obesity, and body image. Their catalog is essential for anyone with an interest in this area. You can find blogs written by professionals on pertinent issues: <http://www.eatingdisordersblogs.com/>

Eating Disorders Healthfinder.gov has resources on a wide range of health topics selected from over 1,600 government and non-profit organizations to bring you the best, most reliable health information on the Internet. <http://www.healthfinder.gov/scripts/SearchContext.asp?topic=267>

Eating Disorders Association (EDA) This organization aims to increase knowledge and awareness of eating disorders. Their website provides information and support to both consumers and mental health professionals, including databases of treatment and self help services in the UK. <http://www.edauk.com>

Academy for Eating Disorders (AED) An international professional organization that provides research and treatment of eating disorders. Assists professionals in their training needs, as well as providing a forum for networking and professional collaboration. <http://www.aedweb.org>

American Psychological Association – Eating Disorders APA's Help Center is an online resource for brochures, tips and articles on the psychological issues that affect your physical and emotional well-being, as well as information about referrals. <http://www.apahelpcenter.org/articles/article.php?id=9>

The National Eating Disorder Information Centre (NEDIC) is a Canadian non-profit organization founded in 1985 to provide information and resources on eating disorders and food and weight preoccupation. <http://www.nedic.ca/>

Center for the Advancement for Health . This organization promotes healthy living and the prevention of disease. The Center examines research and resources from many sources including traditional news, blogs, the Internet, professional organizations and health care institutions. This specific link provides a plethora of useful information on eating disorder prevention: <http://www.cfah.org/factsolife/vol7no11.cfm>

Understanding the underlying causes and symptoms of eating disorders in adolescents.

<http://www.nasponline.org/resources/principals/Eating%20Disorders%20WEB.pdf>

Information on Self-Harm

. If you or a loved one experiences self-injury symptoms, this is a good place to come for information, ways to seek help, and what to expect when seeking treatment. <http://www.selfharm.org.uk/default.aspa>

American Self-Harm Information Clearinghouse. We hope that by disseminating clear, concise, and accurate information about self-harm, we can improve the treatment that those who cope with distress by injuring themselves <http://www.selfinjury.org/>

Understanding and responding to students who self- mutilate

<http://www.nasponline.org/resources/principals/Self-Mutilation%20March%2004.pdf>

Information on Depression

Brief paper educating educators and parents on adolescent depression.

http://www.nasponline.org/resources/principals/nasp_depreng.pdf

Implications of early onset of Bipolar Disorder and what educators can do for students in need.

http://www.nasponline.org/communications/spawareness/bipolar_ho.pdf

Case-study of depression and strategies to aid children with depression in the classroom

<http://www.nasponline.org/publications/cq/cq353depression.aspx>

Depression: When it hurts to be a teenager

<http://www.nasponline.org/resources/principals/Depression%20NASSP%20October%2003.pdf>

What teachers and parents need to know about mood disorders

<http://www.nasponline.org/publications/cq/cq353mooddorders.aspx>

The NYU Child Study Center is dedicated to improving the treatment of child psychiatric disorders through scientific practice, research and education.

http://www.aboutourkids.org/families/disorders_treatments/az_disorder_guide/depression

Healthfinder.gov – Depression. Healthfinder.gov has resources on a wide range of health topics selected from over 1,600 government and non-profit organizations to bring you the best, most reliable health information on the Internet <http://www.healthfinder.gov/scripts/SearchContext.asp?topic=230>

The Depression and Bipolar Support Alliance (DBSA) This organization fosters an environment of understanding about the impact and management of these illnesses by providing up-to-date information.

http://www.dbsalliance.org/site/PageServer?pagename=about_depression_overview

American Psychological Association – APA Help Center - is your online resource for brochures, tips and articles on the psychological issues that affect your physical and emotional well-being, as well as information about referrals.

<http://www.apahelpcenter.org/articles/article.php?id=4>

Loss and Grief

Useful handout on loss and grief and how school personnel can aid children in coping.

http://www.nasponline.org/publications/booksproducts/HCHS2_crisis.pdf

PTSD: Coping after a crisis

<http://www.nasponline.org/resources/principals/PTSD%20NASSP%20January%2004.pdf>

Dealing with death in school

<http://www.nasponline.org/resources/principals/Dealing%20with%20Death%20at%20School%20April%2004.pdf>

Mental Health Information for Teens, Parents, Teachers & Coaches

Teen Growth Depression <http://www.teengrowth.com/> Learn more from this great website which uses a question and answer format as well as articles. Click on ‘Emotions’.

Child and Adolescent Mental Health <http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml> Includes information about ADD, Eating Disorders, Depression, Abuse and Neglect...

Kids' Health: Teens <http://kidshealth.org/teen/> This site contains vital information from medical experts for Teens. Topics include: asthma, contraception, dieting, depression, STDs, eating disorders, steroids, alcohol, date rape, smoking, Lyme disease, self-defense, drugs, abuse, suicide, and so much more.

Teen Health: Healthy Mind <http://www.cyh.com/SubDefault.aspx?p=159> Coping strategies for many mental health issues, including anger, anxiety, bipolar, depression, schizophrenia, stress and suicide.

Helpguide.org <http://www.helpguide.org/> was created in 1999 by the Rotary Club of Santa Monica under the leadership of Rotarians Robert and Jeanne Segal following the tragic suicide of their daughter.

Mental Health and Resiliency in Schools

Best practices in developing exemplary mental health programs in schools.
<http://www.nasponline.org/resources/intonline/61-Pluymert.pdf>

Removing barriers to learning and improving student outcomes by providing mental health services in schools. www.nasponline.org/press/removingbarriers.pdf

Mental Health resources for school personnel
<http://www.nasponline.org/publications/cq/cq337mhinsert.aspx>

Promoting safety and success in school by developing student's strengths
<http://www.nasponline.org/communications/spawareness/5-Paine.pdf>

School-wide methods for fostering resiliency
<http://www.nasponline.org/resources/principals/schoolresiliency.pdf>

Supporting children's mental health and tips for parents and educators
<http://www.nasponline.org/resources/mentalhealth/mhtips.aspx>

Stress in children and adolescents: Tips for parents
<http://www.nasponline.org/resources/listings.aspx>

Motivational Interviewing and Stages of Change

Motivation: A state of readiness or eagerness to change, which may fluctuate from one time or situation to another.

What is Motivational Interviewing?

- A way to help people recognize and do something about their problem(s).
- Helpful for clients who are reluctant to change and ambivalent about changing. It is intended to resolve ambivalence and to get the client moving toward change.
- Overall Goal: to increase the client's intrinsic motivation, so that change arises from within rather than being imposed by someone else. To help people to resolve ambivalence (i.e., conflict) about changing their behavior, while not evoking resistance (e.g., get confrontational, blame, label) (Sobell & Sobell, 2003).

Understanding Resistance

- Clients with eating disorders often express ambivalence about change and recovery.
- This behavior may fill a need in their lives such as power and control.
- It is important to learn to work with clients who are reluctant to change.
- It is important to understand how the functions of the behaviors serve the individual, in order to accommodate the client with helpful interventions.

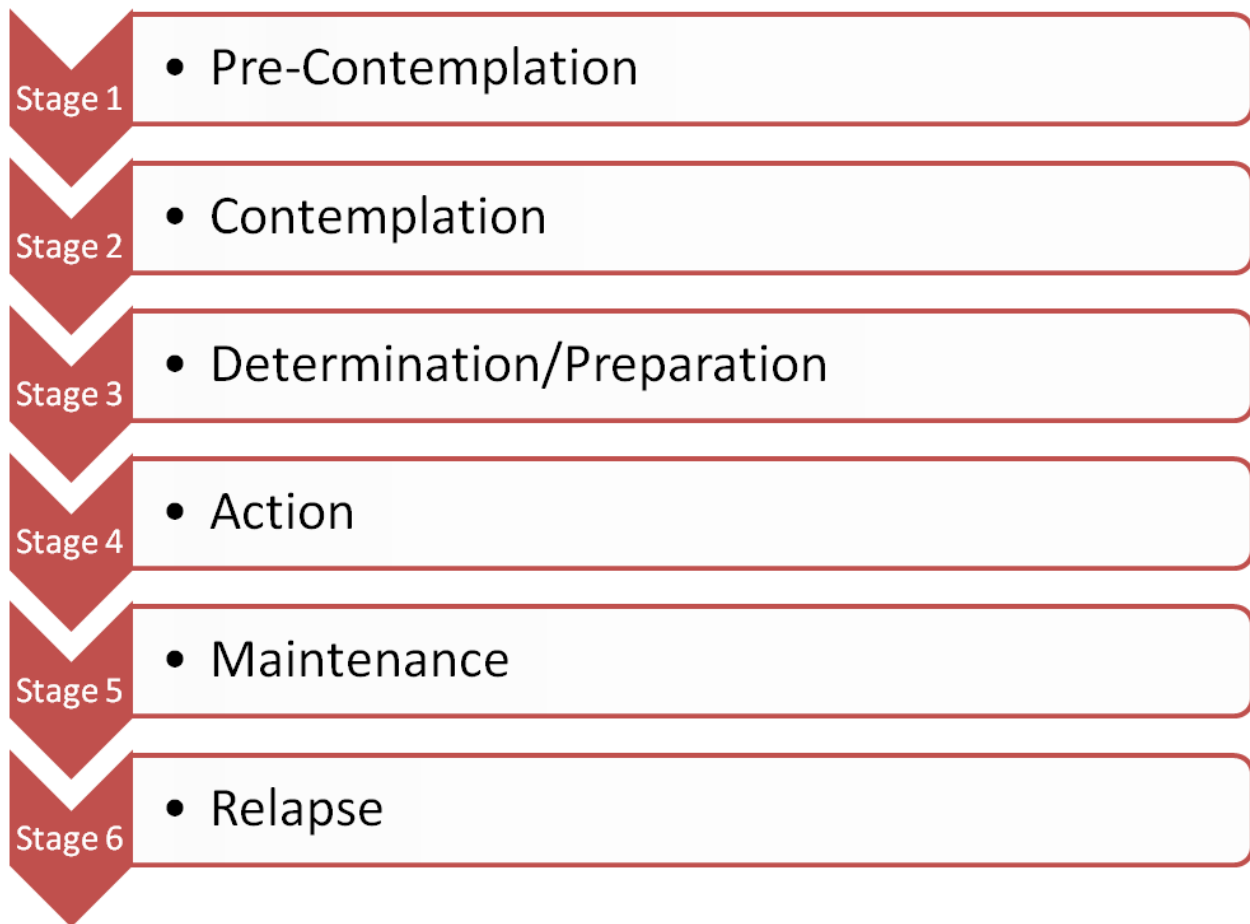
Monitoring our reactions

- Monitor your reactions to clients as treatment can be frustrating.
- Recognize the good in the client's resistance and reframe that behavior.
- Refrain from arguing, lecturing, assuming an expert role, criticizing, shaming or labeling. Try to steer clear of power struggles. They compromise treatment.

Stages of Change

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *J. of Consulting and Clinical Psychology, 51*, 390-395.

1. Pre-Contemplation: 'I don't need to change...I don't have a problem.'
2. Contemplation: 'I know I need to change, but...'
3. Determination/Preparation: 'I've decided to change' (window of opportunity)
4. Action: 'I am doing what is needed in order to change'
5. Maintenance: 'I am committed to my recovery lifestyle and prepared for relapse'
6. Relapse: 'I need to review what I need for change to occur'



This is not a single process; a client can relapse several times and go back through the process or re-enter the process at differing stages.

Stage 1: Pre-Contemplation: A client in this stage may be in denial about their behavior or aware that they have a problem, BUT their attitude and behavior convey that they are unwilling or uninterested in change. They have yet to ‘contemplate’ change. Possibly the client believes that the consequences of the behavior have not become serious enough to warrant change. The GOAL here is to encourage client to think about change.

Acceptance and validation is important in this stage. Education is important for a client in this stage to raise his/her awareness. Precontemplators are most influenced by behaviors ‘cons’ which can nudge one toward contemplation.

Stage 2: Contemplation: Awareness has been raised. This person fluctuates between reasons to change and reasons to stay the same, as well as concern and unconcern. It is important here to build client hope and a belief in the client that he/she can change.

Stage 3: Determination/Preparation: A window of opportunity which opens for a period of time. If the client is engaged during this time, the change process continues, if he or she does not, he/she slips back into contemplation.

Stage 4: Action: In this stage the client engages in actions intended to bring about change.

Stage 5: Maintenance: The challenge here is to maintain the change accomplished during the action phase and prevent relapse. This may require other skills or strategies.

Stage 6: Relapse: If relapse occurs the client's task is to go through the stages again and avoid remaining 'stuck' in this phase. Slips: minor fallbacks; Relapse: major steps back.

Counselor Tasks within the Stages of Change:

1. Precontemplation: Raise doubt- increase client's perception of risks and problems with current behavior.
2. Contemplation: Tip the balance-evoke reasons to change, risks of not changing; strengthening the client's hope and self-efficacy for change.
3. Determination /Preparation: Help client to determine best course of action to take in seeking change. One that is acceptable, accessible, appropriate and effective.
4. Action: Help client to take steps toward change.
5. Maintenance: Help client identify and use strategies to prevent relapse.
6. Relapse: Help client to renew the processes of contemplation, determination, and action, without becoming stuck or demoralized because of relapse.

5 General Motivational Interviewing Strategies:

1. Express empathy
2. Develop discrepancy
3. Avoid argumentation
4. Roll with resistance
5. Support self-efficacy

Effective Motivational Interviewing Techniques:

1. Empathy (client centered strategies)
2. Validation
3. Client is the expert on their own experience
4. Education
5. Remove barriers
6. Provide choices
7. Acknowledge the difficulty of change
8. Speak the client's language
9. Respect the client's individuality
10. Collaboration and clarification of goals
11. Be active, honest, curious and focused on symptoms while balancing client's struggles in other areas.
12. Decrease desirability of the destructive behavior
13. Reframe resistance: as an understandable response to a threat, this reduces conflict and enhances therapy

Five Basic Motivational Interviewing Skills (adapted from Sobell & Sobell, 2003)

1. Ask **Open-Ended Questions (OE)**
Therapist (T): Tell me a bit about school (OE).
Client (CL): I'm a junior in a lot of AP classes. There is a lot of pressure to do well.
2. **Reflective Listening or Paraphrasing (RL)**: Primary way to respond to clients.
T: It sounds like school is quite stressful. (RL)
CL: Yes, it's very challenging, but I have done well and been accepted to my top colleges.
T: So even though school is stressful, you find it rewarding (RL)
CL: Well most of the time, but lately I wonder where it is all going.
T: What other concerns do you have about your school? (OE)
CL: Well, with the end of school coming I just can't relax because of all the tests and I know I will be leaving some of my best friends soon.
T: What kinds of things have you done in the past to relax? (OE)
CL: Biking, but lately I'm too tired.
T: What other kinds of things help you relax? (OE)
CL: Going to the movies at the end of the week with my friends or just hanging out with them. But, lately I haven't done those things much either.
3. Elicit **Self-Motivational Statements**: Get clients to give voice to how they are changing; point out any changes you have observed with the client and ask them how they did this.
T: It sounds like you have made real progress. How do you feel about that?
4. **Affirm** (support, encourage, recognize client's difficulties)
T: It sounds like you are still struggling with making changes, but you have made some changes. How might you reduce your procrastination (self-harming behaviors, etc.) even more?
5. **Summary Statements (SS)**: pull together comments made; transition to next topic
T: You talked about a lot of things going on in your life right now, such as how hard school is, that friends are leaving, and that you feel stressed out. You told me you don't have much energy for doing some of the things you used to like to do and did to relax. What do you think might help you get back doing some of the things you once enjoyed? (SS)

Reframing: Places a different meaning on what the person says to reduce resistance.

Client: My parents have gone crazy over my being caught at school smoking cigarettes. I knew school was going to suspend me but my parents told me to come here for counseling so that I don't get suspended.

Therapist: It sounds like you think your parents are overreacting, but their actions seem to have been the reason that kept the school from suspending you. What do you think about that?

Developing Discrepancy: Create a gap between where the person is and where they want to be.

Strategies & Verbalizing Ambivalence

Tell me some of the good things and less good things about your behavior/concern.
What will your life be like (# years from) if you don't make changes and continue to use?
What was your life like before you started having problems with (the behavior)?
In what ways has your behavior been a problem? What have others said about it?

Looking Forward

If you keep going the way you are going where will you be two years from now?
What goals/things do you want for yourself? Have them list these on cards, and then put the cards in order of priorities. Which is most important? Which is least important? Then ask them where their behavior fits in. Point to the highest priorities and ask them “How many of your priorities would you be willing to give up for your current behavior?”

Colombo Technique: Used when clients are presenting conflicting information or behaviors

Therapist: “On the one hand you are terrified of going to jail, but you continue to (engage in the behavior). I’m confused. Help me understand this.”

Therapeutic Paradox: side with the ambivalence; presents the client with a challenge; do not sound sarcastic. This needs to be stated genuinely. Example (therapist): “Maybe what I’m asking is just too difficult for you right now. Maybe you are not ready to change.”

Emphasizing Personal Choice and Control: If you tell someone what to do this is confrontational and fosters resistance. Allowing personal choice and control over their problems helps to minimize resistance

Readiness to Change Ruler

People come into treatment with different levels of motivation (or readiness) to change
At the first session, ask “On the following 5-point scale from 1 to 5 where 1 is ‘Not Ready’ and 5 is ‘Ready’ where you are now in terms of changing your behavior? People move forward and back along this readiness to change scale. A therapist needs to operate at the same level of change where the client is in order to minimize resistance and gain cooperation

On the following scale (show client) from 1 to 5, what number best reflects how ready you are now to change your (the behavior)? Circle one:

Not Ready	Thinking of	Undecided/	Somewhat	Very Ready
to Change	Changing	Uncertain	Ready	to Change

1 2 3 4 5

Scaling Examples

1. Scaling Multiple Problems

I realize that it may be difficult to put numbers on each of the problems we discussed. Say, 5 is the most urgent and 1 the least.

How do you think you would rate your smoking problem?

What number would you give to each of your other problems—relationships, not sleeping?

2. Coerced Clients: Ask Their View of Referring Person’s Expectations (be empathic)

Therapist: I bet you have better things to do than to sit and talk to me. So, what do you think your mother or father believes has to happen so they will think you won't have to come here anymore?

Th: What will convince your parent(s) that you are a good kid?

MI References

- Martino, S., Carroll, K. M., O'Malley, S. S., & Rounsaville, B. J. (2000). Motivational interviewing with psychiatrically ill substance abusing patients. *American Journal on Addictions*, 9(1), 88-91.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change (2nd edition)*. New York: Guilford.
- Resnicow, K., Dilorio, C., Soet, J. E., Borrelli, B., Hecht, J., & Ernst, D. (2002). Motivational interviewing in health promotion: It sounds like something is changing. *Health Psychology*, 21(5), 444-451.
- Rollnick, S., & Allison, J. (2001). Motivational interviewing. In N. Heather, T. J. Peters & T. Stockwell (Eds.), *International handbook of alcohol dependence and problems* (pp. 593-603). New York: John Wiley.
- Sobell, L. C., & Sobell, M. B. (2003). Using motivational interviewing techniques to talk with clients about their alcohol use. *Cognitive and Behavioral Practice*, 10, 214-221.
- Substance Abuse and Mental Health Administration. (1999). *Enhancing motivation for change in substance abuse treatment (Treatment Improvement Protocol Series)*. Rockville, MD: U.S. Department of Health and Human Services. http://store.health.org/catalog/SC_Itemlist.aspx

Solution-Focused Brief Therapy

Solution focused brief therapy is a strength-based therapy which focuses on exceptions to problems. Steve de Shazer and Insoo Kim Berg developed this positive way of working with clients. They found that it was more effective to focus on solutions rather than focus on problems. They did this by encouraging the conversation to concentrate around three main areas:

1. Past successes and exceptions to the problem
2. Existing skills and positive personal qualities
3. The preferred future.

Solution-Focused Perspective

- Assumption: people are healthy and competent
- Psychotherapy can help enhance lives by focusing on solutions not problems
- Real causes of psychopathology can never be known
- Knowing the cause of a problem does *not* mean you have the cure
- People can make choices

Solution-Focused Principles

1. If it's not broken, don't fix it.

2. If something is working, do more of it.
3. If it is not working, do something different.
4. Small steps can lead to large changes.
5. The solution is not necessarily directly related to the problem.
6. The language requirements for solution development are different from those needed to describe a problem.
7. No problem happens all the time. There are always exceptions that can be utilized.
8. The future is both created and negotiable.
9. Approach each session as if it were the last

Goals

- *Positive* (what behavior will replace the old behavior)
- Focus on *how* change will occur
- Change what happens in the *present*
- Goals must be *practical*
- Goals must be *specific*
- Goals must be *client controlled*
- Goals set in the *client's language*

Selected Techniques

1. Complainant to Customer: Interviewing skills to help create clear goals and focus on behavior they can change, rather than trying to change others or just complain. How can I help *you now*? What will be different when you do not have this concern? What do you want to have be different about you as a result of working with me?

2. Envisioning the Future. Invite clients to imagine a version of the future using a Crystal Ball or Magic Wand and, especially, The Miracle Question: Imagine you go to sleep tonight and a miracle occurs overnight. When you wake up the concerns you discussed with me today are gone. Who would be the first person to notice and what would they notice? What would they notice? What would you notice? These can be helpful too if the client is being referred by someone else, for example “What would your teacher (or others) notice that is different?”

3. Exception Questions – Building on past success. The problem or complaint is not always happening. It helps to identify times when the problem does not exist, or is just a little bit better, and how they made it be better, and what they are doing differently. This encourages clients to see the possibility for change and success. Expand and explore the discussion in detail when exceptions are found.

4. Scaling Questions –Quantifying changes and rating levels of success provides useful information about client’s estimation of how close or far they are to their goal or ‘miracle’ and indicates what they did to get there. Scaling helps to develop awareness of change, and provide a direction for future changes. “On a scale from 0 to 10, with 0 being no change and 10 being lots

of change, rate your change in increasing healthier eating (or completing your homework, or having “good days” with your parents) over the past week?

Scaling Self-Esteem example:

Therapist: Let’s assume that when you first started therapy the problem that brought you here was a 1 and where you want to be after you finish treatment is a 10; where would you say you are today, between 1 and 10?

Client: I would put myself at 4.

Th: What would you say you have to do to move up from 4 to 5?

5. Mapping- Encourage exception’ discoveries: “What did you do to make this change?” “How did you do that when it was such a challenge (mind fields)?” Compliments help to reinforce behaviors the client found useful in moving toward their goals, even if the change is very small. “You were a 2 this week! Wow, how did you do that? If even lower, find something to compliment client about—even though you say it was really bad week, you managed to still go to soccer practice and kept your appointment with me!

Examples from my work with eating disorders:

CHANGES

What positive changes have you noticed in the past 1-2 weeks concerning your eating/exercise?

What did you do to make that happen?

What are times you seem to have fewer problems with eating and food restriction?

What kind of things do you think have been helpful to you?

What do you need most at this time?

GOALS & PLANS

Date:

What are my goals for this week?

What changes am I willing to make this week to meet my goals: (include eating, drinking, exercise, relationships)?

What obstacles might I encounter (or 'holes' I could fall into) that would get in the way of reaching my goals? What worked for me in the last week to be successful?

What am I afraid of?

What are my hopes? What skills/tools/help to I need to help me reach these goals:

How willing am I to do the work it will take to reach my goals (0-100%)

What can I do to increase that?

How will I reward myself when I reach my goals?

Letter to Parents

Dear (parents names)

It would be helpful to (client name) and me to get your perspectives on her progress. I will share this information with (client) when I meet with her next week.

What changes have you noticed in (client name) in a) the last month?:

What are times (client name) seems to have fewer problems with eating and disturbed eating behaviors?

What do you think has been helpful to (client name) since she began high school? (Please include you and the role of your family members).

What do you think (client name) needs from you most at this time?

What would you like from (client name) in the next few weeks?

On a scale from 1 to 10 how much do you think (client name) has improved overall since we began working together six months ago (0=not at all; 10= completely)?

A Mini Solution-Focused Brief Counseling Guided Imagery Experience

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This paper will describe an exercise that can be used to introduce counseling students in a classroom setting to Solution-Focused Brief Counseling (SFBC). As part of a SFBC presentation, this activity provides students with a personal “mini” solution-focused experience to familiarize them with basic concepts related to this model of counseling via a guided imagery.

Students are asked to close their eyes and picture a problem they are having and then are asked a series of solution-focused questions. They are informed that they will not be required to share what they will be experiencing. The group presentation allows an entire class to efficiently and simultaneously experience and understand the SFBC approach rather than having it described to them. This exercise can also be used with groups to stimulate Solution-Focused thinking to begin to overcome the difficulties individuals in the group may be experiencing.

Procedures

Students are asked to close and keep their eyes closed through the entire activity. They are informed that they will be asked a series of questions. In response to these questions students are to visualize/picture their responses as if they were like a video.

The following prompt is given before beginning the exercise to enable students to think of behaviorally-specific answers to the questions asked of them.

“ When I ask you to identify specific things or actions that you would be doing, I would like you to respond in concrete, observable, and detailed behaviors. That is, rather than saying ‘I will be friendly,’ describe the behaviors you will be demonstrating to be friendly such as: ‘I will be smiling, saying hello, and shaking hands.’ ”

Following the prompt, participants were led through the following fifteen- step Solution-Focused Guided Imagery activity.

Step 1

Identify a recent reoccurring problem that you would like to overcome, a) something you would like to do, or something you don’t want to do. When you have this picture in your mind let me know by raising your hand. **Facilitator notes:** When all hands are raised ask: If you had a scale with 0 being the worst this problem has ever been, and 10 represents the total elimination of this problem, where are you right now with this problem?

Step 2

a) If your problem is something you would like to do, describe it below as if it was a video of what you would observe yourself behaviorally doing. (Throughout this visualization-*Do not describe something you would not be doing*).

b) If your problem is something you don't want to do, describe it below as if it was a video of what you would observe yourself behaviorally doing instead.

Step 3

Suppose a miracle happened tonight while you were sleeping, and this miracle solved your problem and since you were sleeping you didn't know this miracle had occurred, and when you woke up you realized that you no longer had this problem. Construct an image/picture of the first small sign (specific observable behavior) that would show you were doing something different the next day? (*Do not describe something you would not be doing*).

Step 4

Imagine who would notice this different thing you would be doing and describe how you think they would act when they notice this different behavior?

Step 5

Picture what you would do (specific observable behavior) in reply to the person's response you have just envisioned.

Step 6

Now imagine what else you would notice you would be doing (specific observable behavior) differently after this miracle occurred?

Step 7

Visualize who would notice this different thing you would be doing and how you think they would act when they notice this different behavior?

Step 8

Picture what you would do in reply to the person's response described above.

Step 9

Recall a time when some of this miracle has already happened even if only a little bit during problem times.

Step 10

Visualize how you made this part of your miracle happen during this problem time. (*Things you thought or did differently - Commitments you made - New behavior you tried, etc.*)

Step 11

As you think about how you made part of your miracle happen for yourself what are your thoughts about how pleased you are with your efforts at the time.

Step 12

On a scale of 0 to 10 with 0 being the worst this problem has ever been and 10 representing the eradication of this problem, where do you think you are right now on the scale?

Step 13

Envision the things you have done to get yourself to that number?

Step 14

Picture what you will be doing differently than you are doing now when you are one number higher. What will you and others see you doing

Step 15

Write yourself a short note describing what you discovered or re-discover about yourself and your situation. When you have finished your note let me know by raising your hand.

Facilitator notes: When all hands are raised ask: If you had a scale with 0 being the worst this problem has ever been, and 10 represents the total elimination of this problem, where are you right now with this problem?

References for Solution Focused Brief Therapy

- Berg, I.K., & DeJong, P.(1996). Solution-building conversations: Co-constructing a sense of competence with clients. *Families in Society: The Journal of Contemporary Human Services*, 77, 376-391.
- Bonnington, S. (1993). Solution-focused brief therapy: Helpful interventions for school counselors. *School Counselor*, 41(2), 126.
- DeJong, P., & Berg, I.K. (1998). *Interviewing for solutions*. Pacific Grove, California: Brooks/Cole Publishing Company.
- Franklin, C., Moore, K., & Hopson, L. (2008). Effectiveness of solution-focused brief therapy in a school setting. *Children & Schools*, 30(1), 15-26.
- Gingerich, W., & Wabeke, T. (2001). A solution-focused approach to mental health intervention in school settings. *Children & Schools*, 23(1), 33.
- McFarland, B. (1995) *Brief Therapy and Eating Disorders*. San Francisco: Jossey-Bass.
- Pichot, T., & Dolan, Y.M. (2003). *Solution-focused brief therapy*. New York: Haworth Press.
- Sklare, G. B. (2005) *Brief Counseling That Works: A Solution-Focused Approach for School Counselors and Administrators*. Thousand Oaks, California: Corwin Press.
- Young, R.S., & Holdorf, G. (2003). Using solution focused brief therapy in individual referrals for bullying. *Educational Psychology in Practice*, 19(4), 271-282.

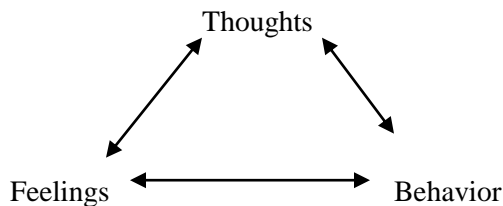
Overview: Rational Emotive Behavior Therapy (REBT)



Introduction: REBT is a counseling theory developed in the 1950's by Albert Ellis who believed that when a highly charged emotional consequence follows a significant activating event (A), event A may seem to cause the problem (C-consequence), but actually does not cause C. Instead, emotional consequences are largely created by B (beliefs), the individual's belief system. When an undesirable emotional consequence occurs (depression or anxiety, for e.g.), this usually involves the irrational beliefs. When these beliefs are actively (D) disputed, then the disturbed consequences are usually reduced.

Basic Assumptions

1. People are predisposed to think rationally (self-constructive) and irrationally (self-defeating) thinking. We can be forward thinking, conscious, and willing to actualize our potential. However we are also capable of being hedonistic, intolerant, perfectionistic, or grandiose, and we sometimes avoid thinking things through.
2. The tendency think irrationally may be exacerbated by culture and family. In our early years we are very suggestible (or conditionable) because of family/cultural and social influences.
3. We perceive, think, emote, and behave simultaneously. We implicitly think. Our actions can be viewed within a framework of prior experiences, memories and conclusions. We seldom emote without 'thinking' because feelings often include an appraisal of a given situation and its importance.



4. A very close therapeutic relationship not necessary to success in therapy.
5. Most psychological problems stem from unrealistic and self-defeating thinking. By disputing beliefs using logical thinking these thoughts can be minimized. The main reason people overreact or underreact to adversity (the 'A' activating event) is because people have dogmatic, irrational, unrealistic beliefs (B).
6. Insight is not enough to produce change in personality

Key Concept: A-B-C Theory

A= Activating event; B= *one's* Beliefs about A; C= emotional Consequences;
D= Dispute; E= Effect (Think more rationally, aware of preferences, wishes & wants).
Increase frustration tolerance, accept the fallibility of humans. Healthier responses:
concern, regret, disappointment, but not overwhelming depression and anxiety.

Example:

A= Brad Pitt did not ask me to Phuket for the weekend

B= It is because I am boring, have nothing to say, uninteresting

C= I am depressed, devastated, despondent and down-hearted

D=What evidence do I have that I am have those qualities? What does it mean to me that he did not ask me out? (Keep questioning...)

E = I am disappointed not to be asked out, but realize he can't ask me out because a) he has never met me, b) even if he met me, he might not ask me out for many other reasons and c) If I met him I might not want to date him anyway.

Examples: Types of Irrational Beliefs

1. I must be loved and approved of by all.
2. I must be completely competent in everything I do
3. When people treat me unfairly, they are bad.
4. It is horrible/catastrophic when things do not go my way
5. My feeling bad is externally generated.
6. When feeling threatened by something, you must ruminate over it.
7. You can be happy without any effort (I am just not happy)
8. Our past must influence our current behavior
9. If people/things/events do not live up to our expectations, it is awful.
10. Life is no good unless I get what I believe I deserve.

Example: Beth reports she is anxious when she walks down the halls at school. She states that other students look at her strangely and sometimes she hears them laughing at her. She tells that no one likes her and that she has no friends.

What is the activating event (a)?

What is/are the irrational beliefs (b)?

What is the emotional consequence (c)?

How would you begin asking Beth to Dispute her beliefs?

RATIONAL EMOTIVE BEHAVIOR THERAPY CHART Adapted from Ellis & Dryden, 1997

Complete this section after completing 'C' section (A) **ACTIVATING EVENT** (Situation that results in particular feelings, such as frustrated, sad, angry...):

Complete this third:	Complete this fourth:	Complete this fifth:
B) IRRATIONAL BELIEFS (IB's) leading to CONSEQUENCES (emotional disturbance or self-defeating behaviors)	(D) DISPUTES for each circled IRRATIONAL BELIEF	(E) EFFECTIVE RATIONAL BELIEFS (RB's) to replace my IRRATIONAL BELIEFS (IB's)
<i>Circle beliefs that apply to this ACTIVATING EVENT (A).</i>	Examples: 'Why MUST I do very well?' 'Where is it written that I am a BAD PERSON ?' 'Where is the evidence that I MUST be approved or accepted?'	Examples: "I'd PREFER to do very well but I don't HAVE TO ." "I am a PERSON WHO acted badly, not a BAD PERSON ." "There is no evidence that I HAVE to be <i>approved of though I would LIKE to be.</i> "
1. I MUST do well or very well!	<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
2. I am a BAD OR WORTHLESS PERSON when I act weakly or stupidly.	<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
3. I MUST be approved of or accepted by people I find important.	<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
4. People MUST treat me fairly and give me what I NEED.	<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>
5. People MUST live up to my expectations or it is TERRIBLE!	<hr/>	<hr/>

Complete this section first (C) **CONSEQUENCES** (Frustrating reactions or self-defeating behaviors that I produced and would like to change), may include feelings (anger, guilt, shame) behaviors (lashing out at others, drinking alcohol or using drugs to numb feelings):

General Types of Coping

Solution-Focused Coping involves a person's efforts to resolve the problem or situation that causes him/her to feel stressed. Examples of solution-focused coping involve:

- Learning more about a situation
- Learning how to relax
- Exercise
- Time management
- Developing organizational skills
- Recognizing what can be changed (e.g., situation, exposure, interpretation)
- Eating and sleeping well, striving for balance

Emotion-Focused Coping refers to a person's efforts to decrease the emotional impact of a stressful situation and/or to increase a sense of emotional well-being. Examples of emotion-focused coping include:

- Talking to a friend or relative
- Seeking support or professional help
- Looking for ways to relax
- Rethinking the meaning of a situation or event
- Identifying distorted thinking or beliefs

Avoidance Coping takes place when an individual attempts to ignore or minimize a problem or stressful situation, and/or looks for ways to escape its impact. Examples include:

- Isolating oneself
- Procrastinating
- Using alcohol or drugs
- Keeping things to oneself
- Suicidal thoughts
- Postponing dealing with a problem or issue
- Oversleeping

From www.sandiego.edu/usdcc/documents/CC-WhatIsStress.doc

Coping strategies: Twelve Families

1. Problem solving: finding alternative ways to cope. Using planning, effort, persistence, and determination.
2. Information seeking: attempts to learn more about a stressful situation or conditions. Including details regarding its course, causes, consequences, and meanings; as well as, strategies for intervention and remediation.
3. Helplessness: giving up; surrendering control.
4. Escape: efforts to disengage or stay away from the stressful event/circumstances.
5. Self-reliance: attempts to constructively express emotions at the appropriate time and place.
6. Support seeking: targets for support, parents, peers, professionals, spouses, and spiritual guidance are all possible resources.
7. Delegation: dependency, maladaptive help seeking, complaining, whining, and self-pity.
8. Social Isolation: actions aimed at staying away from other people or preventing other people from knowing about a stressful situation.
9. Accommodation: attempts to deal with a stressful situation by engaging in alternative pleasurable activity and changing one's view of the situation.
10. Negotiation: attempts to work out a compromise between the priorities of the student and the constraints of the situation.
11. Submission: passive and repetitive focus on the negative and damaging features of a stressful transaction.
12. Opposition: projection, anger, aggression, venting, and blaming others for the situation or stressful circumstances.

- . Skinner, E.A., Edge, K., Altman, J., & Sherwood, H. (2003). Searching for the structure of coping: A review and critique of category systems for classifying ways of coping. *Psychological Bulletin*, 129, 216-269.

Stress Responses

Stress can affect every aspect of our lives: physical, emotional, spiritual, relational, behaviors, cognitive. It is important to remember that many of our reactions are normal responses to an unusual situation. These symptoms can serve as a clue that it is time to do something different!

Relational: Interpersonal relationships are what humans do with much of their time! Relationships can be adversely affected by many of the other symptoms of stress.

Behavior: Eating (under, over), self-medication- alcohol/drug use in an effort to numb or escape, sleeping disturbances, hypervigilance (easily startled), avoidance of reminders, withdrawal from usual sources of support, increased conflicts.

Physical: Symptoms often provide the first clue that we are stressed. Chronic stress can have a negative impact on health and exacerbate physical challenges as well (i.e., existing cardiovascular concerns). Some of the common symptoms include headaches, gastrointestinal problems such as stomach aches, rapid breathing, agitation, racing heart, exhaustion, and changes in sleeping and appetite.

When stress occurs frequently or for long periods of time, there are actual biological changes that occur due to elevated levels of stress hormones. These hormones can change the cells of the body. The immune system may function less effectively, leading to a greater likelihood of developing illness and an inability to fight off disease.

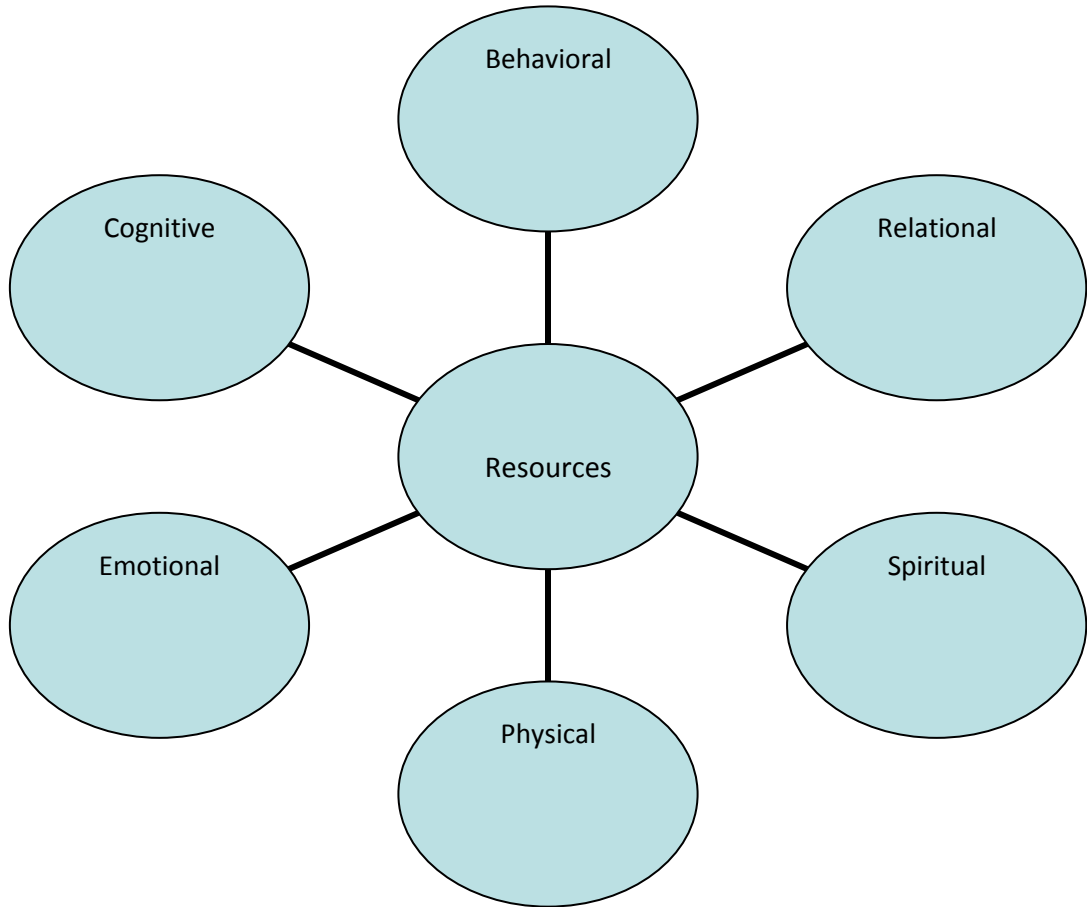
Emotional: Emotional reactions when we are under stress can include being easily angered, irritable, mood swings, feeling helpless/hopeless, anxious, sadness, and depressed. However emotions may run the gamut to include feeling emotionally numb or apathetic.

Cognitive : Stress impacts how you think. Under stress, thinking takes second place to physical reactions. Common signs include feeling confused, disoriented, and you may have difficulty concentrating or find your memory is not serving you well. When you are overwhelmed and preoccupied it is hard to think clearly. People sometimes begin second-guessing themselves and making negative attributions or self-statements which can exacerbate the stress. There is also research indicating the chronic stress can lead to brain shrinkage and abnormalities due to increased glucocorticoids and severe stress.

Spirituality and making meaning: Questioning or losing faith, hope; difficulty making meaning, unable to make sense of things, questioning (i.e, why do bad things happen to good people). See: *When Bad Things Happen to Good People* by [Harold S. Kushner](#) (1981).

Strengthening Resources

“Recovery algorithms”: symptoms point to directions for interventions. Manifestations of stress indicate where you can take action and in what order. For example, if one of your immediate symptoms of stress is tight shoulders, doing simple exercises like shoulder shrugs and deep breathing can let the tension go.



Strength Area 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 (level of strength)

Spiritual

Emotional

Physical

Cognitive

Behavioral

Relational

Colorado Department of Human Services. (n.d.). *Stress Management*. Retrieved February 10, 2009, from http://www.cdhs.state.co.us/dmh/PDFs/Disaster_RedPages_Stressmgmt.pdf

Brief Strategic Family Therapy (BSFT)

It is beyond the scope of this presentation to do much more than emphasize that sometimes the best way to work with a child is to work with the family. This brief overview is intended to highlight information from one model of therapy that has been successful in achieving positive change.

Words from a colleague who works cross-culturally on her views about working with families reluctant to engage in counseling.

“In recruiting reluctant families, I explain that family conversations are an opportunity to review parenting methods, whether the methods work for the developmental stage their teenager is at, or if their parenting style is working with the particular needs of their child/children.

I encourage parents to be on the same page about parenting as this helps them be a more effective team. Parents learn that being more effective at parenting results more respect, and gets better results. Meeting as a family when a child is in trouble brings to the table the important people in the child’s life and gets people on the same page about the goals and is more effective in monitoring progress than working with individuals alone.”

A Brief Introduction

BSFT is a brief solution and strength focused family therapy that has been used with successful outcomes among dominant and culturally diverse families in the United States. The primary goal to provide families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill-building strategies that strengthen families.

The program fosters parental leadership, appropriate parental involvement, mutual support among parenting figures, family communication, problem solving, clear rules and consequences, nurturing, and shared responsibility for family problems. In addition, the program provides specialized outreach strategies to bring families into therapy.

BSFT can be implemented in a variety of settings, including community social services agencies, mental health clinics, health agencies, and family clinics. BSFT is delivered in 8 to 12 weekly 1- to 1.5-hour sessions. The family and counselor meet either in the program office or the family’s home. Sessions may occur more frequently around crises because these are opportunities for change. There are four important steps:

Step 1: Organize a counselor-family work team. Development of a therapeutic alliance with each family member and with the family as a whole is essential for BSFT. This requires counselors to accept and demonstrate respect for each individual family member and the family as a whole.

Step 2: Diagnose family strengths and problem relations. Emphasis is on family relations that are supportive and problem relations that affect youths’ behaviors or interfere with parental figures’ ability to correct those behaviors.

Step 3: Develop a change strategy to capitalize on strengths and correct problematic family relations, thereby increasing family competence. In BSFT, the counselor is plan- and problem-focused, direction-oriented (i.e., moving from problematic to competent interactions), and practical.

Step 4: Implement change strategies and reinforce family behaviors that sustain new levels of family competence. Important change strategies include reframing to change the meaning of interactions; changing alliances and shifting interpersonal boundaries; building conflict resolution skills; and providing parenting guidance and coaching.

Implementation Essentials:

The experts on this model strongly recommend a counselor have a master's degree in a mental health field, including experience in couples and family therapy. However, individuals with bachelor's degrees who have been trained in the model can also be effective. Other essentials include administrative support, training and technical assistance, and time and funds for start-up which includes training, building community resources, and recruitment and screening of suitable families.

From: <http://www.cfs.med.miami.edu/docs/miscellaneous/bsft.pdf>

References

Szapocznik, J., Hervis, O.E., & Schwartz, S. (2003). *Brief strategic family therapy for adolescent drug abuse* (NIH Publication No. 03-4751). NIDA Therapy Manuals for Drug Addiction. Rockville, MD: National Institute on Drug Abuse.

Parenting and Perfectionism

Parenting starts with Y.O.U. Your Own Understanding. Parents need to be able to look at their own perfectionist tendencies and determine why they are that way. Many people adopt perfectionist habits as a way to deal with stress or anxiety. They feel anxious when things are incomplete, messy or not done right. While some degree of perfectionism can be positive and reflect taking pride in one's work, taken to an extreme, it can negatively impact your relationships with your children and others.

Decreasing the stress in a parent's life is one of the most important things we can do to make parenting easier.

Ways to decrease stress include:

1) Cutting down on activities and kids are involved in. The American Academy of Pediatrics has issued a report that children in the US are over involved. Part of their recommendations included limiting activities outside of home and school to 1-2 at any point in time. If getting your child to and from activities creates too much stress for you, that is a good time to consider cutting back the activities. Cut back if your child's grades start to drop or your child is frequently missing other important school or family activities. Questions parents can ask themselves to help determine if they are over scheduling their children:

How much does my child really enjoy the activity? How would my child respond if I said he or she needed to quit? Does my child only like the activity if he/she wins or performs well? Obviously when a child is first learning an activity, like playing a musical instrument, it may take a while for him or her to develop an appreciation for it. We recommend that parents set a specific length of time that is long enough for the child to have a chance of learning to like it. After that point parents should let go. Seldom will children need longer than one year to try to like some activity.

If my child was not doing this activity, what would he or she be doing instead?

Is my child learning skills like teamwork, time management, or responsibility?

Is the activity helping to build my child's confidence or helping my child to make good friends?

What does this activity take away from in terms of my family's time, money and other commitments?

Can my child keep up with his or her grade, chores, friendships, or down time when engaging in this activity?

2) Parents can decrease stress by getting help from family and friends.

3) Exercising at least 3 times per week.

4) Meditation and/or prayer.

5) Scheduling "me time" to do things for yourself.

6) Have regular family meetings to discuss things.

- 7) Use and stick to daily routines for mornings, mealtime and bedtime.
- 8) Laugh and laugh some more.
- 9) Seek counseling for personal or job issues.

Parenting problems also occur when parents deny real problems in their children.

Parental denial is one of the biggest reasons kids are not successful. Parents who deny that they or their children have problems often do not get help until the problem is much bigger and harder to treat. Parents have a tendency to deny that a problem is real because they do not know what to do or how to do it. Parents also deny because they are embarrassed or afraid of what others might think.

Denial may lead a mother to feel like the “mean teachers” are picking on her child when in reality her child has a behavior problem and frequently disrupts class. One good way to know if you should be concerned about something is to look for pattern by using the **Rule of 3’s**. If something has happened 3 or more times, or three or more people tell you something is a problem, you have a pattern that needs to be looked at. If you see a pattern you need to ask yourself “What is my part (or my child’s part) in this?”

If you are unsure that your child has a problem we like this saying, “while love is blind, family, friends and teacher are not.” Ask someone close to you for their honest assessment of a situation with your child.

For some situations like illegal drug possession or physical assault, do not wait for a pattern of 3 events to occur. For illegal behavior it should be one strike and you are out. Get help right away.

Substance abuse is one of the most common problems that parents deny.

Almost 1 in 5 American children come from a home where a parent is abusing drugs or alcohol. Children coming from these families are more likely to have problems with Attention-Deficit/Hyperactivity Disorder, learning disabilities, delinquency and depression. Parents cannot afford to deny a substance abuse problem because it can have a significant effect on their child.

A mother once brought her son into my office. He was struggling in school and had few friends. His mother also said that he “disobeys, steals my stuff and jumps on my bed when I am trying to sleep.” When I spoke to the boy about his behavior, I learned that he was “stealing” his mother’s hidden vodka bottles and pouring the contents down the drain. He would “jump on her bed” at 6:00 in the evening when he was trying to get her to respond when she passed out. Now that mother was in denial!

Emotional problems like depression, anxiety and anger create stress and interfere with successful parenting.

There is no shame in depression – in fact according to the World Health Organization it is the most common disorder in the industrialized world. Depression can be treated. Half of children who live with just one depressed parent are also depressed. Children with depressed parents do worse in school, and have fewer friends and more behavior problems.

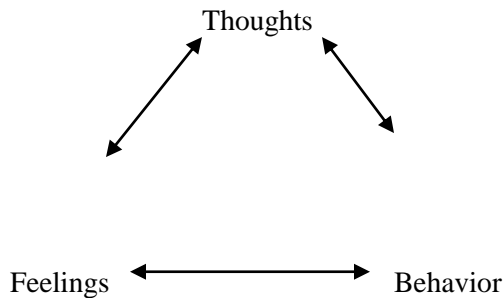
Anxious parents tend to have anxious kids. Angry parents tend to have more aggressive children that act out.

Parents are OK, but their child is a perfectionist.

Certainly it is possible for parents to have minimal difficulty with the above described struggles and yet they have a child who exhibits perfectionistic tendencies. Like adults, children can behave like a perfectionist for a variety of reasons, but anxiety is often a likely culprit.

Children can be anxious about various things like grades, friends and their futures. Perfectionist children and adolescents are more prone to becoming depressed, have panic attacks, poor peer relationships and develop an eating disorder. Like most significant problems, the sooner a parent acts, the easier the problem is to treat.

If parents or teachers find that a child is too much of a perfectionist, it would be useful to discover what the child is worried will happen. Psychologists have known for quite some time that the way we think, feel and behave all interact.



So if we can understand what children are thinking, we can also begin to challenge and change those thoughts. Once we start doing that, we will also change the way they feel and the way they behave!

So when a child is showing perfectionist tendencies, it is important to find out what the child is afraid will happen if the perfectionist behavior is not completed.

For example assume a child will not go out of the house unless her hair and clothing look perfect. First find out what the child is thinking. You can do this by asking 3 questions:

1) What is the worst thing that could happen if you went outside without looking perfect?

The child may say something like, “other kids will laugh at me” or “people will stare at me” or “nobody will like me.”

2) Then ask what is the best thing that could happen if she went outside without looking perfect?

Kids usually have trouble with this one, so you may have to help her, “you would not have to spend so much time getting ready” or “you would not have to worry so much about it.”

3) Finally ask the child, what is the most likely thing that could happen if you did not leave the house looking perfect?

Children sometimes come up with something between the worst and best case scenarios. Such as “I could go outside and feel uncomfortable for a while and then forget about how I look.”

Often, however they stick with their worst case scenarios, “If I left the house without looking perfect, I would be laughed at by other kids on the bus.”

Regardless of how she responds to this third question, as her one more question:

“So you leave the house not looking perfect and the other kids laugh at you. Can you live with that?”

You could also ask, “How do you know that they will laugh at you?” You could even have the child do a little experiment where she is required to go outside with just one thing that is not perfect (socks that are different colors, or berets that do not match her clothing) and see how many people notice the slight imperfection. Then you can gradually work your way up to having her wear striped pants and a plaid shirt! (OK maybe that is taking it too far).

Helping children to recognize that being perfect is unrealistic and unattainable does not teach them to be mediocre, it teaches them to be human.

From : <http://www.7skillsforparenting.com/>

Berdahl, L. & Johnson, B.D. (2009). *7 skills for parenting success*. La Vergne, TN: Lightening Source Press

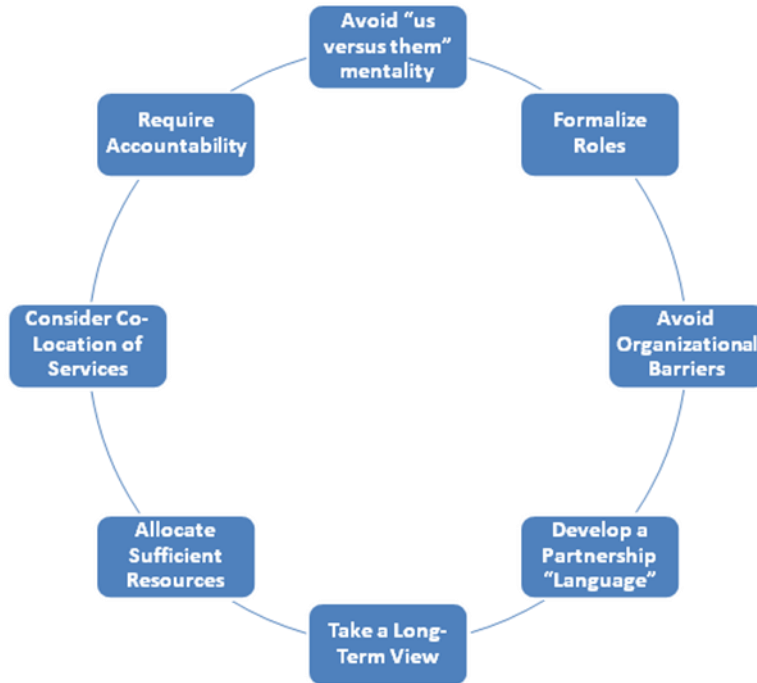
Creating a Mental Health Team

1) Members & roles

- A. School personnel
- B. Family
- C. Community
- D. External resources & agencies
- E. Virtual communities (online resources, blogs, Skype, etc)

2) Attitudes, Behaviors & Characteristics of Successful Collaborations

Attitudes and Behaviors Beneficial to Effective Collaborations



Attitudes and Behaviors Beneficial to Effective Collaborations

- ✚ Avoid “us versus them” Mentality:
 - Be as accessible as possible to collaborative partners and maintain respect for expertise and mission of all involved
- ✚ Formalize Roles:
 - To sustain collaboration, partnership needs to transition from resting on individuals to relying on formalized structures, with defined organizations and process
- ✚ Avoid Organizational Barriers:
 - Prevent processes, traditions, agendas, and other obstacles, be open-minded about what can be done to overcome potential barriers
- ✚ Develop a Partnership “Language”:
 - Each discipline will have its own language and culture. It may be necessary to redefine key terms and concepts for use within the partnership
- ✚ Take a Long-Term View:

- Benefits that come from intensive resources at the beginning of a partnership may last for years, or even decades, but may not be immediately recognizable
- ✚ Allocate Sufficient Resources:
 - Include work with the collaboration in job descriptions, periodically review and reward exemplary collaborative activities
- ✚ Consider Co-Location of Services:
 - Improving communication between providers of differing services may provide more effective and sufficient services
- ✚ Require Accountability:
 - Invite stakeholders to provide feedback on how the collaboration is working and what can be done to improve cooperation

Cohen, R., Linker, J. A., & Stutts, L. (2006). Working together: Lessons learned from school, family, and community collaborations. *Psychology in the Schools, 43*(4), 419-428.

Characteristics Essential to Successful Collaborative Efforts



Characteristics Essential to Successful Collaborative Efforts

- ✚ Mapping Assets and Strengths:
 - Identify key stakeholders and positive aspects of the situation that can be used to strengthen collaboration
- ✚ Solid Partnerships:
 - Open and honest relationships, partners committed to collaborating with and trusting one another
- ✚ Shared Vision:
 - Common vision focused on the good for the whole unites stakeholders and provides momentum
- ✚ Involving Families:
 - Critical to achieving outcome goals in the school as well as in family and community settings
- ✚ Engaging Teachers:

- Extent to which teachers are involved will influence the program's success. Teachers can assist in identifying student needs and creating goals for collaborative efforts
- ✚ Schools Serving Communities:
 - Schools provide benefit to the community as well as having the community serve the schools' needs
- ✚ Strong School Leadership:
 - Administrators should provide support for stakeholders and celebrate the achievement of the group actions
- ✚ Effective Relationships with Agencies/Organizations:
 - Requires participants to address language, cultural and territorial factors that may impede genuine collaboration

Cohen, R., Linker, J. A., & Stutts, L. (2006). Working together: Lessons learned from school, family, and community collaborations. *Psychology in the Schools, 43*(4), 419-428.

Preventing Childhood Eating Disorders

Prevention is any systematic attempt to change the circumstances that promote, initiate, sustain, or intensify problems. National Eating Disorders Organization (NEDO)

10 Tips for Reducing the Risk of Eating Disorders

1. Knowledge

- Warning signs
 - Anorexia nervosa: starvation, irrational fear of weight gain, serious weight loss, distorted body image.
 - Bulimia nervosa: cycles of binge-eating and purging; rapid consumption a large amount of food in a short period of time. Purging includes vomiting, restrictive eating, exercise, laxative & diuretic abuse.
 - Binge-Eating Disorder- rapid consumption a large amount of food in a short period of time; maybe accompanied by periods of severe dieting
 - Subclinical Eating Disorders...
 - Also see: http://www.gurze.com/client/client_pages/abouteating_info.cfm

2. Provide Information

- Teach children to **think** critically about media messages, obsession with appearance, and the consequences of “not measuring up”.
- Explore stereotypes about body image and characteristics (e.g., “thin people are nice”).
- Examine the role of gender in the development of eating disorders.

3. Develop and model healthy coping strategies

- Food is fabulous fuel, but...
- The coping connection
- Constructive coping and developing alternatives

4. Hunger and normal eating

- What is ‘normal’ eating?
- Scaling hunger and satiety
- Balance and choice
- Food as friend or foe? The role of rewards & punishment.

5. Pay attention to food, weight, and body image messages.

- What messages are being communicated in the home and school environment about body image and food?

- Is food usually the focus of social events?

6. Advocacy

- Develop positive attitudes about bodies and food.
- Walk your talk: What are YOU doing?
- What are you saying?
- How do you respond to children's comments about food and weight?

7. Building relationships

- Know your role: reliable, responsible, role model
- Encourage family mealtimes: Connection not correction
- The father-daughter relationship
- Fostering freedom within the family: increased privacy, choice, etc. contributes to self-esteem and resiliency.

8. Stop, watch, and listen!

- Watch for perfectionism, compulsiveness, hypersensitivity, depression, low self-esteem and impulsivity.
- When there are changes in child's life provide as much support as possible. Monitor changes in the family, with friends, physical and emotional changes. These can trigger periods of great stress.

9. Focus on the positive and on inner qualities.

- Bodies: Emphasize function, not just form or appearance: strength for sports, stamina, and endurance.
- Encourage Positive Qualities: i.e., energetic, passionate, persistent, observant, sensitive, friendly.
- Provide love and acceptance.

10. Confronting with Care

- A=Awareness & Acknowledgment
- B = Behaviors, not Blaming
- C =Course of Action

What can schools do?

- Student Assistance Program (SAP)
- Have at least 2 people who are ED interested be willing to serve as resource consultants.
- In-service using educational materials to teachers, coaches, administrators.
- Develop guidelines for prevention programs, intervention, treatment referrals
- Anti-bullying policies: Create a body image accepting environment.

- Decide on a case by case basis who will monitor and refer a student.
- <http://www.nationaleatingdisorders.org/uploads/file/toolkits/NEDA-TKE-A06-SchoolStrategies.pdf>
<http://www.nationaleatingdisorders.org/uploads/file/toolkits/NEDA-TKE-A12-PsychologistTips.pdf>

Helping the friends of students with eating problems

- Confidentiality
- Responsibility (or lack of)
- Maintaining friendships
- Providing age appropriate information
- Supportive listening and encouragement: listen, coping with friend who is struggling, taking care of self, setting limits
<http://www.nationaleatingdisorders.org/uploads/file/toolkits/NEDA-TKE-A06-SchoolStrategies.pdf>

Discussions with Parents

- Preparation: consider cultural factors, family dynamics, and social issues.
- Find a good time to talk
- Empathic Listening
- A,B,C,D,E: acknowledge, behavior, concern, duty, encouragement & external contacts
- Stop while you are ahead
<http://www.nationaleatingdisorders.org/uploads/file/toolkits/NEDA-TKE-A08-CommunicatingTips.pdf>

Tips for Kids: Feeling Good and Eating Well

- Eat when you are hungry, stop when you are full
- Foods are not 'good' or 'bad'
- Food won't make emotional pain go away
- Exercise and activity are fun. Do something you like!
- Fat & thin are body types not personality types
- Appreciate yourself and all that you are!
http://www.nationaleatingdisorders.org/p.asp?WebPage_ID=286&Profile_ID=69224

Resources and References

Essential for educators! http://www.nationaleatingdisorders.org/uploads/file/toolkits/NEDA-Toolkit-Educators_09-15-08.pdf

Essential for parents! <http://www.nationaleatingdisorders.org/nedaDir/files/documents/handouts/10Parent.pdf>
http://www.nationaleatingdisorders.org/uploads/file/toolkits/NEDA-Toolkit-Parents_09-15-08.pdf

Tips for Kids: Healthy eating & feeling good about themselves

<http://www.nationaleatingdisorders.org/nedaDir/files/documents/handouts/TipsKids.pdf>

A few Books (all available from www.gurze.com)

Hirschmann, J.R. & Zaphiropolous, L. *Preventing Childhood Eating Problems.*

Kater, K.J. *Health Body Image: Teaching Kids to eat and Love Their Bodies Too*

Luciano, L. *Looking Good: Male Body Image in Modern America*

Richardson, B.L. & Rehr, E. *101 Ways to Help Your Daughter Love Her Body*

Siegel, M., Brisman, J., & Weinshel, M. *Surviving an Eating Disorder.*

Eating Disorders Assessment

Note: this is typically conducted as an interview format with a counselor

Mary Sean O'Halloran, PhD University of Northern Colorado, Greeley, CO & Louise Ousley, PhD
University of California, Santa Barbara, Feel free to use, but please cite authors.

A. Current Height/Weight

Demographics: name, age, residence, etc.

Current height/weight, Highest and lowest weight at this height, age at these weights?

B. Historical and Current Assessment of Eating/Weight Problem

1) Age at which first had concern with eating/weight (e.g., felt out of control, obsessive thinking...)

2) History of weight loss and gain, dissatisfaction with body.

3) Historical and Current means of controlling weight:

fasting/dieting: type, duration, frequency

binging: types of food, amount, frequency

purging: vomiting, laxatives, exercise: how much, how often

diuretics, appetite control pills: amount, frequency, duration

exercise: types, amount, frequency, duration

substances used for weight control: types, amount, frequency, duration (cigarettes, amphetamines, steroids, medication, etc.)

C) Family/Personal History

- Your family- composition, ages, relationships, deaths, divorces, at what age?
- Immediate family members with history of eating or weight problems? Who? Type of problem, duration, etc.
- Family History of depression, anxiety, other psychological concerns, include extended family. Suicidality in self/family, past & present?
- History of substance abuse: drugs, alcohol in self/family; willingness to seek help, current status?
- History of physical, sexual abuse, relationship violence in self/family- who, when, action taken, current status?
- Who in the family knows about your concerns? Responses, support? ("Team" members?)

D) History of Treatment

What have you done to try to manage this concern? Counseling- what type of have you done? When? What was useful? Not? Family history with counseling? For what reason? Was it helpful?

E) Goals

a) What are your goals?

b) What is your idea of the problem?

c) What are you willing/able to do to get better (with help?) (e.g., gain wt., stop dieting, eat normally, work through painful issues, memories, take medication)

d) What will you lose by giving up the ED?

Terms and Resources: Transitions and Resiliency in the International Community

The **grief** process is a normal reaction to the experience of physical, emotional, or occupational loss. Emotional reactions to grief may include: anger, guilt, anxiety, sadness, or despair. Physical reactions may include: sleeping or physical problems, changes in appetite, or illness.

<http://www.medterms.com/script/main/art.asp?articlekey=24274>

Transition is a passage or change, movement, development, or evolution from one form, state, stage, subject, style, or place to another. <http://www.merriam-webster.com/dictionary/transition>

Resilience: “manifestations of competence in children despite exposure to stressful events” (Garmezy, Masten, & Tellegen, 1984); “facing stress at a time and in a way that allows self-confidence and social competence to increase through mastery and appropriate responsibility” (Rutter, 1985); “successful adaptation despite risk and adversity; a pattern over time, characterized by good eventual adaptation despite developmental risk, acute stressors, or chronic adversities” (Masten, 1994); the ability to thrive, mature, and increase competence in the face of adverse circumstances” (Gordon, 1995).

http://ohioline.osu.edu/b875/b875_1.html

Coping is to effectively deal with something difficult. A coping skill is a behavioral tool which may be used to offset or overcome adversity without removing the underlying issue.

<http://en.wiktionary.org/wiki/Cope>

Stress is the “non-specific response of the body to any demand for change” (Selye, 1936).

<http://www.stress.org/topic-definition-stress.htm> Also see http://www.helpguide.org/mental/stress_signs.htm

Information for parents, teachers, counselors, and school psychologists

The process of grief is different for everyone due to personality factors, life experiences, and the nature of the loss. HelpGuide.org is a useful resource that explores the myths and facts about grief as well as the five stages of grief and common symptoms. http://www.helpguide.org/mental/grief_loss.htm

Change can be stressful, but a transition to something new doesn't have to be a negative experience. The American Counseling Association provides valuable strategies to help with transitions.

<http://www.counseling.org/Publications/CounselingCorner.aspx?AGuid=c5edb78e-5666-4c7c-ac54-907ec41492da>

Because transitions are inevitable, talking with children about changes will help them be more prepared when they occur. In the following article, Elizabeth Brokamp, a school counselor, offers ways to help children and parents cope with change:

<http://www.counseling.org/Publications/CounselingCorner.aspx?AGuid=69f76a5a-feb0-4d49-ac4d-3ff95de57c67> .

The iCHED (International Children's Education) website has articles available for teachers and parents that serve as a resource for understanding experiences of Third Culture Kids. This article briefly outlines the work of David Pollock and Ruth Van Reken from their book, *The Third Culture Kid Experience: Growing Up among Worlds*. http://www.iched.org/cms/scripts/page.php?site_id=iched&item_id=tck_experience

A directory linking kids and teens to a plethora of interesting, fun, and useful sites
http://www.google.com/Top/Kids_and_Teens/Health/Emotional_Health_and_Wellbeing/

Information for students

KidsHealth.org is a website by the Nemours Foundation for children and adolescents that provides a wide range of health-related information. <http://kidshealth.org/>

YouTube videos about the experiences of TCK's

What is a TCK? Explores characteristics unique to TCK's.

<http://uk.youtube.com/watch?v=KDwT3OWv75A&feature=related>

When TCK's move to new places and experience reentry, various factors are involved in adjustment.

http://uk.youtube.com/watch?v=0ETEgYF8yc&feature=channel_page

A story of the TCK experience and coping. <http://uk.youtube.com/watch?v=RKE9edtHbTE&feature=related>

Social support is of utmost importance for TCK's. <http://uk.youtube.com/watch?v=-9sSJymDuuM&feature=related>

A clip from BRATS: Our Journey Home, the first documentary about growing up military.

<http://www.youtube.com/watch?v=qCFZyG06zfY>

Interview with Donna Musil, filmmaker (BRATS), and Paulette Bethel. Discussion about college transition and creating a sense of belonging with people who have similar life experiences.

<http://www.youtube.com/watch?v=Rd-MDc3FIVk&feature=related>

Further resources

Third Culture Kids (TCKs)

Pollock, C. & Van Reken, R. (2001). *Third culture kids: The experience of growing up among worlds*, 2nd edition. London: Nicholas Brealey Publishing.

Websites:

- Families in Global Transition: <http://www.figt.org/>
- Global Nomads Virtual Village: <http://www.gnvv.org/>
- Interaction International: <http://www.tckinteract.net/> - TCK Support group founded by David Pollock.
- TCK World: <http://www.tckworld.com/>
- Third Culture Kids: Focus of a Major Study: <http://www.iss.edu/pages/kids.html>

Missionary Kids & Military Brats

Bowers, J. & McQuilkin, R. (1998). *Raising resilient MKs: Resources for caregivers, parents, and teachers*. Colorado Springs, CO: Association of Christian Schools International.

Eidse, F. & Sichel, N. (2004). *Unrooted childhoods: Memoirs of growing up global*. London: Nicholas Brealey Publishing.

Ender, M. (2002). *Military brats and other global nomads: Growing up in organization families*. London: Praeger Publishers.

Walters, D. (2004). *Missionary children: Caught between cultures*. Farmington Hills, MI: Gale Group.

Parenting Third Culture Kids

Pascoe, R. (1999). *Culture shock! Successful living abroad: A parent's guide*. Portland, OR: Graphic Arts Center Publishing Company.

Pascoe, R. (2006). *Raising global nomads: Parenting abroad in an on-demand world*. Vancouver: Expatriate Press Limited.

Adolescent and Children's Literature

Curnow McCluskey, K. (1994). *Notes from a traveling childhood: Readings for internationally mobile parents and children*. Washington, D.C.: Foreign Service Youth Foundation.

Mansfield Taber, S. (1997). *Of many lands: Journal of a traveling childhood*. Washington, D.C.: Foreign Service Youth Foundation.

Roman, B., Bickel, D., & Cadieux, M. (2003). *Footsteps around the world: Relocation tips for teens, 2nd edition*. Canada: BR Anchor Publishing.

Transitions and Living Abroad

Kalb, R. & Welch, P. (2007). *Moving your family overseas*. Lanham, MD: National Book Network.

Kohls, L. (2001). *Survival kit for overseas living, 4th edition: For Americans planning to live and work abroad*. London: Nicholas Brealey Publishing.

Websites:

- [At Home Abroad](http://www.iht.com/pages/athome/index.php) (regular section of the International Herald Tribune): <http://www.iht.com/pages/athome/index.php>
- US Department of State Links Page: <http://www.state.gov/m/dghr/flo/4580.htm>
- World Weave: <http://www.worldweave.com/GN.html>

Culture Shock

Rabe, M. (1997). *Culture shock! A practical guide: Living and working abroad*. Portland, OR: Graphic Arts Center Publishing Company.

Storti, C. (2007). *The art of crossing cultures*. Boston: Intercultural Press.

Trailing Spouses

Bryson, D. & Hoge, C. (2003). *A portable identity: A woman's guide to maintaining a sense of self while moving overseas*. Glen Echo, MD: Transition Press International.

Repatriation

Bell, L. (1997). *Hidden immigrants: Legacies of growing up abroad*. Notre Dame, IN: Cross Cultural Publications.

Pascoe, R. (2000). *Homeward bound: A spouse's guide to repatriation*. Vancouver: Expatriate Press.

Smith, C. (1996). *Strangers at home: Essays on the effects of living overseas and coming "home" to a strange land*. NY: Aletheia.

Smith, C. (1994). *The absentee American: Repatriates' perspectives on America*. NY: Aletheia.

Storti, C. (2001). *The art of coming home*. Boston: Intercultural Press.

International School Teachers

Langford, M., Pearce, R., Rader, D., & Sears, C. (2002). *The essential guide for teachers in international schools*. United Kingdom: John Catt Educational Ltd.

Parker, E. & Rumrill-Teece, K. (2001). *Here today there tomorrow: A training manual for working with internationally mobile youth*. Washington, D.C.: Foreign Service Youth Foundation.

References for research

- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: Sage Publications.
- Cobb, N. (2007). *Adolescence: Continuity, change, and diversity*. Boston: McGraw Hill.
- Compton, W. C. (2005). *An introduction to positive psychology*. Belmont, CA: Thomson/Wadsworth.
- Craske, M. G., Meadows, E. A., & Barlow, D. H. (2000). *Mastery of your anxiety and panic: MAP-3: Therapist guide for anxiety, panic, and agoraphobia* (3rd ed.). San Antonio, TX: Graywind Publications.
- D'Andrea, M., & Daniels, J. (2001). RESPECTFUL counseling: An integrative model for counselors. In D. Pope-Davis & H. Coleman (Eds.), *The interface of class, culture and gender in counseling* (pp. 417-66). Thousand Oaks, CA: Sage.
- Harris, A. H. S., Thoresen, C. E., & Lopez, S. J. (2007). Integrating positive psychology into counseling: Why and (when appropriate) how. *Journal of Counseling & Development*, 85(1), 3-13.
- Helfer, M. E., Kempe, R. S., & Krugman, R. D. (1997). *The Battered child* (5th ed.). Chicago: University of Chicago Press.
- Herman, J. (1997). *Trauma and Recovery*. New York: BasicBooks.
- Janoff-Bulman, B. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.
- Kushner, H.S. (1981). *When Bad Things Happen to Good People*. New York: Harper-Collins.
- LeDoux, J. E. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. New York: Simon & Schuster.
- Levine, P. A. (1997). *Waking the tiger: Healing trauma: The innate capacity to transform overwhelming experiences*. Berkeley, CA: North Atlantic Books.
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71(3), 543-562.
- National Child Traumatic Stress Network. (2008). *National Child Traumatic Stress Network - Child Trauma Home* Retrieved February 9, 2009, from <http://www.nctsn.org>
- O'Halloran, M.S. & O'Halloran, T. (2001). Teaching courses on trauma and violence: Addressing the issues and the individuals. *Teaching of Psychology*, 28(2), 92-97.
- Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, 390-395.
- Pukay-Martin, N. D., Cristiani, S. A., Saveanu, R., & Bornstein, R. A. (2003). The relationship between stressful life events and cognitive function in HIV-infected men. *Journal of Neuropsychiatry & Clinical Neurosciences*, 15(4), 435-441.
- Rothschild, B. (2003). *The body remembers casebook: Unifying methods and models in the treatment of trauma and PTSD* (1st ed.). New York: W.W. Norton.

Saakvitne, K. W., Gamble, S., Pearlman, L. A., & Lev, B. T. (2000). *Risking connection: A training curriculum for working with survivors of childhood abuse*. Baltimore, MD: The Sidran Press.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, 55(1), 5-14.

Skovholt, T. M. (2001). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. Boston: Allyn and Bacon.

Van der Kolk, B. A., McFarlane, A. C., & Weisæth, L. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: Guilford Press.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, 18(5), 389-399.

Government Publications

U.S. Department of Health and Human Services. (2003). *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations* (DHHS Pub. No. SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Children/Teen Web Sites

American Academy of Child and Adolescent Psychiatry. (2009). *American Academy of Child & Adolescent Psychiatry* <http://www.aacap.org>

American Academy of Pediatrics. (n.d.). *Children & Disasters: Disaster Preparedness to Meet Children's Needs* <http://www.aap.org/disasters/index.cfm>

Child Trauma Academy. (n.d.). *Welcome to Child Trauma Academy* <http://www.childtrauma.org/>

Children's National Medical Center. (2009). *EMSC Publications and Resources* <http://www.childrensnational.org/EMSC/PubRes/PDPreparedness.aspx>

National Child Traumatic Stress Network. (2008). *National Child Traumatic Stress Network - Child Trauma Home* Retrieved February 9, 2009, from <http://www.nctsn.org>

Substance Abuse and Mental Health Services Administration. (2009). *Substance Abuse and Mental Health Services Administration (SAMHSA) Website* <http://www.samhsa.gov>

http://www.google.com/Top/Kids_and_Teens/Health/Emotional_Health_and_Wellbeing/

A directory linking kids and teens to a plethora of interesting, fun, and useful sites

Adult Web Sites

American Red Cross. (2009). *American Red Cross* <http://www.redcross.org>

United States Department of Veterans Affairs. (2007). *National Center for PTSD* <http://www.ncptsd.va.gov>

National Institute of Mental Health. (2009). *NIMH* <http://www.nimh.nih.gov>

Substance Abuse and Mental Health Services Administration. (2009). *Substance Abuse and Mental Health Services Administration (SAMHSA) Website*: <http://www.samhsa.gov>

Specific websites cited:

Colorado Department of Human Services. (n.d.). *Stress Management*.
http://www.cdhs.state.co.us/dmh/PDFs/Disaster_RedPages_Stressmgmt.pdf

The Trustees of the University of Pennsylvania. (2006). *Authentic Happiness - Using the New Psychology* <http://www.authentichappiness.sas.upenn.edu/>

Guide to Cultural Awareness (APA)
http://www.apapractice.org/apo/in_the_news/new_cultural_guidelines.BottomPar.0001.file.tmp/Cultural%20Awareness.pdf