Dear Cape Cod and Islands Community:

On October 4th, 2013, a small group of dedicated behavioral health providers and consumers representing local agencies organized the first behavioral health summit on Cape Cod and the Islands to a sold-out crowd. The outcome of our summit was the creation of the Behavioral Health Provider Coalition of Cape Cod & the Islands (BHPCCCI) whose primary purpose is to facilitate opportunities for networking, communication, and sharing of knowledge between service providers in order to support an integrated and cohesive system of behavioral healthcare for residents of Cape Cod and the Island.

The BHPCCI is proud to highlight these opportunities at our 6th Annual Behavioral Health Summit on Friday, October 5th at the Resort and Conference Center at Hyannis. This year's Summit showcases **"Wellness Through the Behavioral Health Lens: Recognition, Resiliency, and Recovery"**

Presenters at this year's summit include internationally known speakers, healthcare leaders, peer advocates and public safety officials. They will present their experience and expertise in addressing wellness through the behavioral health lens recognizing resiliency and recovery for ourselves and for our patients. The Summit is designed for those who provide care or support services across the entirety of the behavioral health and primary care spectrum including physicians, psychologists, social workers, counselors, nurses, administrators, peer advocates, first responders, public safety, teachers and other health professionals serving children/adults and their families in our community.

Please join us in welcoming our presenters and we hope you find today's agenda educational and informative. BHPCCI thanks you for your participation as we move forward to improve the quality of care to our residents of Cape Cod and the Islands. If you would like to become a member of the BHPCCI Coalition, please visit our website at www.bhpccapecod.org.

Respectfully,

Dan Gray and Diane Ofria
Co-Chair/s, Behavioral Health Provider Coalition of Cape Cod & the Islands

The BHPCCCI would also like to thank the following organizations for their continued support and commitment in making sure our Behavioral Health Summit is a success.

Cape Cod Healthcare · Cape Cod 5 · Duffy Health Center · Gosnold on Cape Cod (Prevention | Intervention | Treatment | Recovery) · vinfen (transforming lives together) · Relief Home Health Services Inc. · Cape & Islands Suicide Prevention Coalition · Whole Health Pharmacy · Recovery Centers of America 1-800-RECOVERY

Summit Schedule - Friday, October 5th

8:00 am to 8:30 am – Registration

8:30 am to 8:45 am – Welcome and Introductions

Welcome: Raymond V. Tamasi – Gosnold on Cape Cod

Sponsorship Introductions: Kumara Sidhartha, MD, Medical Director, Cape Cod Preferred Physicians – Cape Cod Healthcare; Patricia Cawley, Director of Case Management & Integrated Services – Duffy Health Center; Richard Curcuru, LICSW, President & CEO, Gosnold on Cape Cod

Opening Keynote Speaker | 08:45AM – 10:15 AM

The Power of Mindsets: Nurturing Hope and Resilience in Ourselves and Others

ROBERT B. BROOKS, PH.D., CONSULTANT IN PSYCHOLOGY, MCLEAN HOSPITAL AND ASSISTANT PROFESSOR OF PSYCHOLOGY, DEPARTMENT OF PSYCHIATRY, HARVARD MEDICAL SCHOOL

Breakout Review | 10:15 AM – 10:20 AM – Review of breakout sessions

10:30– 10:45 am – MORNING BREAK

Morning Breakout Sessions | 10:45 AM – 12:00 PM

Session 1 - **Recognition -** *How do you begin (or have) the conversation?* **Marty Ferrero, MA, LADC, CMAT**, Senior Clinical Director, Caron Treatment Center Older Adult Program; **Daria Hanson, MD**, Chief Medical Director, Department of Psychiatry, Cape Cod Healthcare; **Chris Morin,** Director of Prevention, Education & Outreach, Independence House; **Kumara Sidhartha, MD**, Medical Director, Cape Cod Healthcare Preferred Physicians

Session 2 - *Road to* **Resilience** *for First Responders, Mental Health Clinicians and Caregivers* **Manny Marrero, MOT, OTR/L, FCE**, Partial Hospital Program Clinician, Cape Cod Hospital; **Sgt. Kevin Marshall**, Crisis Intervention Team Coordinator, Nantucket Police Department; **Lori Myles, LMHC**, Southeast Service Director, Emergency Services Program, BayCove Human Services; **Sgt. George Neilson**, Level III Certified Instructor, Massachusetts Municipal Police Training

Session 3 - *Building Supportive Pathways to* **Recovery** *on Cape Cod* **Stephanie Briody**, Co-Founder, Behavioral Health Innovators; **Amy Doherty,** Founder, Wellstrong; **Sarah Ducie**, Peer Mom Specialist, Moms Do Care Program, Duffy Health Center; **Don Lonergan, Jr.,** Lead Peer, Vinfen; **Adrienne Morosini, LICSW**, Partial Hospital Program Clinician, Cape Cod Hospital; **Jason Raineri**, Certified Peer Specialist

Lunch | 12:00 – 12:45 PM

Afternoon Breakout Sessions – REPEAT OF MORNING SESSIONS | 1:00 PM - 2:15 PM

Excellence in Behavioral Health Service Award | 2:15 – 2:30 PM

Closing Keynote Speaker | 2:30 PM – 3:45 PM **(1.25 hrs)**

A Medicine of Hope and Possibility: Hope for both patients and practitioners

JEFFREY D. REDIGER, MD, MDIV - MEDICAL DIRECTOR MCLEAN SOUTHEAST PSYCHIATRIC PROGRAMS AND INSTRUCTOR IN PSYCHIATRY AT HARVARD MEDICAL SCHOOL

Closing Remarks | 3:45 PM - 4:00 PM

Behavioral Health Provider Coalition
of Cape Cod and the Islands

"The Power of Mindsets: Nurturing Hope and Resilience in Ourselves and Others"

Dr. Robert Brooks has lectured nationally and internationally to audiences of parents, educators, mental health professionals, and business people on topics pertaining to motivation, resilience, family relationships, the qualities of effective leaders and executives, and balancing our personal and professional lives. Dr. Brooks presentation will describe the concept of mindsets, especially focusing on the components of a "resilient mindset." He will highlight strategies we can use to develop this mindset and accompanying behaviors in ourselves in order to lessen stress and burnout and become more resilient. He will also emphasize how these same strategies can be applied to members of the community whom we serve.

Dr. Brooks received his doctorate in clinical psychology from Clark University and did additional training at the University of Colorado Medical School. Dr. Brooks is on the faculty of Harvard Medical School and has served as Director of the Department of Psychology at McLean Hospital, a private psychiatric hospital. His first position at McLean Hospital was as principal of the school in the locked door unit of the child and adolescent program. He has a part-time private practice in which he sees children, adolescents, adults, and families and has appeared regularly on television shows in the Boston area as well as on national cable television. He completed a videotape and educational guide for PBS titled "Look What You've Done! Stories of Hope and Resilience" that focuses on resilience in children with special needs and participated in the production of two videotapes by Sunburst Communications, one about parenting children with learning and attentional problems and the other about developing responsibility in children.

Dr. Brooks received a Gubernatorial Award for Distinguished Public Service for his work with the Governor's Alliance Against Drugs; as part of his contribution to the Alliance, he co-authored a pamphlet for parents about talking with children and adolescents about drugs. Dr. Brooks also received "Hall of Fame" awards from both CH.A.D.D. (Children and Adults with Attention Deficit Disorders) and the Connecticut Association for Children with Learning Disabilities for his work with special needs children and adolescents, a Special Recognition and Media Award from the Massachusetts Psychological Association, the Friends of Family Award from the Family Place, MA and the Mandy Overton Award from St. David's Child Development and Family Services, Minnetonka, MN for his work on behalf of children and families, The Lifetime Achievement Award from the Prentice School in Santa Ana, CA for his efforts on behalf of students with learning differences, the Distinguished Leadership Award from Learning Disabilities Worldwide in recognition of his contributions and commitment to the field of learning disabilities, and the Outstanding Educator Award for Mental Health Education from the New England Educational Institute, Pittsfield, MA. In addition, Dr. Brooks has served as a consultant to Sesame Street Parents Magazine.

Bibliographies

Brooks, R. & Goldstein, S. (2001). *Raising Resilient Children: Fostering Strength, Hope, and Optimism in Your Child.* New York: McGraw-Hill.

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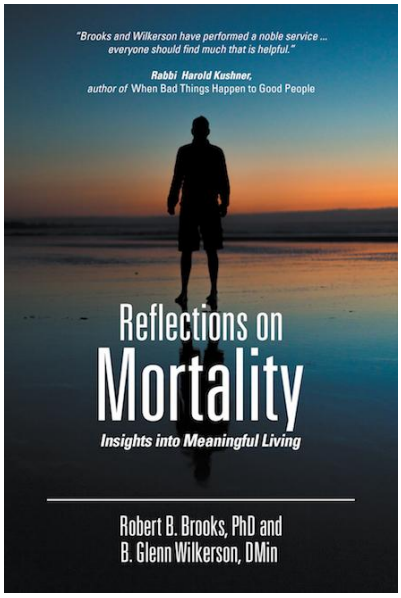
Brooks, R. & Richman, D. (2010). *The Charismatic Advisor: Becoming a Source of Strength in the Lives of Your Clients.* Boston: Charismatic Advisor Publishing.

Reflections on Mortality



Insights into Meaningful Living

By: Robert B. Brooks, PhD & B. Glenn Wilkerson, DMin

About Reflections on Mortality

Many of us fill our lives with so much work, entertainment, and fluff that we fail to consider the reality that our personal journeys on earth must someday come to an end.

This collection of essays and articles points out that human existence is a fragile, terminal gift. Accepting that encourages us to live dynamic, purposeful lives.

Combining insights from thought leaders in the fields of medicine, mental health, and religion, as well as hospice directors, funeral directors, and those who have faced life-threatening situations, the writers and editors of this book share their honest, open views about death, dying, and the possibilities of an afterlife

This is a version of a chapter that appears in *Resilience Interventions for Youth in Diverse Populations* edited by Sandra Prince-Embury & Donald Saklofske. New York: Springer, 2014, pp. 59-82.

Creating Resilient Mindsets in Children and Adolescents: A Strength-Based Approach for Clinical and Nonclinical Populations

Robert Brooks, Ph.D.
Harvard Medical School and McLean Hospital
Suzanne Brooks, Psy.D.
School Psychologist, Weston, MA Public Schools

During the past 25 years there has been a burgeoning interest in the study of resilience in children and adolescents (Beardslee & Podorefsky, 1988; Brooks, 2011; Brooks & Goldstein, 2001, 2007, 2011; Crenshaw, 2010; Goldstein & Brooks, 2012; Goldstein, Brooks, & DeVries, 2013; Prince-Embury & Saklofske, 2012; Werner & Smith, 2001). As described by Masten (Masten, 2001; Wright, Masten, & Narayan, 2013), there have been four different phases or "waves" in examining resilience.

Initially, the focus was on understanding those factors within individuals who had encountered and coped successfully with significant adversity in their lives. A second wave examined developmental processes that contributed to resilience and paralleled the emergence of the field of *developmental psychopathology*. This phase is represented by a greater focus on contextual and developmental variables and not simply on factors residing within the individual.

Masten termed the third wave "intervening to foster resilience," which encompassed both intervention and prevention approaches. Wright, Masten, and Narayan (2012) noted, "Using lessons from the first two waves, investigators of the third wave began to translate the basic science of resilience that was emerging into actions intended to promote resilience" (p. 27). The current fourth wave is focused on "multilevel dynamics and the many processes linking genes, neurobiological adaptation, brain development, behavior, and context at multiple levels" (p. 30). It involves the study of resilience from many vantage points, including genes, gene-environment interaction, and social interaction.

This chapter will include content that is most identifiable with the third wave with an emphasis on both intervention and prevention, but we recognize that the fourth wave embraces an exciting multidisciplinary, multilevel approach that will provide increased information about the forces that contribute to resilience in children and adolescents. Our goal is to outline a framework with specific strategies that can be applied not only to intervene when youth are already experiencing adversity, but also in a preventative way so as to equip all youth with skills necessary to manage future problems they may encounter. We will examine the importance of a strength-based approach with both

clinical and non-clinical populations. In setting the stage for this discussion, we will review the key concepts that serve as a foundation for our viewpoint.

Invulnerable Children?

Some of the earliest writings about resilience focused on studying those children who had experienced significant adversity in their childhood (e.g., physical or sexual abuse; being parented by an adult with an emotional disorder) but as adults were faring well in both their personal and work lives. These youngsters were frequently given the label "invulnerable" (Anthony & Cohler, 1987), which could be interpreted to imply that they were "superboys" or "supergirls" who possessed unusual inborn powers that allowed them to overcome the hardships they encountered. Conversely, to apply this label to a small, selected group of children could lead to the incorrect conclusion that the vast majority of children who were not born with these super-like powers would be incapable of overcoming childhood hardship and trauma.

Masten (2001), in an often-quoted article, eloquently challenged the notion of extraordinary powers involved in resilience. She stated:

> Resilience does not come from rare and special qualities, but from the everyday magic of ordinary, normative human resources in the minds, brains, and bodies of children, in their families, and in their communities. . . . The conclusion that resilience emerges from ordinary processes offers a far more optimistic outlook for action than the idea that rare and extraordinary processes are involved. The task before us now is to delineate how adaptive systems develop, how they operate under diverse conditions, how they work for or against success for a given child in his or her environmental and developmental context, and how they can be protected, restored, facilitated, and nurtured in the lives of children. (p. 235)

Masten's view, to which we enthusiastically subscribe, offers a more hopeful perspective that questions the assumption that only a small number of children possess certain extraordinary attributes necessary to master adversity.

Bonanno (2004) has arrived at a similar conclusion as Masten, primarily from his study of adults who have experienced trauma and loss. He observed:

> A review of the available literature on loss and violent or life-threatening events clearly indicates that the vast majority of individuals exposed to such events do not exhibit chronic symptom profiles and that many and, in some cases, the majority show the type of healthy functioning suggestive of the resilience trajectory. (p. 22)

In his thought-provoking book *The Other Side of Sadness* (2009), Bonanno offered this opinion:

> What is perhaps most intriguing about resilience is not how prevalent it is; rather it is that we are consistently surprised by it. I have to admit that sometimes even I am amazed by how resilient humans are, and I have been working with loss and trauma survivors for years. (p. 47)

Masten and Bonanno's conclusions are not meant to suggest that differences do not exist in the ways in which children or adults cope with adversity. Rather, their view supports the belief that all individuals and not just a small few possess the capacity to become increasingly resilient. Such a belief offers as Masten noted, an "optimistic outlook." It also serves as a challenge to identify those actions that adults must initiate to bring this ordinary magic to fruition in all youngsters.

Resilience Applied to All Individuals: A Belief in Intervention and Prevention

A number of years ago, the first author was invited by a group of parents to give an evening talk about "Raising Resilient Children and Adolescents." A few days prior to Bob's presentation, a woman contacted him and questioned whether his talk would be relevant for her.

She said, "I have three children, ages 8, 11, and 13. They are doing very well in all areas of their lives. Fortunately, they have not faced really difficult situations like some kids do. They do well in school, enjoy sports, and have a number of friends. My husband and I have provided a very loving home. Thus, I'm not certain if a discussion about resilience or what I guess is bouncing back from hardship would pertain to my kids or our family situation."

This mother's question reflected a common and often accepted view of resilience, namely, that the term should be applied only to those individuals who have overcome hardship to lead more satisfying lives—lives that have not been noticeably derailed by major risk factors in their childhood histories. Certainly this view is valid and has prompted much of the research found in the resilience literature. However, as we will detail below, we believe the concept of resilience deserves to be broadened.

Bob's response to this mother captured a shift that had occurred in his thinking that was to become the basis for the ideas he and his colleague Sam Goldstein have advanced in their work and writings about resilience (Brooks & Goldstein, 2001, 2004, 2007). Bob told her that while it is true that research about resilience was rooted in the study of children who had effectively dealt with significant challenges, the way in which he visualized the concept of resilience was that it should be expanded to apply to every child and adolescent and not restricted to those who have experienced hardship. He noted that all youngsters are likely to face stresses at different points in their lives and even those who at one point would not be classified as "at-risk" might suddenly find themselves in that category.

This woman and her husband attended Bob's talk and afterwards informed him that the points he offered were indeed relevant for the ways in which they parented their three children.

The wealth of information collected from examining the lives of youngsters who have successfully managed hardships should certainly be applied by parents, teachers, mental health, and other childcare professionals to design and implement interventions for fostering hope and resilience in children with problematic histories. However, Brooks

and Goldstein (2001, 2007) proposed that this same information was equally relevant in directing our interactions with all children. The adoption of a more inclusive definition of resilience encourages the emergence of a proactive, preventative approach.

Other mental health specialists have also expanded the definition or scope of resilience to go beyond bouncing back from adversity. Reivich and Shatte (2002) contend that "everyone needs resilience," by which they explained:

> . . .resilience is the capacity to respond in healthy and productive ways when faced with adversity and trauma; it is essential for managing the daily stress of life. But we have come to realize that the same skills of resilience are important to broadening and enriching one's life as they are to recovering from setbacks. (p. 20)

In defining the characteristics of resilience, Brooks and Goldstein (2001) included: the capacity to deal effectively with stress and pressure, to cope with everyday challenges, to rebound from disappointments, mistakes, trauma, and adversity, to develop clear and realistic goals, to solve problems, to interact comfortably with others, and to treat oneself and others with respect and dignity. A guiding principal in each interaction that adults have with children, whether in homes or schools or the office of a therapist, should be to strengthen these attributes, which we subsume under the concept of *resilient mindsets*. We now turn to the topic of *mindsets.*

The Power of Mindsets

The concept of mindsets has become an increasingly prominent area of study, especially with the emergence of the field of "positive psychology." As examples, Dweck authored a book titled *Mindset* (2006) in which she distinguished between a "fixed" and "growth" outlook; the research of Seligman and his colleagues about "learned helplessness" and "learned optimism" as well as resilience (Reivich & Shatte, 2002; Seligman, 1990, 1995) have underpinnings in attribution theory, which is basically about mindsets, examining how we understand the reasons for our successes and mistakes (Weiner, 1974).

Brooks and Goldstein (2001) noted that resilient children possess certain qualities and/or ways of viewing themselves and the world that are not apparent in youngsters who have not been successful in meeting challenges. The assumptions that children have about themselves and others influence the behaviors and skills they develop. In turn, these behaviors and skills influence the set of assumptions so that a dynamic process is constantly operating. This set of assumptions may be classified as a *mindset*.

Identifying the components of a resilient mindset, which are described in greater detail below, provides invaluable guideposts for parents as they interact with their children. Knowledge and application of these components are essential for teachers and therapists as well. Adults who adhere to these guideposts have a compass by which to reinforce resilience in children. While the outcome of a specific situation may be important, even more vital are the lessons learned from the process of dealing with each

issue or problem. The knowledge gained in the process provides the nutrients from which the seeds of resiliency will flourish (Goldstein, Brooks, & DeVries, 2013).

In discussing the concept of mindsets it is important to keep in mind that not only do we possess assumptions about ourselves, but whether we realize it or not, we are constantly making assumptions about the behavior of others. These assumptions, even if unstated, have a significant impact in determining effective parenting, teaching, and therapeutic practices, the quality of relationships with children, and the positive or negative climate that is created in home, school, and other environments.

"Punishing a Suffering Child"

As one example of the impact of mindsets, Janet Norton, a single parent of five-year-old Amanda, contacted Bob and said during this initial phone call, "I'm desperate." She described how prior to becoming a parent she told herself that she would never resort to spanking. Yet, she was currently spanking Amanda several times a day, asserting, "It's the only way she'll listen to me and even that doesn't last too long."

In her first appointment Janet described Amanda as a very challenging child to satisfy even from birth, one who often had tantrums, especially when she did not get what she wanted. "Everything is a struggle with Amanda. Nothing pleases her. Things would be so much easier if only she would cooperate more with what I ask her to do. I don't think I'm asking too much of her."

In listening to Janet's description of Amanda and guided by an appreciation of the influence that mindsets have on our reactions to different people and situations, Bob asked, "How do you understand Amanda's behavior or why she acts the way she does?"

Janet hesitated and then replied, "I would tell you, but I think you would think I was crazy."

"Crazy for telling me how you understand Amanda's behavior?"

"Yes."

Again, directed by the ways in which mindsets influence our behaviors, Bob inquired, "Do you know why I asked about how you understood Amanda's behavior?" (We will often pose this kind of question with patients, both as a way of beginning a discussion about mindsets as well as developing a collaborative relationship in which ideas and comments are shared and understood.)

Janet thought for a moment and answered, "I'm not certain."

Bob responded, "In my experience how we understand or interpret someone else's behavior, what I often refer to as our mindset, will determine how we respond to that person."

"That certainly makes sense, but what I'm going to say may still seem crazy. Sometimes I feel that Amanda has a *personal vendetta* against me, that it's like she's always thinking of ways to upset me."

Bob's initial response was to tell Janet that he knew it took a great deal of courage for her to share this view with him—the moment he used the word *courage* Janet seemed

to become more relaxed—and while a *personal vendetta* might be one explanation, there might be other explanations as well. (Aware of Janet's anxiety that Bob would indeed experience her *personal vendetta* interpretation as a sign of her being crazy, he was careful not to judge this explanation but rather to offer another possibility.)

Janet was eager to hear Bob's alternative explanation, which involved a discussion of the different temperaments with which children are born. He cited the seminal work of Chess and Thomas (1996). He said that while some children are born with what researchers have labeled *easy* temperaments, others possess temperaments that are seen as *difficult.* Bob told Janet that from her description, Amanda met many of the criteria for this latter label.

As the discussion continued, Janet wondered that if a child like Amanda is born with a difficult temperament, would she always be difficult even into her teen and adult years. Bob offered realistic reassurance by noting that once adults are aware that a child has certain challenging temperamental qualities, there are techniques they can use to lessen these negative qualities.

Janet then plaintively said, "So I guess that many of the things I've spanked her about were really things she did not have control over."

"Yes, but that doesn't mean we can't help her to gain more control and be more cooperative now without having to spank her."

Janet teared up and offered a very poignant comment, "As I think of all we've talked about, all I can think about is that I've been *punishing a suffering child*."

Bob empathized with Janet and added, "But that's before you really knew about temperament or different strategies to deal with children who are more difficult to parent. We can begin to consider other strategies for interacting with Amanda that do not involve spanking."

Janet was very motivated to learn these other strategies. As she did, her confidence as a parent increased and her relationship with Amanda improved noticeably. She no longer spanked her daughter, observing, "Why would anyone want to spank a suffering child?"

The shift in mindset from a *personal vendetta* to a *suffering child* prompted an entirely different parental approach, which would not have been possible without this change in perspective. In turn, the shift in mindset was reinforced with the positive changes that occurred in Amanda's behavior. Janet developed a more easy-going, satisfying relationship with her daughter and Amanda responded in kind.

"It Seems Like He Wants to Disrupt the Class"

Both authors have collaborated closely with educators. Suzanne meets regularly with teachers in her position as a school psychologist in a district outside Boston as well as in her private practice. Not surprisingly, educators bring assumptions about student behavior into all of their interactions with those in their classrooms and schools. Similar to parents and other caregivers, the more aware they are of these assumptions, the more

they can modify those beliefs that may work against the creation of a positive classroom environment (Brooks, Brooks, & Goldstein, 2012).

Even those assumptions about which we may not be cognizant have a way of being expressed and understood by students. Suzanne consulted with a teacher about Jonathan, an 8-year-old private patient who had learning and attention problems. The child constantly asked questions in class, which triggered the teacher's annoyance and frustration. In discussing Jonathan with Suzanne, the teacher became aware that her annoyance was rooted, in part, in her assumption that his constant asking of questions was an intentional ploy to distract her and the class.

In her consultation, Suzanne reframed the purpose of Jonathan's questions, using information from the evaluation she had conducted, including test data as well as parent and teacher observations. She highlighted both his anxiety as he attempted to understand the material as well as his impulsivity, which contributed to his constant questions.

The teacher displayed refreshing openness in changing her assumptions about Jonathan's behavior, which paved the way for a shift in her approach. Knowing that the presentation of new material was especially problematic and anxiety-provoking for Jonathan, she asked her student teacher to prepare him in advance for this material. She also established a "question time" in which she or the student teacher would put aside a few minutes each hour to listen to and answer Jonathan's questions, a practice that actually decreased the amount of time she had to spend with him. Jonathan felt less anxious knowing that he had this "question time" available, which allowed him to hold off from asking constant questions in class. Another strategy was having Jonathan write down pressing questions to be reviewed at "question time," a technique that addressed his impulsivity.

Most telling was when Jonathan informed his parents that he thought his teacher really liked him. In fact, his assessment was accurate given her change in mindset and the accompanying implementation of effective strategies.

The Characteristics of a *Resilient Mindset*

Given the power of mindsets in determining our behavior, we propose that a major goal for psychotherapists is to reinforce a mindset in patients that is associated with hope and resilience. This goal will be facilitated if therapists are able to identify the attributes of what Brooks and Goldstein (2001) have labeled a *resilient mindset* and nurture these attributes both in the therapy session and in consultation with significant adults in the youth's life. As we emphasized earlier, the same strategies to help at-risk youngsters to become increasingly resilient can be used with children who do not display developmental issues. They are applicable to both clinical and non-clinical populations.

A mother at a presentation that Bob gave for parents of children with special needs summed up this point very succinctly with the following comment:

"As you were talking I realized that all of the resilience strategies you described that would be helpful for my child with special needs are just as applicable for my two

children who do not have special needs. Parents would want all of their children to have a resilient mindset."

Bob wholeheartedly agreed with this mother's observation.

It is our position that understanding the features of a resilient mindset provides parents, therapists, educators, and other professionals specific guideposts to help children manage challenges effectively and to develop those characteristics associated with this mindset.

The mindset of resilient children is comprised of a number of noteworthy feelings and beliefs that are associated with specific skills. Resilient children:

--Feel loved and accepted

--Have learned to set realistic goals and expectations and goals for themselves

--Are able to define the aspects of their lives over which they have control and to focus their energy and attention on those, rather than on factors over which they have little, if any, influence

--Believe that they have the ability to solve problems and make good decisions

--Take realistic credit for their successes and achievements but acknowledge the input and support of adults for these successes

--View mistakes, setbacks, and obstacles as challenges to confront and master rather than stressors to avoid

--Recognize and accept their vulnerabilities and weaknesses, seeing these as areas for improvement, rather than unchangeable flaws

--Recognize, enjoy, and use their strengths or what we call their "islands of competence"

--Feel comfortable with and relate well to both peers and adults

--Believe that they make a positive difference in the lives of others.

To Serve as a "Charismatic Adult"

The key to being an effective therapist or parent or teacher is to view each interaction with a child as an opportunity to reinforce one or more of these characteristics. As noted above, these characteristics serve as guideposts in our day-to-day relationship with children. If we are to use these guideposts consistently and successfully, if we are to lessen our own disappointment, frustration, and possible burnout in our professional or parenting roles, we must keep in mind a basic finding in resilience research, namely, that resilience is rooted in great part in the relationship that children experience with caring adults (Brooks & Goldstein 2001, 2004). The late psychologist Julius Segal, whose work focused on factors that assisted children to master challenges, eloquently noted (1988):

> From studies conducted around the world, researchers have distilled a number of factors that enable such children of misfortune to beat the heavy odds against them. One factor turns out to be the presence in their lives of a *charismatic adult*—a person with whom they can identify and from whom they gather strength. (p. 3)

Bob found Segal's notion of a *charismatic adult* thought-provoking. It immediately prompted him to ask the following questions in therapy sessions with parents or in consultations with teachers:

"When I put my children to bed at night, do I consider this question, 'Is my son or daughter a stronger person because of things I've said or done today or are they less strong? Have they gathered strength from me?'"

"At the end of the school day, do I as a teacher ask this question, 'Are all of the students in my classroom stronger because of things I've said or done today or are they less strong? Have they gathered strength from me?'"

Bob also asked himself as well as therapists he supervised questions similar to those for parents and educators, namely:

"At the end of each therapy session, is my patient stronger because of things I've said or done or is my patient less strong and hopeful? Has my patient gathered strength from me?'"

These are not easy questions to answer, especially since the concept and measurement of strength are far from precise. However, when Bob has informed parents, educators, and therapists about the notion of a *charismatic adult*, and posed the questions listed above, the response has been noteworthy. It is not unusual for Bob to hear parents, teachers, or therapists report that they want to be that kind of figure in the lives of their children or students or patients. It is not unusual for him to hear, "I want to be a charismatic adult. What do I say and do?"

The answer is found in identifying and applying those strategies that reinforce the attributes of a resilient mindset.

Strategies for Nurturing a Resilient Mindset

We have chosen several of the main attributes of a resilient mindset to highlight in the remainder of this chapter. We will describe how they can be nurtured by therapists, educators, and/or parents. This task will be facilitated if all of these adults work in concert with each other.

To believe that adults can be supportive and helpful. The relationship we develop with children is of paramount importance in helping them feel safe, secure, accepted, and loved so that they may become resilient. This statement may appear so obvious that some may question its inclusion. However, our purpose in listing this point is so we might consider different ways in which to help children feel safe and accepted whether at home, or school, or in a therapist's office.

A major skill in fostering these positive feelings in children is for the adults in their lives to truly practice being *empathic*, always attempting to see the world through the child's eyes. In our work with parents and educators we pose certain questions that bring focus to the question of empathy. We have received feedback that these questions elicited much self-reflection, especially in terms of one's interactions with children. The questions include:

"How would I feel if someone said or did to me what I just said or did to my child (student, patient)?

"When I say or do things with my children (students, patients), am I doing so in a way that will help them realize I love and care about them so that they will be most responsive to listening to me?"

"How would I hope my children (students, patients) described me?"

"What have I done on a regular basis so that my children are likely to describe me in the ways I hope they would?" (This particular question encourages adults to consider a specific plan of action that they can take to enrich their relationship with children they are raising or with whom they are working.)

"How would my child (student, patient) actually describe me and how close is that to how I hope they would describe me?"

"If there is a discrepancy between the hoped for and actual descriptions, what steps must I take to lessen that discrepancy?" (Another question to prompt a plan of action.)

An example of the use of these questions to help parents become more empathic and charismatic adults in the life of their child took place with Sally, a shy, 8-year-old who was frequently reminded by her parents Sue and Alan Carter, to say hello to people. The first question that greeted Sally after school was, "Did you speak with anyone in school today? If you don't make the effort, you're not going to have any friends." These kinds of comments backfired, prompting Sally to become increasingly anxious.

The Carters, worried about Sally and desiring her to be more outgoing, failed to appreciate that Sally's cautious demeanor was an inborn temperamental trait that could not be overcome by exhorting her to say hello to others or make friends. Each reminder on their part intensified Sally's discomfort and compromised the development of a warm, supportive relationship with her.

Parent counseling focused on changing their mindset about Sally so that she would experience her parents as supportive rather than critical. They were asked to consider how their current actions and words impacted on their daughter. If they were shy, how would they feel if someone said to them, "You have to make an effort to speak with other kids or you won't have friends"? These questions helped Sue and Alan develop a more empathic stance towards Sally.

They asked how they might approach Sally and if they should avoid saying anything at all about her shy behavior. They were encouraged not to avoid the subject, but rather to help Sally by expressing empathy and by having her feel they were on her side and not judging her. In parent counseling they learned to say to Sally that they knew it was not easy for her to say hello to people she didn't know, adding it was not easy for other children as well. Such a statement, expressed in a genuine fashion, conveyed empathy and also, helped to normalize the problem she faced. Normalizing a problem

permits children as well as adults to feel that they are not alone—a very reassuring feeling.

Sue and Alan then created a problem-solving atmosphere, which as we will highlight below is a major component of resilience. They suggested to Sally that perhaps the three of them working together could figure out small steps that she could begin to take to make it less difficult for her to greet others. They also offered realistic hope by asserting, "Many kids who have trouble saying hello when they're young, find it easier as they get older."

These changes contributed to a more positive relation between Sally and her parents and served as a catalyst for Sally to take the "small steps" Sue and Alan had suggested. Sally's belief that her parents were supporting rather than judging her was a significant change in her mindset that allowed her to venture forth more confidently in her daily interactions with others.

In therapy, there are comments that clinicians can offer that highlight their wish to be empathic and to understand the perspective of their patients. These comments, timed for the appropriate moments, frequently serve to lessen defensiveness and enrich the alliance between the therapist and the patient. They include:

"If you ever feel I'm not understanding something you're trying to tell me, please let me know."

"If you ever feel I'm being critical of you or judging you, please let me know since that would never be my intention." (We have found this comment to be very powerful with children as well as their parents who are quick to feel that they are being judged.)

"If I ever ask you a question and you're not certain why, don't hesitate to ask me why I'm asking the question." (Bob used a similar statement with Janet Norton as he inquired about what her understanding was of her daughter's behavior.)

These and similar statements should not be seen as rigid scripts to be applied indiscriminately but rather as a genuine reflection of the therapist's wish to develop a warm, caring, and empathic relationship with children and their families.

In the home environment there are numerous ways of helping our children to feel secure, loved, and accepted whether they display developmental, behavioral, or emotional problems or not. As we have seen with Janet Norton or Sue and Alan Carter, being an empathic, nonjudgmental parent is a critical attribute for developing a positive relationship with one's children.

In addition, in our parenting workshops we extol the importance of setting aside regular "special times" with our children that often involve a time alone with each child. Parents with young children have been advised to say to them, "When I read (or whatever activity is involved) to you, even if the phone rings, I'm not going to get it since this is our special time together."

A six-year-old boy said with excitement and joy, "I know my parents love me." When asked how he knew this, he responded, "When they read to me and the phone rings, they let the answering machine answer it." Parents should think about this boy's comments when involved with their children and put aside cell phones or any similar devices that distract our full attention from our children.

To appreciate that we have more control over our reactions to events than we may realize. Developing a sense of "personal control" in children is an essential feature of resilience. In identifying *personal control* as a key ingredient of a resilient mindset, Brooks and Goldstein (2004) offered the following description of this concept:

> Taking ownership of our behavior and becoming more resilient requires us to recognize that we are the authors of our lives. We must not seek our happiness by asking someone else to change, but instead always ask, *What is it that I can do differently to change the situation?* Assuming personal control and responsibility is a fundamental underpinning of a resilient mindset, one that affects all other features of this mindset. (p. 7)

While this statement focused primarily on resilience in adults, it is equally relevant for our interventions with children. As therapists, we should be sensitive to understanding whether children and/or their families are burdened by a victim's mentality. Such a mentality is dominated by thoughts and feelings associated with a sense of helplessness and hopelessness. Or, do they entertain the notion that while negative events have transpired in their lives over which they have little, if any, control, what they do have control over is their attitude towards and reaction to the events.

Seth, a nine-year-old boy with a diagnosis of ADHD, was not only struggling in school but with the recent divorce of his parents. In one session, frustrated and angry, he asked, "Why did God choose me to be the one with ADHD?"

It is not unusual for children or adults faced with adversity to ask, "Why me?" or "Why my child?" The problem occurs when the "Why?" question continues to dominate one's thinking year after year. Eventually, feelings of helplessness and a victim's mentality may become the prominent features of a person's mindset. Gerber, Ginsberg, and Reiff (1992) in studying adults with learning disabilities found that those who were more successful in different arenas of their lives had adopted the outlook, "I had no control over being born with learning problems, but I do have control in terms of how effectively I cope with those problems." The less successful adults kept asking, "Why did I have to be born with learning disabilities?"

So how might a therapist respond to Sean's question, "Why did God choose me to be the one with ADHD?" When asked what he thought, Sean could offer no explanation. Gerber, Ginsberg, and Reiff's (1992) findings offer direction. A resilience-based response might include the following: "We're not sure why some kids have ADHD and some don't, but the good news is that now that we know you have ADHD, there are

things that can be done to help kids like yourself and others with ADHD to have more success."

It is important for the therapist to understand both a child as well as a parent's notion of personal control. This understanding may be facilitated using a mindset model that was mentioned earlier in this chapter, namely, attribution theory (Weiner, 1974). Children who struggle with self-esteem and are not very hopeful or resilient believe that any success that comes their way is based on luck or chance or fate. They attribute success to factors that are outside their control, which lessens the probability of future accomplishment. In contrast, youngsters with a more positive outlook will give the adults in their lives credit for their assistance, but they basically believe—and not in an narcissistic way—that their success is predicated in great part on their own effort and resources.

An understanding of a child's beliefs about personal control can begin during the assessment phase. Samantha, a 12-year-old girl was referred to Bob given her feelings of sadness and loneliness coupled with low self-esteem and learning problems in school. During the first interview she immediately described her distress and obvious sense of hopelessness and helplessness. "I'm not very popular, I have trouble in school, and I'm terrible at sports. That's why I stay in my room a lot."

In response to Bob's questions, Samantha acknowledged that she wished things were different. Bob inquired what would she like to change.

Samantha readily responded, "I wish I was as pretty as the other girls and that I was popular and could play sports and get good grades in school."

As the discussion continued, Bob wondered if there was ever a time that Samantha felt more successful. Her reply could have been taken directly from a book illustrating the tenets of attribution theory. Samantha talked about a time another girl complimented her, but she dismissed this gesture by contending, "She felt sorry for me." She also minimized a good grade she received on an English paper with the comment, "I think the teacher was just trying to be nice."

Therapy with Samantha focused on changing these self-defeating attributions or assumptions. Bob, as he frequently does with children and adolescents, explained in language that Samantha could understand, the concept of mindsets and their impact on her behavior. A therapeutic goal was to modify Samantha's mindset by incorporating a more hopeful outlook. As this goal was being realized, Samantha attempted new scripts (Brooks & Goldstein, 2001, 2004) that led to positive outcomes. She "rehearsed" in therapy different ways of approaching a couple of girls with interests similar to her own. She also received assistance from a tutor, especially about preparing for tests, which led to improved grades. In place of sports, she cultivated an interest in painting and enrolled in an art class in a museum.

With each positive result, Bob was very active in asking, "Why do you think that what you did was successful?" Samantha understood why Bob was asking and soon in a playful manner would say, "I know what you're going to ask."

"You do?"

"You were going to ask why I thought I was successful?"

With humor Bob replied, "Wow! I must be really predictable. But let me ask, 'Why do you think you were successful?'"

While the use of humor was involved in this dialogue, an important shift in her outlook occurred when Samantha could acknowledge that her success was based not only on the help of others but, as importantly, on her own effort.

This shift in mindset towards a sense of "personal control," is one that all therapists should assist their patients to adopt. Suzanne regularly reinforces a feeling of personal control in her therapy sessions with children who are experiencing difficulties in school. Anna, an 8-year-old, was beset with social anxiety. Although she was willing to talk with Suzanne about her interests, she became paralyzed when the discussion turned to peer relationships and school. Her teacher reported that Anna hesitated to join groups of two or more children, particularly on the school playground. As long as Anna continued to feel paralyzed in confronting her problems, it would be almost impossible for her to develop a sense of personal control and become resilient.

In this situation, Suzanne utilized an effective technique well-known to therapists, especially those who work with children. She relied on "displacement" so that Anna would not immediately feel threatened. Suzanne informed Anna that she knew a little boy who was having a problem talking with friends and was not certain the best way to help him. Anna, similar to many other children moved into this displacement with ease, asking, "Does he have a hard time on the playground?" Suzanne replied, "Yes, the playground is where he has most trouble."

Even if Anna had not directly referred to the playground, Suzanne could have introduced that specific area within the displacement. It was obvious that Anna was ready to discuss her problems as long as the right venue was found. She asked, "Is he scared to talk with other children?" Eventually, Anna observed, "I think he might be worried they will make fun of him."

Once this worry was verbalized, Suzanne engaged Anna in considering strategies for helping this boy, which, of course, were the same strategies that Anna could implement to deal with her own problems. In essence, Anna no longer felt paralyzed. Rather, in assuming a position of expertise, she felt increasingly in control. Also, Suzanne's strategy touched on two other components of a resilient mindset that we will discuss below, namely, to believe we can solve problems and to believe we make a positive difference in the lives of others.

Bob has found that children often produce images and metaphors in the initial sessions of therapy that afford the therapist an opportunity to begin to reinforce a

message of control and resilience (Brooks, 1981, 1985). This was evident with Meredith, a six-year-old girl referred to Bob because of oppositional behavior and frequent temper tantrums. During the first session she spontaneously informed Bob that she liked grasshoppers, adding, "You have to treat them nicely and not press on them too hard or they won't feel like jumping."

Similar to Suzanne introducing a form of displacement, one could interpret Meredith's "warning" in the image of a grasshopper as a way of attempting to determine how Bob would treat her and how his behavior would determine her response. Accordingly, Bob replied in the following manner (we are offering the interaction in dialogue form to describe the reasoning behind Bob's questions—questions aimed at establishing a beginning foundation for reinforcing a resilient mindset).

Dr. B: Do grasshoppers want to learn to jump? (to assess Meredith's wish to learn and grow)
M: Yes.
Dr. B: Do they need help in learning to jump? (to assess whether she feels others can be helpful)
M: Yes.
Dr. B: Who can help them?
M: The trainer (an apparent therapist figure)
Dr. B: How does the trainer do that?
M: He pushes them.
Dr. B: Does he ever push them too hard? (this was based on Meredith's initial comment)
M: Sometimes.
Dr. B: Why? (to determine whether she experienced the pushing too hard as an intentional and/or angry act)
M: I don't know.
Dr. B: Do you think the trainer wants to push down too hard on the grasshopper?
M: Some trainers might, some trainers are mean. ("mean" was a word that Meredith used to describe her teacher, a woman who Meredith did not like)
Dr. B: How come?
M: I'm not sure.
Dr. B: Gee, you really know a lot about grasshoppers so I'm wondering how would a grasshopper let her trainer know if the trainer was pushing too hard? (to introduce the idea that Meredith could assume some responsibility and ownership for offering feedback—a vital ingredient in personal control)
M: The grasshopper just wouldn't jump. (an oppositional way of coping)
Dr. B: Anything else?
M: The grasshopper could jump in the wrong direction. (another oppositional way of coping)
Dr. B: Would the trainer know why the grasshopper wasn't jumping or was jumping in

the wrong direction? (similar to a previous comment, Bob wanted to reinforce Meredith's responsibility for what transpired in therapy and to encourage Meredith to communicate her feelings)

M: No.

Dr. B: Hmm. That's a problem. If a trainer really wanted to help and was pushing too hard but didn't know it, he couldn't be helpful and the grasshopper couldn't learn. (in part, this comment was an attempt to highlight the self-defeating nature of the grasshopper's coping strategies and to communicate that the trainer could be of help if Meredith provided feedback)

M: Yeah.

Dr. B: That's a problem that needs solving. (the importance of problem-solving, which will be addressed in the next section, is an important message to communicate)

M: Yeah.

Given Meredith's interest in this dialogue, Bob introduced the idea of making up a story about a grasshopper who came to a trainer to learn to jump far and straight. This strategy was predicated on the Creative Characters technique (Brooks, 1981). In the subsequent weeks Meredith, through the grasshopper figure, learned important lessons rooted in a strength-based perspective, including ways of approaching challenging tasks, requesting help, giving feedback, and coping more effectively with frustration. Her introduction of the grasshopper metaphor served as a jumping off point, enabling Bob to understand significant details of her inner world and to communicate important therapeutic messages.

In our homes and schools, adults can reinforce personal control. They can call attention to a child's efforts in determining the outcome of an event. The following are but a few examples of such feedback:

"You really worked hard learning those spelling words and it showed on how nicely you did on this test?"

"I know it wasn't easy for you to memorize the lines for the school play, but all the hours you spent memorizing your part really paid off."

"Do you remember that the last time we went to the restaurant, it wasn't easy for you to wait for the meal and you started to yell? We spoke with you about it and this time you waited so nicely. We appreciate how you behaved."

To believe that problems are for solving rather than being overwhelming. Intimately tied to the task of reinforcing a belief in personal control but deserving special attention is the acquisition and use of problem-solving skills. If children act before they think and if they don't consider the consequences of their behavior, they will have difficulty developing effective coping strategies and a sense of personal control. Many of our patients demonstrate difficulties with problem-solving. In contrast, resilient youngsters are able to identify problems, consider different solutions, select what they

believe will be the most effective solution, and learn from the outcome (Shure, 1996; Shure & Aberson, 2013).

Shure (1996), one of the foremost experts on reinforcing problem-solving abilities in children, has found that even preschool children can be assisted in developing and applying these skills. Shure as well as other professionals believe that even well-intentioned adults often rush in to tell children what to do rather than enlisting their input when faced with challenges. When children are afforded an opportunity to initiate their own plans of action with the guidance of adults, their feelings of ownership and personal control are reinforced.

The ability to solve problems at a young age was evident with six-year-old Carl, a boy diagnosed with ADHD. In his attempt to make friends, he often invaded the space of his peers by giving them hugs, an action that not surprisingly backfired.

Bob asked Carl if he thought his behavior was a problem (this is a question that should always be posed since if children or adolescents do not perceive certain behaviors as problems, then they will not be motivated to change; if a child denies that a problem really is a problem, the therapist can engage in a discussion about why the behavior in question might be problematic). When asked this question, Carl looked sad and replied, "Big problem. I might not have any friends. But I just forget and I hug kids."

When asked if he could think of a way to begin to solve the problem, Carl did not hesitate to say, "I need reminders."

Bob inquired, "What do you mean by reminders?"

Carl said, "I think if the teacher reminded me each morning not to hug another kid, it would help me to remember."

"That's a great idea."

With the permission of Carl's parents, Bob arranged a meeting with Carl, Carl's teacher, and himself. His teacher in an empathic and supportive way began the meeting by telling Carl she was very pleased that he could tell Bob what he thought would be helpful. This comment immediately put Carl at ease.

To reinforce his problem-solving skills, she asked, "How would you like to be reminded?"

Carl said that he noticed that sometimes she would touch children on their shoulder and he thought if she did the same to him at the beginning of the day, it would be a good reminder.

She complimented him on this suggestion and then inquired, "How often would you like me to remind you?"

Carl's response was what the teacher later referred to as "precious." He was just learning to tell time and he jumped off his chair and held one hand up and said, "When the big hand is up and when it is down," which was accompanied by his moving his hand from an up to a down position.

The decision was made to start the reminders every 30 minutes the next day. At the end of the following day, Carl's mother called Bob to provide feedback. She said, "Carl came home very excited and said he thought the reminders were really going to work, but then he added that he thought he needed the reminders every 10 minutes."

Carl's teacher followed this suggestion and in a short time the reminders that were offered every 10 minutes were spaced out to every 30 minutes, and then every hour, and finally not needed at all.

It was Carl's input that led to this problem-solving strategy, a strategy that proved very successful.

Suzanne's work with Anna in which she used displacement in enlisting Anna's input of how to help a boy with anxieties is another example of engaging a child in problem-solving. In her work in schools, Suzanne has found that helping students to understand their learning strengths and weaknesses provides a platform from which they can consider different strategies for learning.

As an illustration, Suzanne asked Noah, a 15-year-old high school freshman who was described by his parents as "highly intelligent and curious but completely unmotivated in school and often distracted in class," if he had ever gone on a trip that he really enjoyed and still thinks about. She posed this question to move away from the more negatively-tinged school environment in order to assess those activities that brought him pleasure and to consider how his interests might be applied to the problems he was encountering in school.

Noah's expression, which had been rather flat and tired looking, lit up as he began to describe his trip to China with his family the past summer. With much animation he described the landscape, the culture, and the people. Suzanne used Noah's response to introduce the different ways we learn, noting that he appeared to be an "experiential learner."

Noah, with obvious excitement in his voice, replied, "That's it. Is that why I'm so bored in class all the time?"

Suzanne explained that in addition to what occurs in the classroom, she and Noah could problem solve and consider ways to supplement his learning with hands-on experiences. Noah loved this idea, which his own self-observations had helped to produce. Fortunately, his high school had a practicum option for students, which connected what they were learning in the classroom with real-life experiences. With Suzanne's assistance, Noah was able to develop a plan that accommodated to his particular learning style. By encouraging his input, she also reinforced his sense of ownership.

We are often asked, "What if a child or adolescent patient is not able to say what might be helpful or has difficulty thinking of different solutions to problems?" It is not unusual for this to occur. When it does, we suggest that a therapist respond by saying,

"Let's try to figure this out together" and by asking certain questions as Suzanne did with Noah to engage the child in a dialogue that will eventually produce solutions.

As Shure (1996) has advocated, beginning at an early age, parents can nurture their children's problem-solving abilities by first providing simple choices (e.g., "Do you want to wear the blue dress or the green dress?" "Do you want to take a bath first or memorize your spelling words first?") and then moving to more complex choices and decisions. Countless situations emerge in which the input of children can be encouraged. The same can be done in schools, such as by inviting children to attend part or all of a parent-teacher-student conference or by having them select what two of three homework questions to answer that they believe will help them to learn best.

Shure and Aberson (2013) quoted the words of a parent who discovered the benefits of applying their problem-solving program. "I learned that I as a parent can be part of the solution for my child rather than adding to the problem. Before using this approach I was trying to take power and felt powerless. Now we solve problems together" (p. 500). In this example, both parent and child had become more resilient.

To appreciate that we all have strengths even when struggling with problems. Resilient children do not minimize or deny problems that they have. Denial runs counter to mastery. However, in addition to acknowledging and confronting problems, youngsters who are resilient are able to identify and use their strengths or their *islands of competence*. This metaphor represents a symbol of hope and resilience, a reminder that all children have strengths.

We regularly ask our child and adolescent patients what they judge to be their strengths or islands of competence. If they are not certain, we reply, "That's okay, it can take time to figure out what we're good at, but it's important to figure out." We always ask the parents and teachers of our patients to identify the strengths of their children or students and discuss ways to reinforce these strengths. It is also important to ask parents what they see as their own strengths, including in the parental role. We must move from a so-called "deficit model" in which the focus is on fixing problems to paying more than lip service to the strengths that reside in all children and adults.

The focus on strengths was embedded in Suzanne's interaction with Noah and their discovery that he was an "experiential learner." This permitted Noah to recognize that he performed at a much higher level with hands on experiences, allowing him to understand that in fact he had strengths that were not readily displayed within a traditional classroom curriculum.

Bob saw 16-year-old Jamie, a high school sophomore, who given her learning problems struggled academically and socially. Her parents described Jamie's difficulty fitting in and being accepted by her peers. When Bob asked Jamie about her strengths, she quickly replied, "I really don't have friends my own age, but I love to take care of younger kids. I babysit a lot in my neighborhood."

Interestingly, when Jamie's parents were asked their view of her strengths, without knowing what she had said her father replied with obvious delight, "She's like the pied piper of the neighborhood, parents love her to babysit for their young children. She's very patient with them. Although Jamie she can be immature at times, she's very responsible as a babysitter."

At a school conference, Bob shared with Jamie's teachers both Jamie's and her parents' assessment of her strengths. The teachers brainstormed about how to use this island of competence. Fortuitously, there was a nursery school right next to the high school. The teachers, displaying an impressive capacity to think and act outside the box, developed a plan. They spoke with the nursery school director and designed a course for Jamie called "child development." During a free period four times a week Jamie went to the nursery, interacted with the children, and then wrote about her experiences.

One of the teachers was also an advisor to the high school newspaper and helped Jamie author an article about her work at the nursery school for the newspaper. When the article was published, several of Jamie's peers who typically would not have gone out of their way to speak with her, came over to compliment her. Jamie felt accepted in high school for the first time. In reading Jamie's article, other students requested to spend time in the nursery school so that the "child development class" was expanded.

In another example, Billy, a 10-year-old boy who disliked school because of his struggles with learning, often refused to comply with teacher requests; he also bullied his classmates. When asked about his islands of competence, he identified his knowledge of taking care of his pet dog. Consequently, the principal appointed Billy as the "pet monitor" of the school to insure that all of the pets in the school were well taken care of. His teacher enlisted him in writing a short book about taking care of pets that she and the principal had bound and placed in the school library. Billy also gave "lectures" in different classrooms about how best to take care of a dog. With his island of competence on display, his attitude towards school improved significantly as did his behavior and academic work.

In our workshops for parents, we suggest that they consider what islands of competence their children have and how best to honor these strengths. One father revealed that he loved sports, but his 7-year-old son did not. Instead, his son loved doing artwork. This father said, "I knew that if I was going to have a good relationship with my son I had to focus less on encouraging him to play sports and more on reinforcing his artwork." This father was not very interested in art, but with his son's enthusiastic approval, he enrolled both of them in an art class at a local museum. After just one lesson the father reported the joy he experienced in watching his son's excitement as they both attended the class.

We advocate that teachers make a list of all of their students and next to the student's name write what that student perceives as his or her island of competence and then ask, "Are we reinforcing this strength in the school setting?"

If children are to be resilient not only must they perceive that they have strengths but, as importantly, they must believe that their strengths are appreciated and supported by the significant adults in their lives.

To believe that we make a positive difference in the world. When Bob was collecting material for his book *The Self-Esteem Teacher* (1991), he requested approximately 1,500 adults to complete an anonymous questionnaire. The first question asked them to report on a positive memory of school when they were students, something an educator said or did that boosted their self-esteem. Bob had not anticipated the content of the most commonly reported positive memory, namely, being asked to help out in some fashion. The following are a few examples:

"I remember when a teacher asked me to pass out the milk and straws."

"I felt so good when a teacher asked me to tutor a younger child."

"I remember when a teacher told me I was a good artist and asked me to draw some signs as part of an anti-litter campaign."

Brooks and Goldstein (2001, 2004)) proposed that there is an inborn need to help that continues to be a powerful force throughout our lifespan. As Werner (1993) captured in her longitudinal research, resilience was nurtured when children were provided opportunities to help others, an activity that Brooks and Goldstein (2001) have called "contributory activities." Involvement in these activities nurtures a very important belief in a child, one that reinforces a sense of purpose, namely, "What I am doing adds to the well-being and happiness of others."

We have already offered several examples in this chapter about the use of activities that contribute to others. They include Suzanne asking Anna for suggestions of how best to help another student, Jamie working with younger children in a nursery school, or Billy providing insights about taking care of pets. In addition, when conducting psychological evaluations, we will often ask the child to help bring the tests from the shelf or closet to the table. We have found that by doing so, the child feels more empowered and more in control of the evaluation process.

Another technique we use as therapists occurs when children arrive at excellent strategies for solving particular problems. We comment how helpful their idea was and in selected instances we add, "That's such a good idea, I'd love to use it with other kids. I think it will really be helpful to them."

We are frequently asked by parents at our workshops what they can do to develop compassion and responsibility in their children. One response we offer is to ask parents to consider how their children would reply to the following questions:

"What are the ways you have seen your parents help other people in the past few months?"

"What activities have you been involved with together with your parents in the past few months in which you have helped other people?"

Children are more likely to become altruistic and caring if they not only observe their parents in helping roles but if they are enlisted in such roles themselves. As parents involve their children in these roles, they would be well-advised to say as often as possible, "We need your help" rather than "Remember to do your chores." Not surprisingly, most children do not like to do "chores," but are especially willing to engage in the same activities when they are cast in terms of helping others. Parents who encourage their children's participation in charitable endeavors, such as walks for hunger or AIDS or breast cancer research, are supporting a resilient mindset.

In our consultation with parents and teachers we have emphasized that charitable activities can be used to reinforce other components of a resilient mindset such as problem-solving (e.g., what charity to support, how to raise money for the charity), empathy (e.g., taking the perspective of the people you are assisting), and applying one's islands of competence (e.g., Jamie's love for and understanding of young children being expressed in her work in the nursery school).

To recognize that mistakes are not only expected but also accepted. Attribution theory teaches us that resilient children, while not thrilled when making mistakes, view setbacks as opportunities for learning. For example, resilient children who fail a test will ask for help and/or problem solve about more effective ways of studying. In sports, resilient children will take extra batting or fielding practice to improve their batting and defensive skills. These youngsters attribute mistakes to variables they can correct.

The picture is much different for children who are not resilient. They attribute mistakes to factors that they cannot change, whether it be their intelligence or an inborn lack of skills. They believe that regardless of what they do, nothing will ever change. Eventually, not wishing to face additional failure and its accompanying sense of humiliation, they often adopt self-defeating ways of coping. They retreat from challenges, become class clowns or class bullies, or blame others for their problems. A boy in therapy said, "I'd rather hit another kid and be sent to the principal's office than have to be in the classroom where I feel like a dummy."

Therapists are in an excellent position to reinforce a positive attitude towards mistakes and lessen self-defeating behaviors in children and adolescents. They can assess a child's mindset about mistakes by asking directly or through displacement (as Suzanne did with Anna) questions that tap the child's attributions. We can wonder with children the reasons they thought they were not successful at a task, what they might do differently next time (this, of course, also engages a child's problem-solving skills), and who might be available to help.

A favorite technique in our therapy or consultation activities occurs when we have helped to develop a plan of action with our child patients and/or their parents and/or their teachers. Given the particular situation, we might say, "This plan sounds great, but what if it doesn't work?" Some might wonder if posing such a question represents a self-

fulfilling prophesy for failure. It could if we did not immediately add, "What is our back-up plan if it doesn't work?"

The reason for asking these questions was prompted by the reaction of some of our patients or those with whom we were consulting when a plan of action proved unsuccessful. Many became frustrated and angry. It was not unusual for us to hear from teachers or parents, "We went out of our way to change things, but the child is still not willing to change" or one parent lamented, "I guess this works for most parents, but I must really be doing something wrong."

We learned that if people are to have a more positive attitude about mistakes, we must build in the possibility of failure occurring together with the message that if one strategy is unsuccessful, we can learn from that setback when initiating other strategies.

In our consultations with teachers, we have frequently said that there is a "raging elephant" that exists in almost every classroom, an elephant that lessens learning and resilience. We identify the elephant as the fear of failure and humiliation and pose the question of how best to remove this negative force. One technique we have recommended is to directly identify the elephant by teachers asking their class at the beginning of the school year, "Who feels they are going to make a mistake or not understand something in class this year?" Before any of the students can respond, we suggest that teachers raise their own hand as a way of initiating a discussion of how the fear of making mistakes affects learning.

As part of this dialogue we encourage teachers to share some of their own anxieties and experiences about making mistakes when they were students. They might even discuss a time when they were embarrassed or humiliated by something one of their teachers said (students love to hear these accounts). They can turn the discussion into a problem-solving exercise by asking, "What can I do as your teacher and what can you do as a class so that no one will ever feel humiliated in this class and no one will be afraid to make mistakes?"

Teachers have reported very positive results when using this exercise. One teacher informed us, "After I openly discussed the issues of mistakes and humiliation, it was the most discipline-free year I've ever had." She discovered that when children are not afraid about making mistakes, they are less likely to engage in negative behaviors in the classroom.

Parents are in an excellent position to help children from a very early age develop the belief that we can learn from mistakes. If children can incorporate this viewpoint, they will be more resilient and better equipped to face challenges. To assist parents with the goal of helping their children to be less fearful of making mistakes, we ask them to consider what their children's answers would be to the following two questions:

"When your parents make a mistake, when something doesn't go right, what do they do?"

"When you make a mistake, how do your parents respond?"

In terms of the first question, parents serve as significant models for handling mistakes. It is easier for children to learn to deal more effectively with setbacks if they see their parents doing so. Bob asked the first question to Joan and Roger Norwood, parents of Betsy, an 11-year-old girl who was very anxious and typically quit at activities after just a brief attempt. As they reflected on the question, Joan realized that they were not "great models for dealing with mistakes." She said that Roger gets very frustrated when he has trouble doing something, often shouting obscenities and blaming others, while she frequently gives up on things herself.

Roger agreed with his wife's observations, adding, "I was also thinking of your second question. I think that Betsy would say that we get annoyed when she makes a mistake, especially when we feel she has rushed through things or put little effort in to what she was doing. I know that we've said some things to her out of our own anxiety and frustration that were hurtful to her such as 'Why don't you stop and think about what you're doing?' or 'You've got to slow down and use your brains.'"

These two questions about mistakes prompted Joan and Roger to assess their reactions to their own mistakes as well as how they responded to Betsy's setbacks. They became more empathic, reflecting on how their actions impacted on their daughter. In addition, they began to use problem-solving techniques by asking themselves and Betsy, "What can we do differently next time so as not to make the same mistakes?"

These changes in their mindset and approach proved fruitful. Joan reported with much delight that Betsy did something she would not have done just a few months earlier. "She tried out for a play in school and while she didn't get the role she hoped she would get, she did get another role that involves a few speaking lines."

Joan and Roger learned an important lesson, namely, that if we are to reinforce a resilient mindset in youngsters, our words and actions must convey the belief that we can learn from mistakes rather than feel judged or condemned for making them.

Concluding Comments

We believe that one of our most important roles we can assume when working with or raising children is that of a charismatic adult. By identifying the characteristics of a resilient mindset, we can interact with children in therapy in ways that will nurture this mindset so that they can lead more hopeful, responsible lives. As therapists we can also engage their parents, teachers, and other involved professionals to assume this same role so that the children and adolescents in our care have many adults from whom they gather strength. Such youngsters will be prepared to overcome current difficulties and face new challenges with greater courage, skills, and perseverance.

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Behavioral Health Provider Coalition
of Cape Cod and the Islands

"A Medicine of Hope and Possibility: Hope for both patients and practitioners."

Jeffrey Rediger, MD, MDiv, is on the faculty of Harvard Medical School, the Medical Director of McLean SE and Community Affairs at McLean Hospital, and the Chief of Behavioral Medicine at Caritas Good Samaritan Medical Center.

Dr. Rediger's presentation will discuss research into the factors associated with improbable recoveries from medical illness and the implications for our understanding of health and illness. This is an exciting time in health-care, where both paradigms of health and wellness and associated technologies are beginning to demonstrate efficacy in arenas where traditional disease-based models have been more limited. Relevant research and associated issues will be discussed, as well as practical steps associated with achieving a new level of personal and professional wellness.

A licensed physician and board-certified psychiatrist, he also has a Master of Divinity from Princeton Theological Seminary. His research with remarkable individuals who have recovered from illnesses considered incurable has been featured on the Oprah Winfrey and Dr. Oz Shows, among others. He has been nominated for the National Bravewell Leadership Award, and has received numerous awards related to leadership and patient care.

APPEARENCES ON:

OPRAH TEDx THE DR. OZ SHOW

A Medicine of Hope and Possibility: Hope for Both Patients and Practitioners

Jeffrey Rediger MD, MDiv
Medical and Clinical Director
McLean SE Adult and Community Programs
McLean Hospital
Harvard Medical School

Chief of Behavioral Medicine
Good Samaritan Medical Center

What is Burn-out?

- *A syndrome characterized by a high degree of:*
  - *Emotional exhaustion*
  - *Depersonalization (i.e., negativity and cynicism)*
  - *Low sense of personal accomplishment from work*

Extent of Burnout among Health Care Professionals

- *55% of physicians are facing burnout*
- *43% of nurses are facing emotional exhaustion*
- *Similar for social workers, therapists, nurse practitioners, and related disciplines*
- *Higher for ED and internal medicine*
- *Nearly twice that of most other professions*
- *Increased by 9% between 2011 and 2014.*

Results of Burnout among Health Care Workers

- *More turnover and job dissatisfaction*
- *Less work effort and productivity; more absenteeism*
- *Less patient satisfaction*
- *More medical errors, hospital-based infections and malpractice suits*
- *Higher medical costs*
- *Costs of replacing a nurse or physician is 1.2 to 1.3 their annual salary or more*

Suicidality among Health Care Professionals

- *Burnout represents real suffering among those most dedicated to alleviating the suffering of others*
- *Suicide rate of male physicians is 40% higher than general U.S. population*
- *Suicide rate of female physicians is 130% higher than that of the general population*
- *Suicide rate of female nurses is 23% greater than the general population; nurses are 4 times more likely to suicide than those in the normal population*

Five Goals for Reducing Burnout at Good Samaritan Hospital

- *Identify burnout where it exists (study submitted to IRB)*
- *Increase understanding of the barriers to employee wellbeing*
- *Provide evidence-based solutions*
- *Monitor effectiveness of their implementation*
- *Create structure for ongoing communication about burnout; e.g., monthly follow-ups, newsletter and flyers, quarterly Grand Rounds on Self-Care and Well-being*

How to Recover Joy and Wellbeing in Patient Care: Putting a Light Back in your Eyes

- Identify self-care strategies that work for you:
  - Exercise, support system at work and home, mindfulness, yoga, art, weekends away, counseling, deep breathing between patients, etc.
  - We become what we focus on: focus on what is positive and true and proactively solve barriers to that

How to Recover Joy and Wellbeing in Patient Care: Putting a Light Back in your Eyes

- Increase your self-awareness:
  - Know your emotions and triggers
  - Biosay
  - Know what helps you thrive in stress

How to Recover Joy and Wellbeing in Patient Care: Putting a Light Back in your Eyes

- Remember that you are a Person, not just the masks that you wear:
  - You are a wife, husband, friend, parent, lover, employee
  - Not just a professional
  - You have a lot to offer. Find what nourishes you
  - Don't minimize depression or anxiety: reach out for help

How to Recover Joy and Wellbeing in Patient Care: Putting a Light Back in your Eyes

- Cultivate Compassion in your life
  - Not only others but also for yourself
- You cannot give to another what you have not first given to yourself
- Compassion is not just for others. You can't thrive without experiencing what is unrepeatable and wonderful about you

How to Recover Joy and Wellbeing in Patient Care: Putting a Light Back in your Eyes

- Vulnerability:
  - Our goal is a culture of wellbeing where honesty and vulnerability are prized and supported
  - The law of personal growth: go down in order to go up. Honesty creates new pathways and creativity
  - Facebook-perfect presentations do not reflect authentic lives for anyone

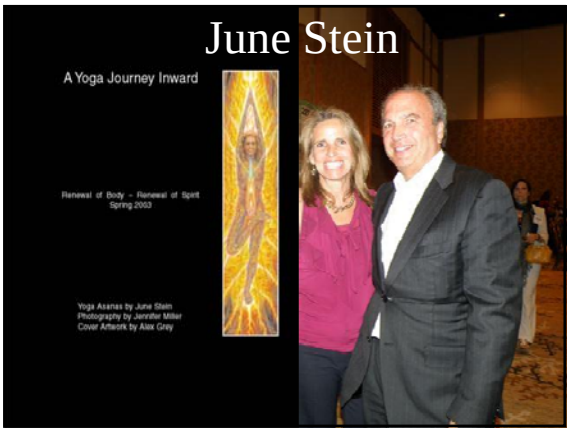
How to Recover Joy and Wellbeing in Patient Care: Putting a Light Back in your Eyes

- Build a support network:
  - Start small and gradually add trusted people at work and home
  - Add a counselor or support group as needed
  - Build in encouragement and accountability to your personal and professional standards
  - Don't deal with grief or stress alone

The Real Heroes of Self-Care: Improbable Recoveries and Achievements with Serious Medical Illness

- There's nothing "spontaneous" about spontaneous remission
- Major, identifiable shifts in lifestyle and perception; no one has asked
- Common sense suggests that we should study ultimate performers in health
- Uncharted wilderness
- A Medicine of Hope and Possibility - stories of improbable recovery or unusual achievement give me hope and new ways of working with people
- Remarkable Recoveries: seeing ability where others see disability and lighting the fire in the belly

"Every block of stone has a statue inside it and it is the task of the sculptor to discover it." -Michelangelo


June Stein
A Yoga Journey Inward
Renewal of Body ~ Renewal of Spirit
Spring 2003
Yoga Asanas by June Stein
Photography by Jennifer Miller
Cover Artwork by Alex Grey


Dana Lewis

Physicist Stephen Hawking

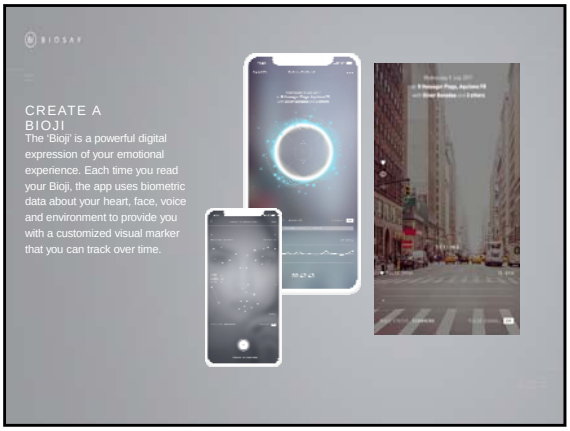
Aimee Mullins

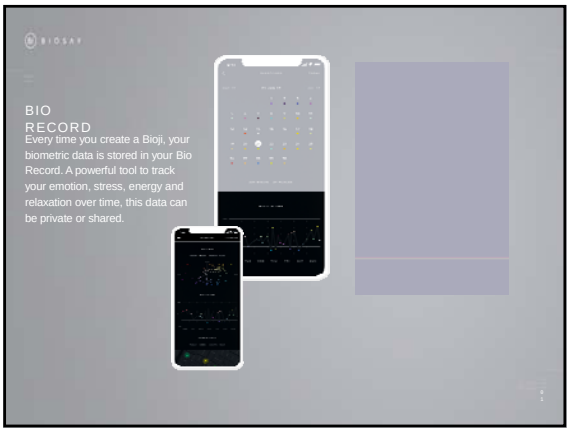
Illness as Opportunity: To Become More Fully Human

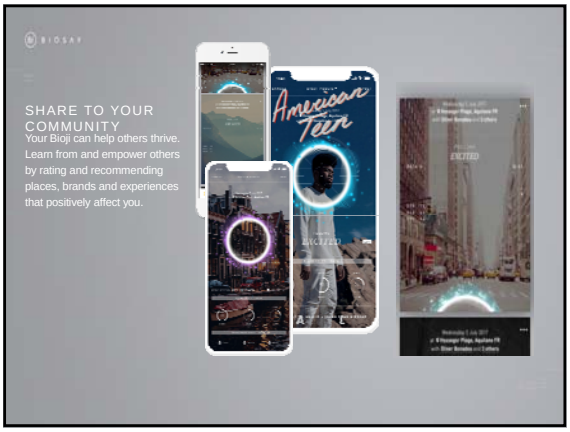
Stress as Opportunity: To Become More Fully Human

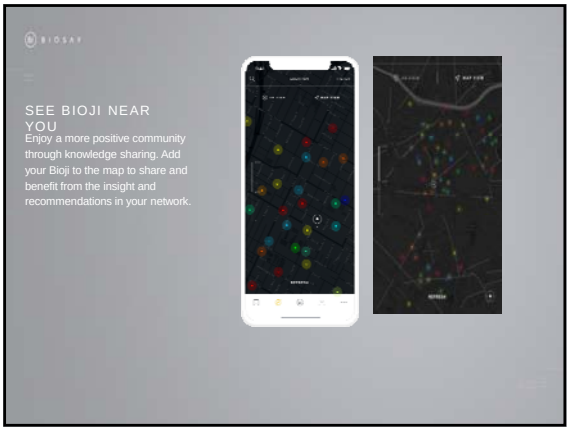
- Started a conversation about the way society looks at disabilities
- "It is no longer a conversation about overcoming deficiency. It's a conversation about potential. A prosthetic limb doesn't represent the need to replace loss anymore…So people that society once considered disabled can now become the architects of their own identities and indeed continue to change those identities by designing their bodies from a place of empowerment… it is our humanity, and all the potential within it, that makes us beautiful."

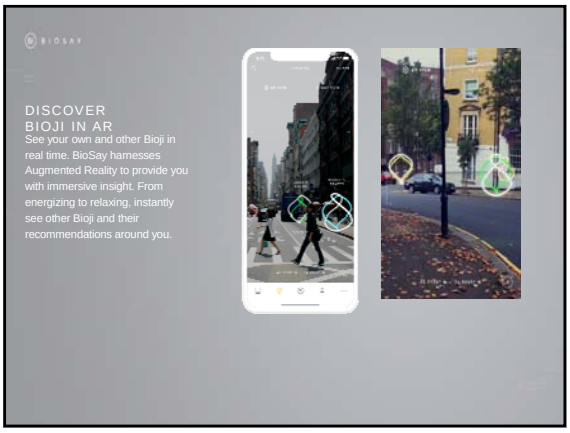
Rachael Donalds & Biosay




BIO
RECORD
Every time you create a Bioji, your biometric data is stored in your Bio Record. A powerful tool to track your emotion, stress, energy and relaxation over time, this data can be private or shared.

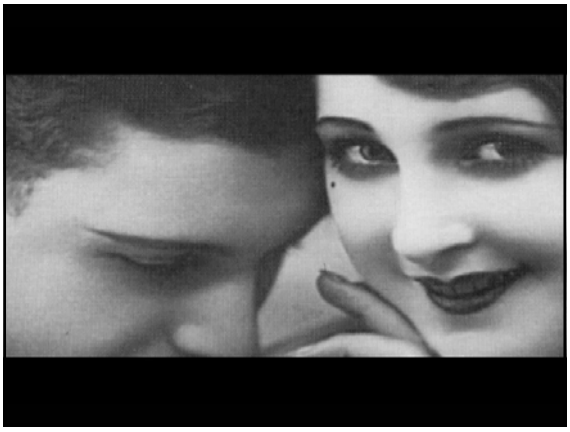

SHARE TO YOUR COMMUNITY
Your Bioji can help others thrive. Learn from and empower others by rating and recommending places, brands and experiences that positively affect you.
American Teen


SEE BIOJI NEAR YOU
Enjoy a more positive community through knowledge sharing. Add your Bioji to the map to share and benefit from the insight and recommendations in your network.



Parts vs. the Whole: Illness with Roots beyond the Physical Body

- In the West, we focus on parts but forget the living person:
  - A medical problem is sent to the physician
  - A psychological problem is sent to the therapist
  - A spiritual problem is sent to the priest, rabbi or minister



Behavioral Health Provider Coalition
of Cape Cod and the Islands

Breakout Session #1

"Recognition - *How do you begin (or have) the conversation?"*

Presenters:

Marty Ferrero, MA, LADC, CMAT, Senior Clinical Director, Caron Treatment Center Older Adult Program

Daria Hanson, MD, Chief Medical Director, Department of Psychiatry, Cape Cod Healthcare

Chris Morin, Director of Prevention, Education & Outreach, Independence House

Kumara Sidhartha, MD, Medical Director, Cape Cod Healthcare Preferred Physicians

Child Welfare Information Gateway

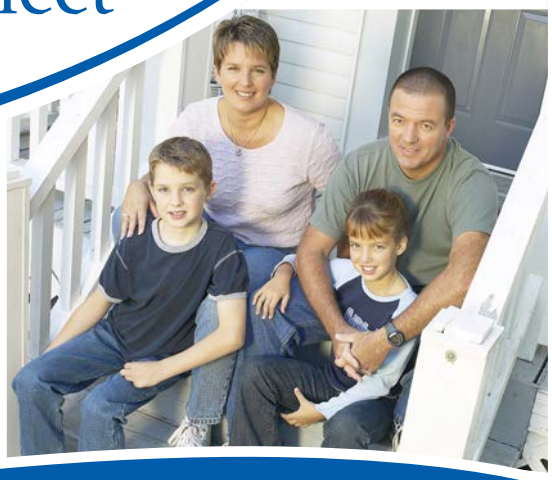
PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

FACTSHEET

July 2013

Disponible en español
https://www.childwelfare.gov/pubs/factsheets/sp_long_term_consequences.cfm

Long-Term Consequences of Child Abuse and Neglect



For fiscal year (FY) 2011, States reported that 676,569 children were victims of child abuse or neglect (U.S. Department of Health and Human Services, 2012). While physical injuries may or may not be immediately visible, abuse and neglect can have consequences for children, families, and society that last lifetimes, if not generations.

What's Inside:

Use your smartphone to access this factsheet online.

Children's Bureau

Child Welfare Information Gateway
Children's Bureau/ACYF/ACF/HHS
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
800.394.3366
Email: info@childwelfare.gov
https://www.childwelfare.gov

The impact of child abuse and neglect is often discussed in terms of physical, psychological, behavioral, and societal consequences. In reality, however, it is impossible to separate the types of impacts. Physical consequences, such as damage to a child's growing brain, can have psychological implications, such as cognitive delays or emotional difficulties. Psychological problems often manifest as high-risk behaviors. Depression and anxiety, for example, may make a person more likely to smoke, abuse alcohol or drugs, or overeat. High-risk behaviors, in turn, can lead to long-term physical health problems, such as sexually transmitted diseases, cancer, and obesity. Not all children who have been abused or neglected will experience long-

The Federal Government has made a considerable investment in research on the causes and long-term consequences of child abuse and neglect. These efforts are ongoing; for more information, visit the websites listed below:

Adverse Childhood Experiences (ACE) Study is a collaboration between the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente's Health Appraisal Clinic in San Diego, CA. It is the largest ongoing examination of the correlation between childhood maltreatment and adult health and well-being outcomes. Data are collected from more than 17,000 participants undergoing regular health screenings who provide information about childhood experiences of abuse and neglect. Findings show that certain experiences are risk factors or causes for various illnesses and poor health.
http://www.cdc.gov/ace/index.htm

LONGSCAN (Longitudinal Studies of Child Abuse and Neglect) is a consortium of longitudinal research studies on the causes and impact of child abuse and neglect. It was initiated in 1990 with grants from the National Center on Child Abuse and Neglect. The size and diversity of the sample (1,354 children from five distinct geographical areas) enables LONGSCAN researchers to examine the relative impact of various forms of maltreatment, alone and in combination. LONGSCAN studies also evaluate the effectiveness of child protection and child welfare services.
http://www.iprc.unc.edu/longscan

NSCAW (The National Survey of Child and Adolescent Well-Being) is a project of the Administration on Children, Youth and Families to describe the child welfare system and the experiences of children and families who come in contact with the system. Survey data are collected from firsthand reports of children, parents, and other caregivers, as well as reports from caseworkers, teachers, and administrative records. NSCAW will continue to follow the life course of these children to gather data about services received during subsequent periods, measures of child well-being, and longer term results for the study population. This information will provide a clearer understanding of life outcomes for children and families involved with child welfare. http://www.acf.hhs.gov/programs/opre/research/project/national-survey-of-child-and-adolescent-well-being-nscaw-1

term consequences, but they may have an increased susceptibility.

This factsheet explains the long-term physical, psychological, behavioral, and societal consequences of child abuse and neglect. For more information on abuse and neglect, including definitions, the different types, and the signs and symptoms, read Child Welfare Information Gateway's *What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms:* https://www.childwelfare.gov/pubs/factsheets/whatiscan.cfm

Factors Affecting the Consequences of Child Abuse and Neglect

Individual outcomes vary widely and are affected by a combination of factors, including:

- The child's age and developmental status when the abuse or neglect occurred
- The type of maltreatment (physical abuse, neglect, sexual abuse, etc.)
- The frequency, duration, and severity of the maltreatment
- The relationship between the child and the perpetrator

Researchers also have begun to explore why, given similar conditions, some children experience long-term consequences of abuse and neglect while others emerge relatively unscathed. The ability to cope, and even thrive, following a negative experience is often referred to as "resilience." It is important to note that resilience is not an inherent trait in children but results from a mixture of both risk and protective factors that cause a child's positive or negative reaction to adverse experiences. A number of protective and promotive factors—individually, within a family, or within a community—may contribute to an abused or neglected child's resilience. These include positive attachment, self-esteem, intelligence, emotion regulation, humor, and independence (Shaffer, 2012).

Physical Health Consequences

The immediate physical effects of abuse or neglect can be relatively minor (bruises or cuts) or severe (broken bones, hemorrhage, or even death). In some cases, the physical effects are temporary; however, the pain and suffering they cause a child should not be discounted.

Child abuse and neglect can have a multitude of long-term effects on physical health. NSCAW researchers found that, at some point during the 3 years following a maltreatment investigation, 28 percent of children had a chronic health condition (Administration for Children and Families, Office of Planning, Research and Evaluation [ACF/OPRE], 2007). Below are some outcomes other researchers have identified:

Abusive head trauma. Abusive head trauma, an inflicted injury to the head and its contents caused by shaking and blunt impact, is the most common cause of traumatic death for infants. The injuries

may not be immediately noticeable and may include bleeding in the eye or brain and damage to the spinal cord and neck. Significant brain development takes place during infancy, and this important development is compromised in maltreated children. One in every four victims of shaken baby syndrome dies, and nearly all victims experience serious health consequences (CDC, n.d.).

Impaired brain development. Child abuse and neglect have been shown to cause important regions of the brain to fail to form or grow properly, resulting in impaired development. These alterations in brain maturation have long-term consequences for cognitive, language, and academic abilities and are connected with mental health disorders (Tarullo, 2012). Disrupted neurodevelopment as a result of maltreatment can cause children to adopt a persistent fear state as well as attributes that are normally helpful during threatening moments but counterproductive in the absence of threats, such as hypervigilance, anxiety, and behavior impulsivity (Perry, 2012). Child Welfare Information Gateway has produced two publications on the impact of maltreatment on brain development.
Supporting Brain Development in Traumatized Children and Youth:
https://www.childwelfare.gov/pubs/braindevtrauma.pdf
Understanding the Effects of Maltreatment on Brain Development:
https://www.childwelfare.gov/pubs/issue_briefs/brain_development/brain_development.pdf

Poor physical health. Several studies have shown a relationship between various forms of child maltreatment and poor health. Adults who experienced abuse or neglect during childhood are more likely to suffer from cardiovascular disease, lung and liver disease, hypertension, diabetes, asthma, and obesity (Felitti & Anda, 2009). Specific physical health conditions are also connected to maltreatment type. One study showed that children who experienced neglect were at increased risk for diabetes and poorer lung functioning, while physical abuse was shown to increase the risk for diabetes and malnutrition (Widom, Czaja, Bentley, & Johnson, 2012). Additionally, child maltreatment has been shown to increase adolescent obesity. A longitudinal study found that children who experienced neglect had body mass indexes that grew at significantly faster rates compared to children who had not experienced neglect (Shin & Miller, 2012).

Psychological Consequences

The immediate emotional effects of abuse and neglect—isolation, fear, and an inability to trust—can translate into lifelong psychological consequences, including low self-esteem, depression, and relationship difficulties. Researchers have identified links between child abuse and neglect and the following:

Difficulties during infancy. Of children entering foster care in 2010, 16 percent were younger than 1 year. When infants and young children enter out-of-home care due to abuse or neglect, the trauma of a primary caregiver change negatively affects their attachments (ACF/OPRE, 2012a). Nearly

half of infants in foster care who have experienced maltreatment exhibit some form of cognitive delay and have lower IQ scores, language difficulties, and neonatal challenges compared to children who have not been abused or neglected (ZERO TO THREE, 2011).

Poor mental and emotional health. Experiencing childhood trauma and adversity, such as physical or sexual abuse, is a risk factor for borderline personality disorder, depression, anxiety, and other psychiatric disorders. One study using ACE data found that roughly 54 percent of cases of depression and 58 percent of suicide attempts in women were connected to adverse childhood experiences (Felitti & Anda, 2009). Child maltreatment also negatively impacts the development of emotion regulation, which often persists into adolescence or adulthood (Messman-Morre, Walsh, & DiLillo, 2010).

Cognitive difficulties. NSCAW researchers found that children with substantiated reports of maltreatment were at risk for severe developmental and cognitive problems, including grade repetition (ACF/OPRE, 2012b). In its final report on the second NSCAW study (NSCAW II), more than 10 percent of school-aged children and youth showed some risk of cognitive problems or low academic achievement, 43 percent had emotional or behavioral problems, and 13 percent had both (ACF/OPRE, 2011).

Social difficulties. Children who experience neglect are more likely to develop antisocial traits as they grow up. Parental neglect is associated with borderline personality disorders, attachment issues or affectionate behaviors with unknown/little-known people, inappropriate modeling of adult behavior, and aggression (Perry, 2012).

Behavioral Consequences

Not all victims of child abuse and neglect will experience behavioral consequences. However, behavioral problems appear to be more likely among this group. According to NSCAW, more than half of youth reported for maltreatment are at risk for an emotional or behavioral problem (ACF/OPRE, 2012b). Child abuse and neglect appear to make the following more likely:

Difficulties during adolescence. NSCAW data show that more than half of youth with reports of maltreatment are at risk of grade repetition, substance abuse, delinquency, truancy, or pregnancy (ACF/OPRE, 2012b). Other studies suggest that abused or neglected children are more likely to engage in sexual risk-taking as they reach adolescence, thereby increasing their chances of contracting a sexually transmitted disease. Victims of child sexual abuse also are at a higher risk for rape in adulthood, and the rate of risk increases according to the severity of the child sexual abuse experience(s) (Felitti & Anda, 2009; Messman-Morre, Walsh, & DiLillo, 2010).

Juvenile delinquency and adult criminality. Several studies have documented the correlation between child abuse and future juvenile delinquency. Children who have experienced abuse are nine times more likely to become involved

in criminal activities (Gold, Wolan Sullivan, & Lewis, 2011).

Alcohol and other drug abuse. Research consistently reflects an increased likelihood that children who have experienced abuse or neglect will smoke cigarettes, abuse alcohol, or take illicit drugs during their lifetime. In fact, male children with an ACE Score of 6 or more (having six or more adverse childhood experiences) had an increased likelihood—of more than 4,000 percent—to use intravenous drugs later in life (Felitti & Anda, 2009).

Abusive behavior. Abusive parents often have experienced abuse during their own childhoods. Data from the Longitudinal Study of Adolescent Health showed that girls who experienced childhood physical abuse were 1–7 percent more likely to become perpetrators of youth violence and 8–10 percent more likely to be perpetrators of interpersonal violence (IPV). Boys who experienced childhood sexual violence were 3–12 percent more likely to commit youth violence and 1–17 percent more likely to commit IPV (Xiangming & Corso, 2007).

Societal Consequences

While child abuse and neglect usually occur within the family, the impact does not end there. Society as a whole pays a price for child abuse and neglect, in terms of both direct and indirect costs.

Direct costs. The lifetime cost of child maltreatment and related fatalities in 1 year totals $124 billion, according to a study funded by the CDC. Child maltreatment is more costly on an annual basis than the two leading health concerns, stroke and type 2 diabetes (Xiangming, Brown, Florence, & Mercy, 2012). On the other hand, programs that prevent maltreatment have shown to be cost effective. The U.S. Triple P System Trial, funded by the CDC, has a benefit/cost ratio of $47 in benefits to society for every $1 in program costs (Mercy, Saul, Turner, & McCarthy, 2011).

Indirect costs. Indirect costs represent the long-term economic consequences to society because of child abuse and neglect. These include costs associated with increased use of our health-care system, juvenile and adult criminal activity, mental illness, substance abuse, and domestic violence. Prevent Child Abuse America estimates that child abuse and neglect prevention strategies can save taxpayers $104 billion each year. According to the Schuyler Center for Analysis and Advocacy (2011), every $1 spent on home visiting yields a $5.70 return on investment in New York, including reduced confirmed reports of abuse, reduced family enrollment in Temporary Assistance for Needy Families, decreased visits to emergency rooms, decreased arrest rates for mothers, and increased monthly earnings. One study found that all eight categories of adverse childhood experiences were associated with an increased likelihood of employment problems, financial problems, and absenteeism (Anda et al., 2004). The authors assert that these long-term costs—to the workforce and to society—are preventable.

Prevention Practice and Strategies

To break the cycle of maltreatment and reduce the likelihood of long-term consequences, communities across the

country must continue to develop and implement strategies that prevent abuse or neglect from happening. While experts agree that the causes of child abuse and neglect are complex, it is possible to develop prevention initiatives that address known risk factors.

For more information, visit Information Gateway's Preventing Child Abuse and Neglect web section: https://www.childwelfare.gov/preventing/

Trauma-Informed Practice

While the priority is to prevent child abuse and neglect from occurring, it is equally important to respond to those children and adults who have experienced abuse and neglect. Over the past 30 years, researchers and practitioners have developed a better understanding of the effects of trauma. More has been done in the way of developing supports to address these effects, build resiliency, and, hopefully, prevent further trauma. Trauma-informed practice refers to the services and programs specifically designed to address and respond to the impact of traumatic stress. The importance of this approach has become especially evident in the child welfare system, as a majority of children and families involved with child welfare have experienced some form of past trauma. When human service systems recognize and respond to the impact of trauma and use this knowledge to adapt policies and practices, children, youth, and families benefit (Wilson, 2012).

The National Child Traumatic Stress Network strives to raise the standard of care and improve access to services for traumatized children, their families, and communities: http://www.nctsn.org/

For more information on trauma-informed practice, visit Information Gateway's Treatment and Trauma-Informed Care web section: https://www.childwelfare.gov/responding/trauma.cfm

Summary

There is a significant body of ongoing research on the consequences of child abuse and neglect. The effects vary depending on the circumstances of the abuse or neglect, personal characteristics of the child, and the child's environment. Consequences may be mild or severe; disappear after a short period or last a lifetime; and affect the child physically, psychologically, behaviorally, or in some combination of all three ways. Ultimately, due to related costs to public entities such as the health-care, human services, and educational systems, abuse and neglect impact not just the child and family, but society as a whole. Therefore, it is imperative for communities to provide a framework of prevention strategies and services before abuse and neglect occur and to be prepared to offer remediation and treatment when necessary.

Resources on Child Welfare Information Gateway

Child Abuse and Neglect
https://www.childwelfare.gov/can/

Definitions of Child Abuse and Neglect
https://www.childwelfare.gov/can/defining/

Preventing Child Abuse and Neglect
https://www.childwelfare.gov/preventing/

Reporting Child Abuse and Neglect
https://www.childwelfare.gov/responding/reporting.cfm

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Behavioral Health Provider Coalition
of Cape Cod and the Islands

Breakout Session #2

"Road to Resilience for First Responders, Mental Health Clinicians and Caregiver"

Presenters:

Manny Marrero, MOT, OTR/L, FCE, Partial Hospital Program Clinician, Cape Cod Hospital

Sgt. Kevin Marshall, Crisis Intervention Team Coordinator, Nantucket Police Department

Lori Myles, LMHC, Southeast Service Director, Emergency Services Program, BayCove Human Services

Sgt. George Neilson, Level III Certified Instructor, Massachusetts Municipal Police Training

Road to Resilience

For first responders, mental health clinicians and caregivers

Overview

- Speaker 1: Lori Myles and Sergeant George Neilson
- Speaker 2: Manny Marrero
- Speaker 3: Sergeant Kevin Marshall
- Panel Q&A

Speaker 1:

Lori Myles and Sergeant George Neilson

TRAUMA

- A deeply distressing or disturbing experience.
- A highly stressful event
- Extreme stress that overwhelms a person's ability to cope
- Subjective

SECONDARY TRAUMA/COMPASSION FATIGUE/VICARIOUS TRAUMA

- Caregivers play host to a high level of compassion fatigue
- Extreme state of tension and preoccupation with the suffering of those being helped to the degree that it can create a secondary traumatic stress for the helper
- A gradual lessening of compassion over time
- When caregivers focus on others without practicing self-care, destructive behaviors can surface
- Common among workers who work directly with victims of disasters, trauma, or illness.

SECONDARY TRAUMA/COMPASSION FATIGUE/VICARIOUS TRAUMA

- Symptoms – what to look for in ourselves and others
  - Apathy – no longer caring
  - Isolation
  - Bottled up emotions
  - Substance abuse
  - Hopelessness
  - A decrease in experiences of pleasure
  - Constant stress and anxiety
  - Sleeplessness or nightmares
  - Pervasive negative attitude
  - Decrease in productivity
  - Inability to focus
  - Development of new feelings of incompetency and self-doubt
  - Signs of depression

SECONDARY TRAUMA/COMPASSION FATIGUE/VICARIOUS TRAUMA

- Personal attributes of those at risk?
  - Overly conscientious
  - Perfectionists
  - Self-giving
  - Low levels of social support
  - High levels of stress in personal life
  - Previous history of trauma with negative coping skills (bottling up, avoiding emotions, small support systems)

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Speaker 2:

Manny Marrero, MOT, OTR/L

Positive Association Between Resilience and Emotional Intelligence

Presented by: Manny Marrero, MOT, OTR/L

Cape Cod Healthcare

How I Cultivated Resilience after War

11

CPL Manny Marrero (Age 21)
USMC

Fallujah, Iraq 2004

Resilience

12

- A resilient person is one who can successfully navigate difficult life experiences, and emerge from these experiences a stronger and healthier individual. **A resilient person does not simply bounce back, but bounces forward, transformed by the process of moving through personal challenges**. This process involves decreasing stress, effectively solving problems, and building healthy relationships with others that result in positive changes and growth. (Crawford, Hill, Shrestha, 2015)

Five factors of resilience

13

- **Meaning and Purpose:** By many accounts, meaning and purpose plays a major role in the cultivation of resilience.
- **Perseverance:** steadfastness despite difficulty or delay in achieving success.
- **Self-Reliance:** reliance on one's own powers and resources rather than those of others.
- **Equanimity**: mental calmness, composure, and evenness of temper, especially in a difficult situation.
- **Social Connection:** Loneliness is toxic to the human body.

Five factors of resilience

14

- **Meaning and Purpose:** By many accounts, meaning and purpose plays a major role in the cultivation of resilience.
- **Perseverance:** steadfastness despite difficulty or delay in achieving success.
- **Self-Reliance:** reliance on one's own powers and resources rather than those of others.
- **Equanimity**: mental calmness, composure, and evenness of temper, especially in a difficult situation.
- **Social Connection:** Loneliness is toxic to the human body.

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Emotional Intelligence

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- Emotional Intelligence (EQ) is how well individuals identify and manage their own emotions and react to the emotions of others.
- EQ is the basic understanding how those emotions shape your thoughts and actions so you can have greater control over your behavior and develop the skills to manage yourself more effectively.
- Becoming more emotionally conscious allows us to grow and gain a deeper understanding of who we are, enabling us to communicate better with others and build stronger relationships.

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Emotional Intelligence

16

- **The Four Branches of Emotional Intelligence**
- **Perceiving Emotions:** The ability to perceive emotions in oneself and others as well as in objects, art, stories, music, and other stimuli
- **Facilitating Thought**: The ability to generate, use, and feel emotion as necessary to communicate feelings or employ them in other cognitive processes
- **Understanding Emotions:** The ability to understand emotional information, to understand how emotions combine and progress through relationship transitions, and to appreciate such emotional meanings
- **Managing Emotions:** The ability to be open to feelings, and to modulate them in oneself and others so as to promote personal understanding and growth

Importance of Social Connection in Building Resilience

17

- Culture in the U.S. tends to be more individualistic and often can lead to social isolation, which we now know is toxic both to the human body and to mental health. Can increase mortality by as much as 15%. Self efficacy and a sense of connection are paramount in the more independent cultures.
- In more tribal and egalitarian cultures, the individual is part of a collective so pain and suffering is often a shared burden. Support is ever present and the individuals flexibility is key to overcoming setbacks.
- Sebastian Junger “Tribe” Spoke on veterans coming home and feeling isolated and disconnected from their tribe. Increase in suicidality and PTSD symptoms.

How Mindfulness and Meditation increases Emotional Intelligence

18

- Meditation helps you become aware of and detach from negative thoughts without allowing them to take you for a ride. This mindset helps you stay calm and balanced, and is integral to a high EQ.
- Meditation helps you read the emotions of other people: meditation helps to increase self understanding and awareness of others’ energy, facial expressions, and body language.
- Meditation has been shown to increase empathy
- Allows to see life without the filter of past traumas or insecurities and decreases judgment towards self and others.

Resources

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Speaker 3:

Sergeant Kevin Marshall

Self Care For Law Enforcement

Sergeant Kevin A. Marshall
Nantucket Police Department

The Need

Nationwide U.S. Population Rate

2017:
13.26/100,000

In 2017
44,193 d.b.s.
140 p.a.

Data provided by APSP, Law Officers Tactic Technology and Ruderman Family Foundation

State of Massachusetts: 2017

Ranks 47th suicide rate
in the U.S.
8.87/100,000

Data provided by American Foundation for Suicide Prevention

Cape Cod and the Islands

Massachusetts 8.7 per 100,000

Cape Cod 12.1 per 100,000

There are 123 suicides everyday

=

1.4 times higher than Mass.

Cape and Islands

2016 26

2017 40

Nantucket

2017 7

Data provided by Barnstable County Human Service

Cape and Islands District Attorneys Office

Law Enforcement Risk Factors

- Suicide is the leading cause of death in active law enforcement officers (over three times the rate of homicides)
- Police officers have suicide rates that are as much as 3 to 4 times higher than the general population
- Substance abuse disorders are involved in nearly 60% of all suicides. Alcohol alone is a factor in 25-43%.
- Law Enforcement officers are almost 4 times more likely to abuse alcohol and prescription drugs than the national average
- Law Enforcement divorce rate and health problems are much higher than the general population.

The lethal triad: Act now!

When these 3 are present the risk of violence is high. Reduce any or all of them immediately and lives can be saved.

The Fix

Administration Responsibilities

- Importance of support from the top down
- Support from first line supervisors
- Ensure all officers are healthy
- Reduce stigma in the work place

Officers Responsibilities

- We are our brothers' and sisters' keepers
- We do care for our own
- We **CAN** recognize and respond to signs and symptoms of suicide
- Trained **Peer Support** can intervene and assist fellow officers and employees in crisis.

Education and Training

- Counseling
- Life Coach
- Confidentiality
- EAP Program
- Peer Support Program
- Chaplains
- Crisis Intervention Team to include LE Suicide Prevention
- Mental Health First Aid
- ***Interactive Screening Program***

Resources

American Foundation Suicide Prevention

Barnstable County Human Serves

Bureau of Justice Assistance (2015) L.E Suicide Prevention. St. Petersburg, FLA., Florida Regional Community Policing Institute

Cape and Islands District Attorneys Office

Gatekeeper/QPR Institute

Law Enforcement Wellness Association

Law Officers Tactic Technology

Ruderman Family Foundation

The International Association of Chiefs of Police Center for Officer Safety and Wellness. 2018 . *The Signs Within: Suicide Prevention Education and Awareness.* Washington, DC.: Office of Community Oriented Policing Services.

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Panel Q&A

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Taylor & Francis
Taylor & Francis Group

Emotional Intelligence and resilience in mental health professionals caring for patients with serious mental illness

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ABSTRACT

Emotional Intelligence (EI) and resilience may be considered as prerequisites for mental health professionals caring for patients with serious mental illness (SMI), since they are often exposed to severe emotional stress during daily work. Accordingly, this cross-sectional study assessed both EI and resilience and their interrelationship in 61 individuals belonging to an assertive outreach team for patients suffering from SMI compared 61 control subjects without healthcare-related working conditions. EI was assessed by means of the German version of the Mayer-Salovey-Caruso-Emotional-Intelligence Test (MSCEIT), resilience was assessed using the German version of the Resilience Scale. Both groups showed an average level of EI in all categories of the MSCEIT and indicated high levels of resilience. They did not differ significantly from each other, neither in terms of EI nor resilience. Correlation analysis revealed a positive association between EI and resilience, albeit small in magnitude. Our results suggest that mental health professionals are not more resilient and therefore not more 'protected' from stressors than the general population. Though this finding warrants cautious interpretation, the positive correlation between EI and resilience suggests that EI may be a potential target for education and training in order to strengthen resilience even in healthy individuals and vice versa.

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KEYWORDS
Emotional Intelligence; resilience; mental health professionals

Introduction

Mental health professionals caring for patients with serious mental illness (SMI), e.g. schizophrenia or mood disorders are often exposed to severe emotional stress during daily work. This 'Emotional Labour', a concept introduced by Hochschild (1979), correlates with experienced stress levels in nursing professionals (Mann & Cowburn, 2005). Emotional Intelligence (EI) focuses on exactly these personality traits and abilities enabling people to cope with both their own feelings as well as those of others (Mayer, Salovey, Caruso, & Sitarenios, 2001).

The term 'resilience' refers to a 'successful adaptation despite risk and adversity' (Masten, 1994) and Schumacher, Leppert, Gunzelmann, Strauß, and Brähler (2005) spoke of the phenomenon that some individuals, despite marked negative circumstances and risk factors remain

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healthy or easily recover from adverse events, while others are particularly vulnerable to disorders and illness. Resilient individuals also experience negative affect, but these episodes are shorter in duration and do not lead to long-term psychopathological impairment (Davidson, 2000; Holtmann, Poustka, & Schmidt, 2004; Shallcross, Troy, Boland, & Mauss, 2010).

Both EI and resilience may be considered as prerequisites for professionals working with patients suffering from SMI. A considerable number of studies address EI in general healthcare workers and even more in nursing students, but investigations in mental health professionals are rare. Van Dusseldorp, van Meijel, and Derksen (2011) for instance investigated 98 Dutch nurses caring for psychiatric patients and found significantly higher EI scores in nurses compared to the general population, and a recent study in female student health professionals found higher EI levels to be associated with less perceived stress and higher levels of life satisfaction and happiness (Ruiz-Aranda, Extremera, & Pineda-Galán, 2014). This corroborates the findings of an earlier study in nursing students (Por, Barriball, Fitzpatrick, & Roberts, 2011).

To the best of our knowledge, studies assessing both EI and resilience and their interrelationship in mental health professionals haven't been conducted yet. Accordingly, the current cross-sectional study investigated these features in mental health professionals compared to a control group without healthcare-related working conditions.

Methods

All procedures contributing to this work complied with the standards of the local Ethics Committee and were conducted according to GCP standards.

Participants

The study sample included individuals belonging to an assertive outreach team for patients suffering from schizophrenia or bipolar disorder, including psychologists, social workers and psychiatric nurses, who had spent considerable time in mental health service provision. Control subjects (matched for age and sex) without healthcare-related working conditions were recruited from local shopping centres or factories and from other organizations.

A medical screening interview was used to exclude subjects with any physical or neurological illness or any condition or medication affecting neural or cerebrovascular function. Psychiatric disorders were excluded by means of the *Mini Mental Neuropsychiatric Interview* (*MINI*) (Sheehan et al., 1998) and the German version (Fydrich, Renneberg, Schmitz, & Wittchen, 1997) of the *Structured Clinical Interview for Axis-II-Disorders* according to DSM-IV (*SCID II*) (First, Gibbon, Spitzer, Williams, & Benjamin, 1997).

Emotional Intelligence

EI was assessed by means of the German version of the Mayer-Salovey-Caruso-Emotional-Intelligence Test (MSCEIT) (Steinmayr, Schütz, Hertel, & Schröder-Abé, 2011), which provides eight task scores that measure the four branches of the EI model for adults: perceiving emotions, using emotions, understanding emotions and managing emotions. These branches cover all aspects of EI and can be assigned to the areas of emotional experiencing (perceiving + using emotions) and emotional reasoning (='strategic' EI; understanding + managing

emotions). The overall reliability of the test is $r = .93$. It is both content and structurally valid and shows discriminate validity from measures of analytic intelligence and many personality constructs (Brackett & Salovey, 2006).

Resilience

Resilience was assessed using the German version (Schumacher et al., 2005) of the Resilience Scale [RS-25; Wagnild & Young, 1993], which covers five factors of resilience: purpose, perseverance, self-reliance, equanimity and existential aloneness. Items are scored on a seven-point scale ranging from 1 = strongly disagree to 7 = strongly agree, with possible scores ranging from 25 to 175. Higher values indicate higher resilience.

Neurocognitive functioning

In order to control for neurocognitive deficits as a potential source of emotional or resilience-related impairments the 'Brief Assessment of Cognition in Schizophrenia' (BACS) (Keefe et al., 2004) was conducted. In addition, verbal intelligence was measured using the German adaptation (Lehrl, Triebig, & Fischer, 1995) of the National Adult Reading Test (Nelson, 1982), the 'Mehrfachwahl-Wortschatz-Test-B' (MWT-B), a reliable and valid multiple-choice vocabulary test.

Statistical methods and data analysis

The distribution of continuous variables was checked for deviations from normality by means of the Shapiro–Wilk test. Comparison of mental health professionals and control subjects with regard to sociodemographics, EI and resilience was performed by means of the respective two-sample tests, i.e. *t*-Test, Mann–Whitney *U*-test and chi-square test, depending on the variable type. Associations between MSCEIT subscales and RS-25 were investigated by correlation analysis. As the majority of the MSCEIT subscales showed significant deviations from a normal distribution, the Spearman rank correlation coefficient was used. In addition, partial correlation analysis was applied to adjust for an effect of sociodemographic variables and neurocognition.

Results

Sample characteristics

Demographic characteristics of participants are summarized in Table 1. The two groups were comparable with respect to age, sex, BACS composite score and verbal intelligence, but differed with regard to education. However, adjustment for educational level left our findings virtually unchanged.

Emotional Intelligence and resilience

MSCEIT scores were available for all study participants and RS-25 scores for all mental health professionals and 49 control subjects. Both groups showed an average level of EI in all

Table 1. Demographic variables.

Variable		Mental health professionals ($N = 61$)	Control subjects ($N = 61$)	p-Value[a]
Age, mean ± SD, years		41.9 ± 9.6	39.9 ± 11.8	.316
Sex, N (%)	Male	17 (27.9)	25 (41.0)	.182
	Female	44 (72.1)	36 (59.0)	
Education, mean ± SD, years		16.4 ± 2.5	12.9 ± 3.3	<.001
BACS composite score, mean (average range: 40–60)		57.9 ± 7.7	57.3 ± 9.5	.858
MWT-B, mean ± SD, percentile		81.4 ± 14.8	71.9 ± 21.1	.063

Notes: *Abbreviations:* BACS = Brief Assessment of Cognition in Schizophrenia, MWT-B = Mehrfachwahl-Wortschatz-Test-B.
[a]Mann–Whitney *U*-Test or Fishers exact Test (for sex), respectively.

Table 2. Comparison of mental health professionals and control subjects in terms of Emotional Intelligence and resilience.

	Group				Statistics	
	Mental health professionals ($N = 61$)		Control subjects ($N = 61$, EI) ($N = 49$, RS)		Effect size	p-Value[b]
MSCEIT (Sub-)scale[a]	Mean	SD	Mean	SD	d	p
Perceiving emotions	104.9	12.8	104.8	15.9	.01	.540
Using emotions	109.1	10.7	106.0	14.1	.24	.314
Understanding emotions	103.4	12.6	99.6	15.4	.27	.133
Managing emotions	106.9	12.9	105.1	14.8	.13	.596
Experiential EI	107.7	12.0	106.2	16.1	.10	.984
Strategic EI	106.6	12.4	103.2	16.4	.24	.374
MSCEIT total score	108.9	11.8	106.1	16.9	.19	.614
RS-25 total score (range: 25–175)	150.0	14.7	151.7	11.1	–.12	.698

Abbreviations: MSCEIT = Mayer-Salovey-Caruso-Emotional-Intelligence Test, EI = Emotional Intelligence.
RS-25 = Resilience Scale.
[a]MSCEIT scales were calibrated to have a mean of 100 and a standard deviation of 15 in the general population.
[b]Mann–Whitney *U*-Test.

MSCEIT branches and were comparable in this regard as well as with respect to RS-25 total scores (Table 2). None of the sociodemographic variables showed a significant association with MSCEIT or RS-25 scores, and the same was true for cognition (BACS composite score).

Association of Emotional Intelligence with resilience

As shown in Table 3, correlation analysis revealed a positive association between the RS-25 total score and the following parts of the MSCEIT: 'using emotions', 'managing emotions', 'experiential EI' and the MSCEIT total score. Partial correlation analyses, adjusting for cognition as measured with the BACS composite score, showed that cognition was not responsible for the observed associations between the RS-25 and the MSCEIT subscores and also not for the lacking correlation with the subscale 'understanding emotions'. Similar findings were obtained when adjusting for age, sex and education.

Table 3. Correlation between Emotional Intelligence and resilience.

MSCEIT (Sub-)scale	RS-25 total score[a]
Perceiving emotions	.167
Using emotions	.233*
Understanding emotions	−.022
Managing emotions	.211*
Experiential EI	.199*
Strategic EI	.129
MSCEIT total score	.199*

Notes: Spearman rank correlation coefficient. *Abbreviations:* MSCEIT = Mayer-Salovey-Caruso-Emotional-Intelligence Test, EI = Emotional Intelligence, RS-25 = Resilience Scale.
*$p < .05$.
**$p < .01$.
[a]Note that *p*-values were denoted only when significance was attained.

Discussion

The primary objective of this study was to investigate EI and resilience in mental health professionals compared to a control group without healthcare-related working conditions.

Intuitively, we expected higher EI levels in the assertive outreach team members as compared to the general population. However, both assertive outreach team members and control subjects showed relatively high levels of EI and did not differ in this regard. By contrast, van Dusseldorp et al. (2011) reported on significantly higher levels of EI in mental health nurses than in the general population. These different outcomes are most probably caused by the different kinds of EI measures used in the two studies.

Our findings suggest that the daily working routine as an assertive outreach team member for patients suffering from SMI does not serve as 'training' and has no influence on ability-based EI. Similarly, the two groups were also comparable with regard to resilience as measured by the RS-25. Accordingly, mental health professionals may not be more resilient and therefore not more 'protected' from stressors than the general population. This is of special relevance, since health care professionals may consequently be at increased risk for burnout and other stress-related health issues (Mealer, Burnham, Goode, Rothbaum, & Moss, 2009).

When interpreting our data one has to consider a close professional relationship between the assertive outreach team and our clinic. Some study participants have voiced concerns about protection of privacy and providing personal data to persons, to whom they have a professional connection. This points to a possible selection bias since we did not obtain information from those team members who did not consent to study participation and clearly, less resilient or 'emotionally intelligent' caregivers may theoretically have stopped working in this field due to the burden associated with this profession.

Importantly, we found a positive association between resilience and most branches of EI, albeit – probably due to the small sample size – only small in magnitude. Based on this finding, one could suggest that training of EI may strengthen resilience. It will be critical to investigate this issue in a larger sample with a more homogeneous professional background. In addition, future studies could also examine the association between EI/resilience and effectiveness or career satisfaction. Lastly, longitudinal follow-up data are needed to determine how both facilitating resilience as well as metacognitive and social cognition training programs, which have been shown to improve affect recognition, social cognition and psychosocial functioning in patients suffering from SMI (Bersani et al., 2013;

Rocha & Queirós, 2013; Sachs et al., 2012) may have a positive impact even on healthy individuals' EI and resilience, respectively, and how the associations of these features interact and change over time.

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No potential conflict of interest was reported by the authors.

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Behavioral Health Provider Coalition
of Cape Cod and the Islands

Breakout Session #3

"Building Supportive Pathways to Recovery on Cape Cod"

Presenters:

Stephanie Briody, Co-Founder, Behavioral Health Innovators

Amy Doherty, Founder, Wellstrong

Sarah Ducie, Peer Mom Specialist, Moms Do Care Program, Duffy Health Center

Don Lonergan, Jr., Lead Peer, Vinfen

Adrienne Morosini, LICSW, Partial Hospital Program Clinician, Cape Cod Hospital

Jason Raineri, Certified Peer Specialist

Behavioral Health Provider Coalition
of Cape Cod and the Islands

Individuals with lived experience, families, advocates, researchers and health providers have fully embraced the expectation that mental health conditions and substance use disorders can be managed successfully and that recovery is possible. The federal government through the Substance Abuse Mental Health Services Administration (SAMHSA) has established the working definition for recovery as *a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential*. Join us to learn from local recovery-oriented programs and peer recovery advocates how focusing on health, home, purpose and community can support the pathway to successful recovery.

Participants attending this panel presentation and discussion will be able to:

1. Discuss "Guiding Principles of Recovery" as outlined by SAMHSA (Substance Abuse & Mental Health Services Administration).
2. Identify critical components necessary for an evidenced based recovery oriented program.
3. Describe the role of leadership in implementing a successful recovery program in a community setting.

Journal Articles:

Farkas, M., Gagne, C., Anthony, W., Chamberlin, J. (2005). Implementing Recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal, Vol. 41, No. 2.* DOI:10.1007/s10597-005-2549-6

Slade, M., Amwering, M., Farkas, M., Hamilton, B., O'Hagan, M., et al (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World psychiatry;13:12-20.*

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SAMHSA's WORKING DEFINITION OF RECOVERY: 10 GUIDING PRINCIPLES OF RECOVERY

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Substance Abuse & Mental Health Services Administration
1 Choke Cherry Road • Rockville, MD 20857 • 1-877-SAMHSA-7

U.S. Department of Health and Human Services

SAMHSA's WORKING DEFINITION OF RECOVERY: 10 GUIDING PRINCIPLES OF RECOVERY

BACKGROUND

Recovery has been identified as a primary goal for behavioral health care. In August 2010, leaders in the behavioral health field, consisting of people in recovery from mental health and substance use problems and SAMHSA, met to explore the development of a common, unified working definition of recovery. Prior to this, SAMHSA had separate definitions for recovery from mental disorders and substance use disorders. These different definitions, along with other government agency definitions, complicate the discussion as we work to expand health insurance coverage for treatment and recovery support services.

Building on these efforts and in consultation with many stakeholders, SAMHSA has developed a working definition and set of principles for recovery. A standard, unified working definition will help advance recovery opportunities for all Americans, and help to clarify these concepts for peers, families, funders, providers, and others.

DEFINITION

Working definition of recovery from mental disorders and/or substance use disorders

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

Health

Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.

Home

A stable and safe place to live

Purpose

Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society

Community

Relationships and social networks that provide support, friendship, love, and hope

10 GUIDING PRINCIPLES OF RECOVERY

Hope	Relational
Person-Driven	Culture
Many Pathways	Addresses Trauma
Holistic	Strengths/Responsibility
Peer Support	Respect

Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experience—that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues.

Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

Drawing on research, practice, and personal experience of recovering individuals, within the context of health reform, SAMHSA will lead efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them.

Please see SAMHSA's Recovery Support Initiative (http://www.samhsa.gov/recovery) for more information on recovery.