Resilience and Recovery in Family Mental Health Care

by A. Kathryn Power, Director, Center for Mental Health Services

I never cease to be amazed at the resilience of people. I am convinced that resilience is the natural state of affairs for each and every one of us...it only requires our efforts to remove obstacles that get in the way of its expression.

During my years as an advocate for the needs of individuals with mental illness and my tenure as Director of Rhode Island’s Department of Mental Health, Retardation and Hospitals, I was fortunate to see, time after time, the real-life results of resilience in the face of chronic illness and the importance of family and relationships in the process of recovery.

Promoting mental health
It is these experiences, along with a heartfelt belief in the resilience of people, that I now bring to my work at the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services (CMHS). SAMHSA is the federal agency within the U.S. Department of Health and Human Services charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

Within SAMHSA, the Center for Mental Health Services seeks to improve the availability and accessibility of high-quality community-based services for people with or at risk for mental illnesses and their families. CMHS supports programs that apply knowledge about best community-based systems of care and services for adults with serious mental illnesses and children with serious emotional disturbances. CMHS also collects, analyzes, and disseminates national data on mental health services.

Yes, we have taken to heart the theme of “mental health.” In a recent article by the psychiatrist George Valliant in the American Journal of Psychiatry, the issue of just what is mental health was tackled. Arguably, it is many things. Dr. Valliant notes that mental health is the antonym of mental illness, yet it is not the absence of mental illness; that it is more than the “average” psychological wellness of the population; that it is more that simply subjective well-being. In fact, he argues, mental health must also embrace concepts of maturity, emotional or social intelligence, and resilience. How then does our interest in mental health intersect with our mission to serve the seriously ill?
RESILIENCE AND RECOVERY continued from page F1

Consumer and family driven care

CMHS has been assigned the federal lead to implement the recommendations of Achieving the Promise: Transforming Mental Health Care in America, the final report of the President’s New Freedom Commission on Mental Health. Achieving the Promise outlines a vision of a national mental health care system that is unified, consumer and family driven, and focused on recovery. Not surprisingly then, Goal 2 of the Commission’s six goals is “Mental Health Care is Consumer and Family Driven.”

This goal emerges from the finding that without family involvement in the development, planning, and delivery of mental health care, services will be unable to support the ultimate goal of recovery from mental illness. There is much work to do to make this a reality. But positive actions are already being taken throughout government:

- The Agency for Children and Families funds the 61-site National Network of University Centers for Excellence in Developmental Disabilities Education, Research, and Service (UCEDD). Established in 1963, UCEDDs engage in four broad tasks: conducting interdisciplinary training, promoting exemplary community service programs and providing technical assistance at all levels from local service delivery to community and state governments, conducting research, and disseminating information to the field. At the Early Childhood Center in New York City, for example, toddlers and preschool age children with developmental delays and disabilities and their families receive psychotherapeutic supports and behavioral interventions.
- The Department of Education is funding a project to develop, implement, and evaluate the effectiveness of two different family support practices intended to foster social and emotional development and resilience in infants and toddlers with or at risk of disabilities.
- At the National Institutes of Mental Health, research is addressing the extent to which mental health interventions can fit within real-world systems. The Schizophrenia Patient and Family Continuity of Care program is providing web-based services for consumers and families with schizophrenia, including online support groups, monitoring by mental health professionals, and consumer-friendly information on the illness and its treatment.
- The Indian Health Service funds a mental health and community safety initiative that focuses on strategies to meet the mental health, behavioral, and substance abuse needs of young people and their families at risk for or involved with the juvenile justice system.
- At the Center for Mental Health Services, the Comprehensive Community Mental Health Services Program for Children and Their Families provides grants for the improvement and expansion of systems of care to meet the needs to the estimated 4.5 to 6.3 million children nationwide with serious emotional disturbances and their families. First authorized in 1992, the program has funded some 90 grantees across the country. These grants support a broad array of services designed to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families. They coordinate “systems of care” by developing partnerships with mental health, child welfare, education, juvenile justice, and other local, public and private agencies. Each project provides services that are underdeveloped or nonexistent in most communities, such as intensive family-based services, respite care, day treatment, clinic- and school-based services, crisis outreach services, therapeutic case management, therapeutic foster care, and diagnostic and evaluation services.

A new emphasis on family

This represents only a small fraction of the work being done that directly or indirectly allows the natural resilience of the family to emerge, thus fostering the recovery of family members with mental illness and strengthening the mental health of the family system. In the years to come, implementing the recommendations of the President’s New Freedom Commission on Mental Health will bring a newly invigorated emphasis on the family. The support of committed professionals and organizations such as the National Council on Family Relations will be essential to the success of this long-term endeavor. I hope you will continue your efforts and contribute your deeds and ideas as we work to build a transformed system of mental health care that results in stronger and healthier American families.

Coming Up in Family Focus

**June 2004: Family Life Education**

The deadline is April 5, 2004. To contribute a piece, please contact the editor, Nancy Giguere, immediately at gigue001@umn.edu.
“What about the Couple?”: Exploring the Presence of Psychological Distress Among Interracial Couples

by Jenifer Bratter, Ph.D, Assistant Professor, Department of Sociology, University of Houston; and Karl Eschbach, Ph.D., Associate Professor, Division of Geriatrics, Sealy Center on Aging, University of Texas Medical Branch – Galveston

According to the U.S. Census Bureau, in 2000 there were over one million couples consisting of partners of different racial backgrounds. Despite a growing number of families that cross race and ethnic boundaries, concern still exists about how interracial families fare in comparison with their racially similar counterparts. Since the 1920s, scholars have focused on one area of well-being, mental health and psychological adjustment.

Most studies have asked whether individuals living within multietnic contexts experience specific stresses or strains in reconciling an existence “between two worlds.” Psychologists and sociologists alike have investigated this issue in terms of identity development focusing mostly on multiracial offspring, responding to the question, “What about the children?”

Fewer studies have focused on the interracial couples themselves. When such studies have been done, they have been based on small community-based or clinical samples. Few, if any studies, have explored the psychological health of interracial couples using a population-based survey.

The National Health Interview Survey

This article reports the results of recent analyses of the National Health Interview Survey (1997-2001). The survey examines whether or not persons in interracial unions are at greater risk of non-specific psychological distress. The presence of psychological distress is measured using a symptom-based scale called the K6 that was developed by Ronald Kessler and associates. Persons who report an elevated frequency of symptoms, such as sadness, nervousness, restlessness, and hopelessness, receive a high ranking on the K6 scale and are considered to be experiencing high levels of “psychological distress.”

At the outset, we predicted that the intermarried or cohabiting would have higher rates of psychological distress in light of accounts, focusing mostly on Black-White unions, of stressful experiences related to reactions of family and friends to a racially different partner.

Black-White marriages

Our analyses demonstrated that having an interracial partner does coincide with higher level of psychological distress for certain groups. For example, 8.8 percent of White females whose husbands are White reported a high degree of psychological distress, compared to 12.3 percent of White women with non-White partners. But this was not the case for non-White males whose partners were White females. The rate of distress for Black males was 6.8 percent for those with White partners. This was only slightly higher than the rate of 6.1 percent for men whose partners were Black. This finding is interesting in light of classic notions of the stigma supposedly attached to interracial marriage between African Americans and Whites. These findings indicate that in such marriages the White partner, particularly the female partner, may be more prone to psychological distress than the African American partner.

Beyond Black and White

What of groups who intermarry more often? We anticipated that Asians, Hispanics, and Native Americans in interracial couples would experience less stress since having a different race partner is a more common occurrence. This seemed to be the case for Asians, whose rate of distress was 6.6 percent for Asian men with Asian partners and only 5.9 percent for Asian men with non-Asian partners. Similarly, the rate for Asian females with Asian partners is 7 percent, while the rate for those with non-Asian partners was 8.6 percent.

Findings for Hispanics and Native Americans revealed more complexity. While both groups intermarry or cohabit across racial lines relatively often (18 percent of Hispanics have non-Hispanic partners and over 50 percent of the Native Americans in this sample have non-Native partners), the patterns of psychological distress varied by gender and race of the interracial partner.

Rates of distress among intermarried Hispanics tended to be higher only among those Hispanic men and women whose partners were both non-White and non-Hispanic (African American, Native American, Asian, or Pacific Islander). By contrast, the rate of distress among intermarried Native Americans was low for both men (6.1 percent) and women (5.8 percent) regardless of the race of their partner.
Depression in the Perinatal Period

by Carol Mertens, Ph.D., CFLE, Research Coordinator; Michael O’Hara, Ph.D., and Scott Stuart, M.D., Co-directors, The Iowa Depression and Clinical Research Center, The University of Iowa

The mental health of women during pregnancy and in the postpartum period has recently received a great deal of media attention. Women of childbearing age are generally at high risk for depression. Women of this age are also at their greatest risk of experiencing their first episode of major depression. In addition, the perinatal period—that is, the months just before and just after giving birth—is a time of profound physiological and psychological transition. Although many people characterize this period as a time of great joy and excitement, it is also a time when depression and the mental health of the mother can become serious concerns.

WHAT ABOUT THE COUPLE? continued from page F3

American, or Asian). This is important to note since these marriages constitute a minority of interracial marriages involving Hispanics.

For Native Americans, psychological distress was higher among those in interracial unions among the men, not the women. The data show that 8.3 percent of Native American men with Native American partners reported a high level of distress compared to 17.8 percent of those with non-Native partners.

Several accounts have focused on the problems faced by couples due to the reactions of friends, family members, and even strangers. But elevated distress rates of White females are partially explained by the influences of income, educational background, having children, or type of relationship (married or living with a partner). This was not the case for Native Americans and Hispanics in interracial marriages, who, regardless of social class or family structure, maintained higher rates of distress. Hispanics with White partners were the one exception.

Debunking the myths
What does this mean? Ultimately, it is our hope that these findings will debunk classic notions that interracial marriage or relationships are in and of themselves stressful or distressing. These results raise questions as to the quality of this strain and whether the severe stress faced by such couples is related to issues of racial difference.

Elevated levels of distress for White women who are married or cohabiting with non-White men are partially explained by the socioeconomic factors suggesting that this pattern may be due to socioeconomic realities, rather than conflicts specific to being an interracial couple. Results for Hispanics that reveal elevated distress rates for those with non-White partners question the classic understanding of the “White-non-White” racial divide as a source of conflict, especially as “Hispanics” encompass several ethnic and racial groups. Unfortunately, small sample size limited our ability to look at these issues with ethnic specific subgroups. Despite this limitation, notions of ethnic dissimilarity and its implications should be expanded to include interactions among communities of color.

Finally, the results demonstrate that multi-ethnicity needs to be better incorporated into research on family dynamics and mental health. As numbers of interracial marriages and multiracial children continue to grow, issues faced by this “new family form” can no longer be separated from larger concerns of families in general.

For more information, contact Jenifer.Bratter@mail.uh.edu.

A widespread problem
Estimates of the prevalence of depression during pregnancy range from 4 to 18 percent, with a general consensus of about 10 percent. Approximately 25 percent of women who have a psychiatric history of depression develop depression during pregnancy. While some pregnant women may not meet criteria for a major depressive episode, it has been estimated that up to 30 percent of pregnant women experience depressive symptoms that significantly interfere with daily functioning.

A recent meta-analysis of 59 postpartum depression prevalence studies, encompassing 12,810 women around the world, found an average prevalence rate of 13 percent. A previous history of depression, the absence of close, confiding relationships, and feelings of depression and anxiety during pregnancy have all been associated with postpartum depression. Clearly, women in the perinatal period are susceptible to depression or depressive symptoms.

Associated problems
Depression during pregnancy has been found to be significantly associated with cigarette, alcohol, and other substance abuse. Women who experience depression during pregnancy are at higher obstetrical risk because they are less likely to seek prenatal care than women who are not depressed. In addition, women who experience depression during pregnancy are at high risk of developing postpartum depression.

Depression during the postpartum period inhibits the mother’s ability to properly care for the infant and increases the risk that difficulties in care taking will occur. Depressed mothers are more likely to give up breastfeeding early and...
Depression: A Deterrent to Psychological Well-Being Among Poor, Rural Mothers

by Leigh Ann Simmons-Wescott, MFT, Ph.D. Candidate, Department of Child and Family Development, The University of Georgia; and Bonnie Braun, Ph.D., Extension Family Life Specialist, Department of Family Studies, University of Maryland

Most people agree that good mental health, or psychological well-being, improves the quality of life. Psychological well-being is critical if one is to work, be a productive and contributing citizen, and effectively raise children. For individuals with mental health disorders the tasks—and the enjoyments—of daily life become ongoing challenges. This is especially true for individuals living below or near the poverty level. Although the direction of causality is unclear, research demonstrates a strong correlation between poverty and mental health disorders. Compared to individuals in higher income brackets, poor individuals experience mental health problems more often and with greater severity.

Given the relationship between poverty and mental health problems, findings from the first wave of “Rural Families Speak,” a longitudinal, multi-state study on the well-being of rural, low-income families, were not surprising. Nearly 49 percent of the mothers scored as being at risk for clinical depression. This compares to national estimates of 9.5 percent for the general population. The high incidence of depression in this sample indicates a need to better understand the effects of depression on the overall well-being and perceived quality of life of these rural mothers.

DEPRESSION IN THE PERINATAL PERIOD continued from page F4

to report difficulties managing their infants’ crying and demands. Depressed mothers have been found to be more punitive, more hostile, more rejecting, less responsive, and less affectively available to their children than mothers who are not depressed. Research has shown an association between postpartum depression and impaired mother-infant bonding as well as later problems in children’s cognitive and socio-emotional development.

Women in the perinatal period face specific challenges that may impact their mental health including redefining roles and relationships with their partners, family members, and other important people in their lives. Other issues for women include those related to work and child care, parenting techniques and philosophies, and a woman’s own beliefs about her ability to parent. These challenges, along with a history of depression or a genetic predisposition toward depression can leave women in the perinatal period vulnerable to depression. Without question, the perinatal period is a time when recognition of and effective treatment for depression are crucial.

The need for nonpharmacological intervention

Treatment of depression during pregnancy is complex and involves clinical judgments about the risks of the illness versus the risks of treatment. Although antidepressant medication has been shown to be an effective treatment for depression, no antidepressant medication has been approved by the FDA for use during pregnancy or for mothers that breastfeed. Safety of medications during pregnancy cannot be assumed, since there is a lack of controlled medication studies in pregnancy.

This means that the use of nonpharmacological interventions during the perinatal period is important. Many parents simply do not wish to take the risk, however small, of harming their offspring’s development. Pregnant women may even decrease or discontinue medication usage when they learn they are pregnant.

Psychotherapy is an effective and safe treatment for depression during the perinatal period, and should be strongly considered, since the use of antidepressant medication is relatively contraindicated, especially for mild or moderate depression.

Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) is a time-limited, empirically based treatment for depression. IPT focuses specifically on interpersonal relationships as a means of bringing about symptom relief and improving interpersonal functioning. The two most important goals of IPT are to help patients improve their interpersonal relationships or change their expectations about them and to assist patients to strengthen their social support network so they can better manage interpersonal distress.

In 2000, the Iowa Depression & Clinical Research Center (IDCRC) completed a study of IPT funded by the National Institute of Mental Health. The study found that IPT is an effective nonpharmacological treatment for women experiencing
A DETERRENT  continued from page F5

Barriers to mental health care
Rural residents are particularly vulnerable to mental health disorders because they face significant barriers to treatment. Many of these barriers are the results of limitations in the infrastructure of the mental health system, including: (a) a shortage of available and qualified mental health care providers, (b) the long distances help-seekers must travel to receive services, and (c) the high cost of treatment. Many rural counties have only one or even no inpatient facilities, and outpatient facilities are few and far between.

Despite the special needs of rural areas, the delivery systems and methods imposed on them are drawn from urban models. Very little programmatic research on preventive interventions with rural residents has been conducted. Evidence suggests that the existing rural mental health system is outdated and in need of revamping. To make matters worse, many low-income rural residents do not have health insurance. This means they often can’t afford care even if it is available.

The limitations in infrastructure are compounded by stigma. Many rural residents say they do not obtain mental health care because of the negative labeling and perceived shame associated with having a mental health problem and seeking professional help. According to recent research, this negative sentiment is especially true among rural individuals who report higher levels of depressive symptoms and are most in need of care.

Negative effects of depression
Since nearly half of the 387 respondents in this study reported symptoms of clinical depression, we asked the question: What effect does depression have on these mothers’ quality of life and overall well-being? Specifically, we examined the relationship of depression to other characteristics of well-being, including physical health, the ability to work and earn a living wage, confidence in parenting abilities, receipt of social support, and overall life satisfaction.

We found that mothers who scored in the depressed range were less likely to be working. If they did work, they were more likely to earn lower wages. These same mothers were also more likely to feel less confident in their parenting skills, have less satisfaction with social supports, report more chronic health conditions, and have less overall life satisfaction.

Perspective and age matter
One of the interesting findings in this study was that many of the mothers did...
Noncustodial Mothers and Mental Health: When Absence Makes the Heart Break

by Deborah Eicher-Catt, Ph.D., Assistant Professor of Communication Arts and Sciences, The Pennsylvania State University, York

Mending a broken heart is not only a concern for romantic partners. All familial relationships throughout the life course can cause mental suffering when relational expectations are shattered—a father severely disappointed by his son or a sister betrayed by her brother may be as grief-stricken as abandoned lovers.

Even more painful is the inability of many divorced or separated women to be with and care for their children everyday. For women who have lost or given up custody, the absence of their children is like a knife through the heart. After experiencing the repeated hellos and goodbyes of “visitation,” one of my co-researchers said she didn’t realize that her “heart could break so many times.”

According to the Bureau of the Census, there are over two million noncustodial mothers in the United States. Noncustodial mothers are of various racial and ethnic backgrounds, but most are 25 to 45 years old, heterosexual, lower-to-middle class, educated, and have more than one child.

De-legitimized status

Most people agree that it is possible to be an effective noncustodial father, but there is no model that legitimizes noncustodial mothering within the wider network of social relations. The role these mothers play is ambiguous: they both are, and are not, mothers. Over the last 12 years, I have conducted numerous qualitative interviews with these women and have heard their stories of heartbreak.

Noncustodial mothers are barely visible on our social landscape. Not wanting to understand the effects of depression and poor mental health on rural residents over time. It is clear that the need for mental health care exists among these mothers. To provide that care will require the development of effective delivery systems within a culture that holds negative beliefs about having, and seeking treatment for, mental disorders. Additional research in this area is vital if we are to develop prevention and treatment programs that will truly meet the needs of rural residents.

For more information contact, Leighann@uga.edu. To learn more about “Rural Families Speak,” visit www.ruralfamilies.umn.edu.
NONCUSTODIAL MOTHERS  continued from page F7

be labeled “bad” or “unfit,” most noncustodial mothers try to hide the fact that they hold such a de-legitimized status.

Involuntary loss of custody
Some noncustodial mothers have involuntarily lost custody of their children due to suspected physical or mental abuse or neglect. Under these circumstances, mothers spend time with their children through court-ordered supervised visitation procedures. Their challenge becomes learning to effectively maneuver within “the system” while attempting to maintain some kind of contact with their children.

These women become easily discouraged by the constant demands placed on them by the system: parenting or anger management classes, regular meetings with their case worker or counselor, the need to find or maintain a steady job. Because their parenting relationship is jeopardized, many of these women have no idea how to relate to their children. It is an “uphill battle” that often leaves them hopelessly depressed. In the end, many women give up the fight.

Voluntary loss of custody
Women who voluntarily give up custody for financial reasons or who are awarded only partial custody are haunted by the myths about noncustodial mothers. These women may feel even more socially scorned than mothers who have been deemed legally “unfit.” This is true even though many of these women felt it was in their children’s best interest to give up custody. As one mother told me, “Crucify me for leaving my children in their familiar home, neighborhood, and school environment rather than moving them to a one-bedroom apartment in the city!”

Our social norms, of course, dictate that women should be the primary care providers for young children. Women in general are so programmed to accept this idea that many noncustodial mothers constantly struggle with deep depression, overwhelming guilt, self-doubt, and low self-esteem. Several women with whom I spoke had tried to commit suicide because they concluded that whatever emotional attachment they previously shared with their children had vanished. Women who can afford to seek professional counseling for their conflicted feelings often find that mental health practitioners either prejudge their situation or lack the background in mothering issues to provide effective help.

Two strategies
Unfortunately, there is no “recipe” for how to be an effective noncustodial mother. There are few first-hand descriptions of this experience that can help mothers prepare for this new role.

Mothers in this situation commonly try one of two strategies for dealing with this difficult issue. The first is overcompensation. This entails attempting to re-enact the traditional norms of motherhood in the atypical situation of visitation. Unfortunately, this strategy fails miserably because the context of visitation requires different communication patterns than those “prescribed” by the traditional mother role. As a result, the mother is repeatedly reminded that she can no longer meet the ideal, no matter how hard she tries.

The second strategy involves appealing to the context of visitation for help in determining what the mother should say and do. Mothers who use this strategy try to be “friends” or “advice-givers” to their children. But this strategy also fails because parenting demands more than friendship requires. These mothers too easily relinquish whatever parental authority they had left. Consequently, discipline becomes an increasing problem. With either strategy, noncustodial mothers vacillate between two contradictory perceptual frameworks—that of “traditional mother” and that of “mother as friend.” Neither is effective and both undermine these women’s overall mental health.

Changing the focus
Mental health practitioners would find it useful to counsel noncustodial mothers to focus solely on the relationship they re-establish with their children during visitation. It is the relationship, after all, that will re-create and maintain the bonds of kinship the women so desire. Practitioners should ask each noncustodial mother: What kind of relationship do you want to have with your children? Is it a relationship based solely on parental authority? Or is it a relationship based upon mutual trust, true caring, and nurturing—regardless of the time and space that separate you from your children?

Such a reframing helps mothers make the shift from focusing on the role of mother to focusing on sustaining a relationship with their children, in whatever form that relationship may assume. According to the veteran noncustodial mothers with whom I spoke, this reframing is the key to mending the broken hearts of every family member involved.

For more information, contact dle4@psu.edu.

There are over two million noncustodial mothers in the United States.

Deborah Eicher-Catt, Ph.D.
Case Study: When a University Student has Mental Health Problems

by Jennifer Yim, B.S.W, PGDE, M.Ed., RSW, Counselor, Student Affairs Office, The Hong Kong Institute of Education

The World Health Organization has warned that depression, which is an emotional illness, will become the second most prevalent killer in the world. Many young people are showing signs of depression and other mental illness: for example, Hospital Authority figures in Hong Kong show that between 1998/99 and 2000/01, the number of adolescents under 15 receiving mental health treatment rose from 1,355 to 2,321, an increase of over 70 percent.

Severe stress often affects the mental health of university students. At the Hong Kong Institute of Education, there are about 3,500 full-time students and over 20,000 part-time students. Many seek help from counselors for problems with adjustment, relationships, finances, sexual issues, and mental illness. In recent years, however, the number of students suffering from mental health problems such as psychosis, anxiety, and depression has increased dramatically. Students with these problems commonly suffer from low self-esteem, feelings of inadequacy, ineffective coping skills, maladaptive behavior, unsatisfactory interpersonal relationships, and poor general functioning. A recent survey of nearly 8,000 first-year tertiary education students found that 40 percent suffered moderate to severe anxiety. Over 20 percent suffered from depression, anxiety, and stress.

As an example, I will discuss the case of Mr. Lee, whose mental illness was aggravated by the pressures of his university experience.

Current situation and history

Mr. Lee was a 23-year-old student in his second year at the university. Since 1989, he had suffered from mental illness, mostly mania, for which he had taken medication for a number of years. He had been in remission for over one year before being admitted to the university. He felt that his first year of study was happy and that his academic performance was good.

But after he began his second year of study on a new campus, he began to have difficulty in adjusting to the environment and the academic subjects. He panicked when he failed to find the right classroom. During a life-skils class, he became very emotional and kept repeating in a loud voice that he was mentally ill. The lecturer thus referred Mr. Lee to a counselor for follow-up services.

Mr. Lee seemed very nervous and tense when he talked with the counselor. His speech was fast, and he appeared agitated and fearful. He would continuously talk about his past experience without a break unless someone stopped him. He understood cognitively what he needed to do, but he was helpless and not motivated to make changes. He blamed the environment—his family and the university—for his problems. His conversation reflected some symptoms of hallucination and illusion.

Mr. Lee realized that his academic experience was very stressful. His lack of adjustment to the new environment caused him to panic and he showed symptoms of illusion and hallucination. He claimed the drugs made him sleepy and tired. He could not concentrate on his studies. In addition, he feared that he would not be able to catch up with his assignments after being absent for several weeks. Therefore, he was idle at home and spent most of his time sleeping and watching television. Mr. Lee decided that he should quit school because it was too stressful.

Family attitudes

Mr. Lee’s mother said she wanted him to continue his schooling. She blamed him for being lazy and avoiding his problems. But at the same time, she did not want to push her son as she felt this would negatively affect his mental condition. It was obvious that she wanted her son to attain a higher educational qualification.

Mr. Lee’s sister said family members had indulged her brother in the past, and that this was the reason for his current unhappiness. She wanted her brother to go to school, but she understood that...
this would be difficult since her brother was quite unstable and emotional. Mr. Lee’s grandmother realized that he did not go to school because he lacked confidence to face up to life’s difficulties. The counselor did not interview Mr. Lee’s father. But Mr. Lee said that his father would allow him to make his own decision.

The counselor’s evaluation
Under the over-protection of family members, Mr. Lee had been deprived of the opportunity for personal growth. Instead he always tried to meet the expectations of family members. As a result, he hesitated to stand up for his own rights and was blocked from learning independence. Even though cognitively he did not agree with his parents’ demands and expectations, he failed to strive to meet his own needs. Thus, it was hard for him to make his own decisions.

In addition, his failure to achieve academically during F5 and his withdrawal from another university further weakened his self-image and self-confidence about his ability to handle stressful life events. Thus, he tended to withdraw from stressful social encounters and avoided academic pressure.

Mr. Lee also felt stressed because his mother always pushed him to obtain higher qualifications. His mother lacked insight into her son’s problems. Her only feeling was that she regretted that he had missed the chance to study in a famous university in Hong Kong. Her high expectation of her son caused her to neglect his needs.

The counselor observed that Mr. Lee had a rather negative self-image and low self-esteem. He strongly feared academic failure and had difficulty adjusting to a new environment. He had an irrational belief that he could not catch up with his work, and he feared being punished by the lecturers. As a result of this strong sense of fear and powerlessness, his anxiety mounted. In addition, the side effects of the psychiatric drugs made tired and sleepy. He preferred to stay home and resisted attending class.

The counselor also noted that the mother-son relationship was too close and also conflictual. The family system did not provide the emotional support that Mr. Lee needed to become more independent. Mr. Lee’s father was apathetic about his son’s problems. As a result, Mr. Lee was reluctant to continue his education.

Goals and action plan
When the counselor began working with Mr. Lee, she focused on two short-term objectives:

- Agreeing on a behavioral goal that he would work toward achieving.
- Prioritizing and exploring the problems that affected Mr. Lee’s growth. The purpose of this was to help both Mr. Lee and his family understand his situation and accept his strengths and limitations.

The counselor also created a plan of action, which would be reviewed at the end of three months. This consisted of:

- Working through Mr. Lee’s negative feelings about his last academic experience, while helping him recognize that he had made efforts to face the problem and to make changes.
- Continuing drug therapy until Mr. Lee’s emotional state became more stable.
- Encouraging Mr. Lee to attend class as often as he felt able.
- Helping Mr. Lee’s parents to accept their son’s limitations and strengths and to respect his right to make his own decisions.
- Exploring other alternatives for Mr. Lee if he did decide to quit school.
- Helping Mr. Lee find ways to cope with difficulties as they arose.

To carry out these objectives, the counselor used three main strategies:
- Strengthening the father-son subsystem
- Challenging the enmeshment of the mother-son subsystem.
- Strengthening the parental subsystem.

Results
After three month’s intervention, the family situation had some what improved. The mother seemed more accepting of her son’s problems and began to lower her expectations for him. Mr. Lee was trying to attend class whenever he felt emotionally stable. The mother invited her husband to work with her to help their son. They accepted his problem, and at the same time began to realistically assess his ability for change. Nevertheless, Mr. Lee was still finding it difficult to catch up with his academic work. He also feared the upcoming Teaching Practice.

During therapy, Mr. Lee’s counselor was concerned that her client’s mental state might affect his teaching career, since this is a profession that demands great responsibility. She wondered if the Institute would allow him to graduate if his condition did not improve. This issue often aroused much discussion among the teaching staff at the Institute. The counselor notes that family therapy offers a wide range of techniques, but their application in an individual family situation is left up to the individual counselor. In Mr. Lee’s case, the counselor was not able to apply many different techniques due to time constraints, as well as the fact that the family members were not ready for drastic change.

For more information, contact swyim@ied.edu.hk.
The Role of the FLE in Infant Mental Health

by Sandra Huff, M.A. candidate, Human Services, Concordia University, St. Paul, Minnesota

In today’s society, parents are pulled in many directions. They must deal with the pressures of working outside of the home and meeting the financial needs of the family; finding affordable, quality day care; and spending quality time with their children. Unfortunately, society often allows families to struggle alone. Handling all of these issues at once can create “stress pile up,” leaving parents feeling helpless in the face of all these needs. For parents with infants and toddlers, the challenge is even greater. Infants and toddlers need a great deal of responsive and nurturing care for healthy development. This care lays the foundation for development into adulthood.

A significant factor in the social-emotional development of young children is the relationship between parent and infant. It is through this relationship that children learn and develop trust, empathy, compassion, generosity, and conscience—the qualities necessary for healthy cognitive development and school readiness. These are the building blocks of the infant’s mental health.

Defining “infant mental health”
The term “infant mental health” is a relatively new concept. The idea that an infant can experience mental health issues is a challenging concept—how can infants demonstrate symptoms of mental health issues when they lack life experience and have not yet faced the changes and pressures of the life cycle? Researchers have found, however, that infants do experience mental health issues and that their mental health status directly correlates with the quality of the parent-infant relationship.

If the relationship between infant and parent is responsive and nurturing, the child has a foundation for healthy development. But if a child’s cries go unattended and basic needs are not met, then this foundation can begin to crack and healthy development can be in jeopardy.

Importance of the FLE
Mental health, which should be considered simply as “one’s mental state,” has too often been directly associated with mental illness. This association has made many hesitant to seek professional intervention, such as therapy, when they or their children experience symptoms. In addition, a shortage of mental health professionals in some regions, especially rural and isolated areas, may make it impossible for children and families to receive services.

The family life educator (FLE) can play an important role in preventing problems by educating parents about children’s developmental needs. Parents are their infant’s first and most important teachers. Unfortunately, parenting does not come with a universal manual or handbook on how to raise a healthy, happy infant who will develop into a healthy, happy adult with the ability to function in today’s society. Instead, parents tend to rely on their own experiences with parents and other caregivers as foundation for their parenting skills. This may mean that parents lack appropriate parenting models. This may lead to poor relationships between parents and their infants and toddlers, which sometimes results in child abuse and neglect.

Relationship + routine = ritual
FLEs can help parents learn how to provide an environment conducive to the infant’s mental health. They do this by providing support for parents and teaching them how to create relationships, routines, and rituals with their children.

Early relationships do matter. It is important that parents learn how to read their infant’s cues so that they can meet their child’s basic needs. It is through this responsive interaction with the parent that an infant develops the capacity for trust, empathy, compassion, generosity, and conscience.

Routines are an essential component of a healthy parent-infant relationship. Routines develop naturally when parents can read the infant’s cues and follow the child’s lead in a responsive manner. This helps the infant develop internal patterns and learn how to self-regulate.

Basic needs such as feeding, sleeping, playing, and diaper changing can be enhanced when these activities are performed in regular patterns and within nurturing, responsive relationships. Meal times that include conversations between parent and infant and bedtime that begin with a bottle, followed by rocking and a story are examples of routines that are essential to health development.

The establishment of relationships and routines leads to the development of rituals. Rituals are intentional. They are designed for the sole purpose of strengthening the relationship between parent and child. They create predictability and connection for all family members involved. This predictability and connection creates family identity and values, which, in turn, create a “way of being” that can be continued into adulthood and passed down from generation to generation.

While there is definitely a role for mental health professionals in the area of intervention in infant mental health, FLEs can play an even bigger role in the area of prevention and education.

For more information, contact shuff@mail.ewu.edu.
KID CONNECTS: Integrating Mental Health and Primary Health Care

by Tracy Kraft-Tharp, Project Specialist, Kid Connects, Colorado Department of Human Services/Mental Health

The baby won’t stop crying. Mom has tried everything she knows. She has asked everyone for advice—her friends, her mother, her neighbors. She is exhausted because she has had little sleep since the baby was born. She is so tired that she may lose her job. The little relief she has is when the baby is at child care. Except now the child care center is calling. The baby can’t stay at the center because her constant crying is disrupting all the other children. Mom doesn’t know what to do.

Over 61 percent of U.S. children under age 4 are in some form of regularly scheduled child care. The Surgeon General’s report estimates that one in five children are suffering from social or emotional problems. In a recent Colorado survey of over 1000 early childhood care and education providers representing more than 26,000 children ages 0-8 years, those surveyed indicated that 15.4 percent of the young children in their care had emotional or behavioral problems serious enough to disrupt classrooms and distress teachers. Unfortunately, most child care providers deal with disruptive children by expelling them. According to the survey, children with emotional or behavioral challenges were 20 times more likely to be expelled than typically developing children.

Many children exhibiting aggressive and inappropriate behaviors may in fact be experiencing unscreened health problems. This may be especially true for low-income children who are less likely to receive physical and dental check-ups and follow-up care. In 2002, 7.8 million, or 16.8 percent of young children were uninsured. According to the Children’s Defense Fund, uninsured children are more than three times as likely to lack a regular source of health care and more than four times as likely to have delayed medical care because of cost. They are also more than three times as likely to lack necessary dental care, more than twice as likely to go without needed prescription medications, and more than twice as likely to go without eyeglasses.

On-site services

Kid Connects is an innovative program that integrates the provision of mental health and primary health care. Kid Connects provides mental health consultation and health care screening for young children in child care centers and family child care homes. This means that Mom can get assistance at her child care center. The mental health consultant will help her and the center teacher learn new ways to soothe the baby. Health care screenings may reveal a physical problem and the consultant will help Mom and the teacher follow up with care.

The Mental Health Corporation of Denver’s Pearl Project is currently implementing the Kid Connects model in four Head Start centers and one family child care home. The model is also being used by the Mental Health Center of Boulder County’s Child Development Program in three private centers and two family child care homes.

These programs are funded through a three-year State Innovation Grant from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services, which was awarded to the Colorado Department of Human Services, Division of Mental Health.

Two kinds of services

Experts have defined mental health consultation as a problem-solving and capacity-building intervention within a collaborative relationship between a mental health professional and one or more individuals with other areas of expertise, primarily child care staff. The mental health professional spends time in the classroom working with teachers, parents, and children. The Kid Connects model provides two kinds of mental health consultation:

- Center-based services involve consultation to center directors and staff about child development, strategies to handle behavioral problems, overall classroom environment, and quality improvements. Center-based activities could also include trainings on topics such as planning classroom transitions, sensory integration, and discipline for infants and toddlers.

- Child-specific services include direct involvement with specific children and consultation with their parents and teachers. These services focus on reducing problem behaviors and encouraging social and emotional competence in that particular child. Child-specific services can also include direct involvement with the child individually or in a small group. In some cases, children may be referred for further evaluation and treatment of related problems.

In a partnership with the Health Departments, Kid Connects provides annual health care screenings in each center and home. Each child receives vision, hearing, dental screenings. The mental health
Youth Mentoring and Mental Health

by Rayna A. Sage, M.A., Research Assistant; James P. Marshall, Ph.D., LMFT, Extension Family Life Specialist; and Thomas R. Lee, Ph.D., Director Youth and Families with Promise, Department of Family, Consumer, and Human Development, Utah State University

Early adolescence is a time of rapid development that can create disequilibria for young teens and their families. Important developmental tasks and milestones of this period include physical and sexual maturation, as well as new cognitive abilities.

The role of positive developmental experiences

In a 30-year longitudinal study conducted by Emmy Werner and her colleagues, several participants were identified as “resilient” or had achieved a stable development, despite significant environmental risks and stressors (“overcoming the odds”). In this study, 14 percent of the participants at the 18-year follow-up were identified as having serious mental health problems. By the 30-year follow-up, half had recovered.

Those who did not recover by age 30 were more likely to be from single-parent homes, have less positive relationships with their parents, and have lower verbal test scores at age 10. At the 30-year follow-up, resilient participants had achieved more education, vocational status, and marital success when compared to their high-risk peers. These findings indicate that positive developmental experiences during early adolescence can be especially important for overall well-being and long-term mental health for those most at risk. This has stimulated the expansion of prevention and youth development programs such as formal mentoring programs.

Natural mentors and formal programs

Mentors are older adults who provide support, friendship, and guidance. They inspire youth to do their best, despite significant obstacles. Naturally occurring mentor relationships have been identified as instrumental in positive outcomes for adolescent mothers and for youth growing up in poverty-stricken environments. Studies have shown that participants who

KID CONNECTS continued from page F12

consultant follows up on health referrals with parents.

Promising results

We are still evaluating Kid Connects, but the preliminary results look promising. More than one-third of the children receiving child-specific services showed improvement. Mental health consultants, teachers, and parents already notice a difference. Here are typical comments:

- Mental health consultant: “Two-year-old Tommy is at risk of being expelled from the child care center. He has been biting other kids and throwing toys. If Tommy is expelled, his caregiver grandmother may not be able to keep her job. The family may need to rely on public support. Now, I’ll work with Tommy, his grandmother, and his teacher to de-escalate his behaviors and help him be successful at the center.”

- Director of day care center: “With classroom ratios of 1 teacher to 12 children, I guess that we are lucky to stop kids from sticking their fingers in outlets, much less have the time to carefully analyze and work with each child’s social emotional issues. We have a lot of single parents in our center who work all day then come home and want to have quality time with their children. They are running all the time. These kids seem to pick up the stressors at home and bring them into the classroom. Since we have had Kid Connects services in our centers we have had only one expulsion, and that was because the parents made the decision to pull their child out. Teachers don’t leave messages on my voice machine saying, ‘It’s me or that child!’ Now teachers ask for more of our mental health consultant’s time!”

- Parent: Our 5-year-old seems feisty, but is actually a pretty anxious child. He worries about everything from going to the store to getting to school in the morning. We have really appreciated the advice from the mental health consultant on different behavior management techniques that we can use. He is going to kindergarten this year and while we are a little worried and sad about leaving our center and our consultant, we know that we will be all right.”

Children with social and emotional problems may have difficulty forming relationships. They may also exhibit aggressive or other inappropriate behaviors. Without intervention, these young children may be expelled from preschool and child care settings. They may lack the readiness to enter school and be at risk for child abuse, out-of-home placement, and later involvement in the mental health, criminal justice, and welfare systems. Since most children do participate in regularly scheduled child care, the child care home or center is an ideal location for reaching these troubled young preschoolers.

For more information, contact tkthc@aol.com.
YOUTH MENTORING  continued from page F13

grow up “against the odds” are likely to identify several non-parental supports in their community (for example, extended family, teachers, and religious leaders) whose informal mentorship encouraged them to make good choices at significant points and stay on a positive trajectory. For many youth, these non-family mentors are significant sources of emotional support.

The need for such relationships, and the fear that some children may not have opportunity to build them, stimulated the creation of several formal mentoring programs during the last century. Large-scale, rigorous evaluations of national mentoring programs such as Big Brothers/Big Sisters indicated that well-designed mentoring programs can create a protective buffer for youth who are at risk for poor outcomes. According to a large-scale meta-analysis of research on mentoring by David DuBois and his colleagues, formal programs are most effective when they include the following components:

- Leaders who monitor and maintain program fidelity
- Mentor screening
- Mentor-youth matching based on similarity of interests
- Initial and on-going training for mentors
- Supervision
- Mentor support
- Structured activities
- Parent involvement and support
- Expectations for intense and long-term commitment to the mentor-youth relationship

The duration of the relationship seems to be a key indicator of success, with longer mentor-youth relationships reaping more benefits than shorter mentor-youth relationships. Some research has even suggested that mentor-youth relationships lasting less than six months may actually cause harm to the youth in the long run.

Youth and Families with Promise

Over the last decade Utah State University Extension has developed and implemented a multidimensional mentoring program that complements the efforts of the 4-H program by involving youth in one-on-one mentoring, 4-H program activities, and family events designed to strengthen family bonds. Youth and Families with Promise (YFP) is an early intervention/prevention program for youth, ages 10 to 14, who are showing early signs of low self-confidence, behavior problems in school or in the community, or who are experiencing academic difficulty. An important and unique component of YFP is the use of older community members who serve as “grandmentors” to the youth’s entire family.

Since YFP is designed to be a prevention/early intervention program, it strives to foster of many of the 40 “developmental assets” identified in a national study by the Search Institute of Minneapolis. Through extensive community and parental involvement, the program enables youth to become competent, caring, and contributing members of society by strengthening social skills, academic motivation, and family relationships.

Community participation

While YFP offers the opportunity for just hanging out and being friends, it also channels the interests of the mentor and youth into participation in the community. YFP enrolls youth and their mentors in the local 4-H program to give them opportunities to develop and explore new interests. Service projects also help youth learn to give back to the community. During a monthly “Family Night Out,” parents and siblings alike can participate together in fun, recreational experiences followed by a short “debriefing” of their experience together.

Dramatic outcomes

YFP has been introduced in most of Utah’s 29 counties, where it is administered by the local Utah State University Extension Agent and YFP Site Coordinator, in collaboration with an advisory board of local community leaders and parents. More than 500 youth, over 2,000 other family members, and approximately 300 mentors are currently active in the program. In addition, YFP mentors, advisory board members, and other volunteers contributed over 21,500 hours of volunteer service last year.

Evaluation has documented the effectiveness of YFP in reducing and preventing delinquency and other problem behaviors through its focus on strengthening and improving family relationships, increasing interpersonal competence (people skills), and improving academic attainment. Some of the outcomes of the YFP mentoring program have been dramatic. Youth, parents, and mentors who have participated in YFP have been surveyed using a post-then-pre research design. Of the youth involved in a mentoring relationship who reported the following problems prior to their involvement in YFP, 74 percent were less involved in stealing, 70 percent were less likely to use cigarettes or tobacco, 63 percent were less likely to use alcohol, 61 percent were less involved in gang activity, 58 percent were less likely to skip school, and 50 percent received fewer D or F grades in school. In addition, 99 percent of parents reported they would participate again and recommend the program to others.

For more information, contact jamesm@ext.usu.edu.

More about Mentoring

Building on Strengths in Community Settings, the spring 2002 issue of Focal Point, offers a variety of articles on mentoring youth with emotional and behavioral challenges. Focal Point is published by the Research and Training Center on Family Support and Children’s Mental Health, Portland State University, Portland, Oregon. www rtc.pdx.edu/pgFPS02TOC.php
Mental Health and Adjustment Among Immigrant Youth

by James M. Frabutt, Ph.D., Associate Director, Center for Youth, Family, and Community Partnerships, University of North Carolina at Greensboro; and Tania S. Castillero, M.Ed., Program Director, Catholic Social Services of High Point, North Carolina.

National interest in children’s mental health as a significant public health issue has heightened over the last decade. For example, several recent reports released by federal departments indicate the national significance of preventing and addressing the mental health needs of children in the United States, since an estimated one in 10 children and adolescents suffers from mental illness severe enough to cause some level of functional impairment.

One in five youth in the United States is a child of an immigrant, and children of immigrants are the most rapidly growing segment of the U.S. population under age 18. Consequently, there is a great need to understand the psychosocial impact of immigration on children’s mental health and adjustment. It is striking, however, that researchers studying the mental health consequences of migration have focused more on adult adaptation than on how the migration process impacts the lives of children.

A project currently underway at Ben L. Smith Senior High School in Greensboro, North Carolina, is shedding light on the mental health challenges faced by immigrant youth. This cooperative project, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), builds on the strengths of an existing local coalition. The Guilford County Multicultural Advisory Coalition (MAC), in partnership with the Center for Youth, Family, and Community Partnerships and the Center for New North Carolinians (both located at UNC-Greensboro), is developing and refining a community-based approach to address youth violence among vulnerable immigrant youth at Smith High School. The first phase of this project was a local school-level needs assessment that highlighted some of the critical mental health issues experienced by immigrant youth.

**Interacting factors**

The process of migration is a dynamic interaction among several factors, each of which can impact children’s later adjustment and mental health. One set of factors is comprised of the family characteristics and the developmental stage of the migrating youth. For example, what are the race, language, and socioeconomic status of the family? How old is the child at the time of migration? Does the child have a stable relationship with an adult? Which family members came to the US and which were left behind? Has the migration given the child a different role within the family (as a translator or a caregiver for a younger sibling)?

Also important are the circumstances surrounding the migration itself. Is the family fleeing threats of violence? Is the family seeking economic opportunity? Will the family be joining an already established social network?

The characteristics of the host receiving community represent a third set of factors. Is the reception by the local community one of resentment or welcome? What are the characteristics of the neighborhood and schools near the family’s new home?

**Temporal dynamics**

There is also a temporal dynamic to understanding mental health and adjustment among immigrant youth. Factors that either lead to or preceded the migration—such as witnessing violence, fear, preparing for migration, and abrupt separation from primary social supports—produce consequences that can either be short-term or long-lasting. During the migration itself, legal status (that is, legal, illegal, undocumented) and eventful versus uneventful admissions into the country (for example, border crossings) are important. The loss of social support, specifically the loss of intergenerational family ties, adds to the emotional stress experienced by the family. Moreover, loss of loved ones and beloved objects may be felt at that time in an especially poignant way.

Once in the host country, the psychological trauma of uprooting and adapting to a new culture often becomes manifest as acculturative stress. Researchers have documented the significant psychological distress caused by the migration experience, including heightened alienation among school peers and lowered self-esteem and self-efficacy. Several studies have documented high rates of exposure to violence exposure and the frequency of post-traumatic stress syndrome among immigrant and refugee youth. Factors contributing to high stress among immigrants and refugees are poor communication skills in English, facing discrimination from the host culture, and cultural conflicts (negative perceptions, stereotypes, and native beliefs within an ethnic group). Researchers have also noted that when mental health problems appear among immigrant children, they tend to manifest themselves in adolescence as behavior disorders and identity disorders.

**Moving toward strength-based services**

It must be noted, however, that despite the myriad challenges before them, the majority of immigrant youth adapt in psychologically healthy ways both at home and at school. A focus—almost a bias—in the research literature on acculturative stress has drawn attention...
IMMIGRANT YOUTH continued from page F15

away from the mental health resources, adaptation, and resilience of immigrant youth. What are the variables or processes that minimize the stress of immigration? What are the variables that help explain the most optimal development and successful adjustment? The needs assessment and planning at Smith High School, for example, has lead us to the implementation of a strength-based intervention for vulnerable immigrant youth. In doing so, we hope to derive a community-based, culturally competent, and replicable model that can be used at other school and in other communities.

It appears that researchers, practitioners, and educators need more grounding in the normative experiences and adaptive mechanisms that lead to developmental success for immigrant youth. Ultimately, research and practice that documents immigrant child and family adjustment will form the basis for developing effective, appropriate, and strength-based services and supports for immigrant youth.

For more information, contact jmfrabut@uncg.edu.

Matching Local Needs with Evidenced-Based Interventions

It’s a challenge to match local needs with evidenced-based interventions. Here, in a nutshell, is how the Project SAFE team did that at Smith High School:

Key informant interviews

As part of the school-level needs assessment, the project team conducted semi-structured interviews with school administrators, community organizers, parents, youth, and Smith High School faculty.

Collection of current school-level data

We consulted multiple data sources in order to define both violent activity and the dynamics at Smith High School generally. We also examined the current School Improvement Plan for Smith. This document presents a comprehensive overview of the school’s strengths and resources and includes detailed plans to achieve benchmarks.

Another source of information was The School Crime and Violence Incident Report. With state-level support, each school collects and maintains a database tracking incidents relevant to school safety. This tracking tool catalogs the type of offense, type of weapon used or possessed, location of incident, time of occurrence, perpetrators, and victims. The project team also collected the 2001-2002 results from the Smith High School Safety Survey, a questionnaire that assesses general perceptions regarding school safety and violence. The survey also asks about categories of behavior, physical and verbal threats, witnessing violence, gang involvement, and racial conflict.

Lastly, we examined the Greensboro Police Department’s data on 2002 youth offenses, with a focus on the law enforcement tract in which Smith High School is located. This inquiry allowed us to examine how frequently offenses such as simple assault, disorderly conduct, and weapons possession occurred on school property.

Compilation of evidence-based program models

Beginning in the summer of 2003, the Project SAFE team began to create a portfolio of evidence-based programs/interventions. The project director and the Special Populations Coordinator from Smith High School both attended the youth violence annual conference. Both the printed materials and the presentations from the conference were useful for guiding our local decisions about selecting evidence-based programs. The Center for Youth, Family, and Community Partnerships at UNCG possessed in-house capability or familiarity with several models. Several online databases and one printed resource in particular—SAMHSA’s guide to Science-Based Prevention Programs and Principles—were extremely useful resources for identifying program models that were potentially relevant for use at Smith High School.

Matching the evidence-based intervention with community/school need

Some of our key criteria for sorting through and selecting an appropriate intervention were: (a) target age of our population, (b) whether the program had been used with mixed ethnicity groups, (c) documented effectiveness, (d) whether the program addressed youth violence or behavioral difficulties, (e) featured person-level versus classroom- or school-level interventions, and (f) whether technical assistance was available to support program start-up and implementation.

Based on those criteria and with continual direction and input from school-based staff and our community liaison, our Project SAFE team selected the CASASTART program. CASASTART is a community-based, school-centered program designed to keep preadolescents free of drug and crime involvement. CASASTART uses an intensive case management model, preventive services, and community-based law enforcement to address the individual needs of participants as well as the broader problems of their families and communities. The Project SAFE team has established contact with Lawrence F. Murray, CSW, (CASASTART program developer at the National Center for on Addiction and Substance Abuse at Columbia University) and is moving forward to execute a contract for technical assistance around program implementation.

—James M. Frabutt
Physical Patterns of Aging Affect Communication

by Jaylie Beckenhauer, M.A., CFCS, Lecturer, Department of Family and Consumer Sciences, Baylor University

Just as physical growth and development can be predicted for children based on normative patterns, so can physical degeneration be expected in older adults. Researchers who study communication among older adults need to consider normative development and how it affects communication patterns. Let’s begin by defining the terms “older adult” and “elderly.”

Definitions
Defining “older adult” depends to a large extent upon the source of the definition. For example, in his book Development across the Life Span, Robert Feldman defines an older adult as someone who is between age 60 and death. According to the Older Americans Act, a person must be 60 years of age or older to be eligible for services. According to the Social Security Administration, eligibility for retirement begins between ages 65 and 67. Membership in AARP is open to individuals over age 50. Many restaurants, movie theaters, other businesses give senior citizen discounts to customers age 55 or older.

But no matter how one defines “older,” there are more older people than ever before, and the older population itself is aging. According to the U.S. Department of Health and Human Services, the 65-74 age group (18.4 million) was eight times larger in 2000 than in 1900. The 75-84 group (12.4 million) was 16 times larger and the 85+ group (4.2 million) was 34 times larger.

For the purposes of this article, the term “older adults” will refer to those over 60 years of age. “Elderly” will refer to a state of physical health in which lifestyle choices are limited by physical abilities. It is difficult to determine an exact age when this limitation will begin. For some people, it begins before retirement age, while for others, it may begin only in their late 70s or 80s.

Changes in vision
Physical changes that may affect communication are those in vision, hearing, speech, and mobility, according to Dacey and Travers in Human Development Across the Lifespan. Normative visual changes begin around age 40 when the lens of the eye starts to lose its elasticity and whiteness, affecting ability to focus on nearby objects and detect certain colors. Around 50, the iris begins to respond less well to light, causing the eyes to adapt slower to changes in lightness and darkness. By age 60, the retina requires more illumination in order to perceive a stimulus.

Other visual problems include floaters (particles suspended in the jelly substance of the eyeball), dry eye (diminished tear production), senile macular degeneration (faded, distorted, or blurred central vision), cataracts (clouding of the eye lens that impairs vision), and glaucoma (increased pressure caused by fluid in the eye that may damage the optic nerve).

Visual impairment may make reading and writing more difficult, resulting in reduced communication via letter writing or e-mail. Depending on the severity of the vision loss, it may impede mobility, creating a sense of isolation from community.

Hearing and speech difficulties
According to some researchers, hearing loss may be a more serious problem than decline in vision. Many people are less willing to wear hearing devices than to wear glasses, probably related to the stigma accompanying hearing loss and being “old.”

Normative changes in hearing also begin around age 40 when the ability to detect certain tones decreases. Increasing age necessitates louder volume particularly in the higher frequencies, which are the tones hardest to hear. Understanding human speech seems to decrease with age as the ability to hear certain consonants decreases. Cognitive capacity also comes into play in interpreting speech. The ability to listen to someone alone versus in a crowded room becomes more difficult with age. As hearing decreases, lip reading and context become much more critical to communication. Adaptive strategies include facing the speaker and asking the speaker to repeat more slowly what was said.

Speech may become impaired in the elderly as a result of tooth loss, mini-strokes, dry mouth, or other physical changes in the speech organs. It is a common perception that older adults ramble or speak off-topic more than do younger adults, particularly about autobiographical details. Some researchers suggest that this may simply be due to the fact that older people value communicating about their life experiences.

Off-topic speech may also be related to hearing difficulty. It is difficult to follow a conversation when one only hears part of it. Instead of asking speakers to repeat what was said, the hard-of-hearing elder may change topics inadvertently or ramble to avoid the stigma of hearing loss. When listeners perceive that the speaker is not attending, they may talk to the elder less frequently. Seniors themselves can learn more about communication.
PHYSICAL PATTERNS  continued from page F17

and how to reverse the negative cycle. For example, they can use assertive responses, take greater responsibility for satisfying their own needs, and find ways to reach out to others through community outreach programs.

Other physical changes
Normative physical aging includes bone loss, which can lead to osteoporosis; collagen loss, which depletes muscle tone; slowing of nerve reaction time and general processing, which can result in slower decision making and more accidents; reduced efficiency in the respiratory and circulatory systems, which make breathing and physical activity more difficult.

Perhaps the most common physical disorder among the aging population is arthritis, an inflammation of the joints. Arthritis strikes around half of older people and can be disabling. It causes great difficulty in many daily living tasks like opening jar lids, turning keys and doorknobs, and lifting objects.

About one-third of older adults have hypertension, or high blood pressure, which can raise the risk of heart attack and stroke. Any combination of physical degeneration can lead to loss of mobility, which affects the ease with which older adults interact with the world around them. Less interaction often means less communication and even isolation for the older adult.

Unique communication needs
Although the elderly may be able to communicate verbally or in writing as effectively as younger people, their needs are unique. Perhaps this is most obvious in the medical arena. Mobility and lack of self-transportation make it physically difficult for the elderly to visit the doctor in their office. Next comes the ability to discuss their condition with the doctor.

Hearing and speech limitations make this a cumbersome process and can affect the quality of medical care. Learning more about health concerns via Internet and using online medical consultants may make this process easier. Older persons can also ask a relative or friend familiar with their health to accompany them when they go to the doctor.

Some changes in physical abilities have a direct relationship to communication patterns. Difficulty seeing or being able to control hand movements will affect how often older people try to write letters. They may even need to have correspondence read to them.

People with severe hearing loss may choose to stay away from crowds and decrease communication via telephone because they have difficulty understanding conversation. Often other people are reluctant to talk with forgetful people, those who are perceived as being “lost in the past,” or those who cannot keep to the main conversation thread. Communication for the older speaker may thus become less frequent and less meaningful.

Older adults who have difficulty walking and moving may prefer to stay home where it is easier to navigate. And if most of their friends are in the same shape, the result may be isolation. This is especially true if hearing loss make it hard to understand telephone conversations.

Using technology
Researchers and professionals who work with older adults should be aware that normative physical changes affect communication. Positive adaptation to aging requires an awareness of these changes. Older people may need to find ways to communicate from home if they are to keep in touch with the outside world.

Many of the degenerative physical changes that are part of the aging process can be compensated for through the use of communication devices. For example, telephones and computer programs are available for users with hearing, vision, and kinetic impairments. Some of these may be covered by Medicare or grants.

New technology should be investigated for maintaining relationships while still considering limitations of physical condition, living arrangements, socio-economic situation, and support systems. Not only can communication be increased, but quality of life can also be enhanced when older persons can maintain a continued connection to other people.

Useful Web Sites

Resources for aging people and professionals who work with them:

Administration on Aging, www.aoa.gov

Administration on Aging Elder Page: Information for Older Americans, www.aoa.gov/elderpage.html

American Association of Retired Persons (AARP), www.AARP.org

FDAs Older Persons Web site, www.fda.gov/oc/olderpersons

International Longevity Center-USA, www.ilcusa.org

Ohio State University Extension Fact Sheet (Addresses all stages of the family life cycle and individuals through the life span), http://ohioline.osu.edu/hy-fact/5000/5227.html

SeniorNet, www.seniornet.org/php

Post-Traumatic Stress and Mental Health

by James P. Marshall, Ph.D., LMFT, Extension Family Life Specialist, Department of Family, Consumer, and Human Development, Utah State University

One of the simplest definitions of stress is “a state of physical and emotional arousal that is brought on by a stressor,” for example, the experience of being startled. Stress consists of a combination of neurologic, neuroendocrine, and endocrine arousal response mechanisms that can affect and alter every organ and function of the human body.

Stress is a normal part of everyone’s life that affects all human systems simultaneously. Stress can accelerate the aging process—Hans Selye refers to stress as the “sum total of wear and tear on the body.” In fact, it is estimated that as many as 60 to 80 percent of visits to the doctor may be stress-related.

**Stress: good and bad**

Good stress is called eustress, and it can increase our motivation to do well and be successful. Bad stress is called distress, and it can negatively affect our health. High levels of stress over time can contribute to physical or emotional illness.

When bad stress builds up over a period of time it is called cumulative stress, and it can result in deteriorating performance, relationships, and health. Cumulative stress is sometimes described as rust-out because it is a slow process of physical and emotional decay that may result in cynicism, lethargy, procrastination, and sometimes even suicidal or homicidal thoughts. Statements such as, “I can’t take it anymore,” or “I can’t take you anymore,” are indications of a high level of stress. Statements like these should be taken seriously, and we should make sure that the person making them does not pose a threat to himself or others.

It is impossible to live a completely stress-free life, but we may be able to experience less stress by avoiding or altering stressors. Adapting to the stressor may, however, be our best defense since stress is caused by our reaction to the event rather than the event itself. The philosopher Epictetus once said, “Men are disturbed not by things, but the views which they take of them.” If we can learn to manage the more controllable everyday stress of life, perhaps we will be less likely to be overwhelmed when something occurs that we cannot control.

**Critical incidents**

An event that is stressful enough to overwhelm our usually effective coping skills is called a critical incident. Such an event is sudden, powerful, and outside the range of ordinary human experience. It may be experienced directly or indirectly and may include military combat, violent personal assault, being kidnapped or taken hostage, terrorist attack, torture, incarceration, natural or manmade disasters, severe automobile accidents, being diagnosed with a life-threatening illness, or observing the serious injury or unnatural death of another person.

The terrorist attacks of September 11, 2001, certainly qualify as critical incidents. The attacks ended the lives of thousands of people, and forever changed the lives of millions more. The events of that day and the rescue and clean-up efforts that followed were overwhelming, particularly for those people who were most directly involved, but also for many people throughout the world who viewed them on television.

Critical incidents frequently happen on a much smaller scale. Although what constitutes a critical incident can vary widely from person to person, some events should always be considered critical incidents, and the persons involved should be provided with the opportunity for some type of mental health services. These events include:

- A death in the workplace or line of duty
- Serious injury in the workplace or line of duty.
- The suicide of a co-worker, friend, or family member.
- Any incident or disaster with multiple casualties.

- A police shooting or the death or injury of a civilian as a result of operational procedures or events with extreme threat.
- Significant events involving children.
- The death or serious injury of a person who is related or known to the helper.
- Prolonged incidents, especially with loss.
- Excessive media interest in an event.

Finally, any powerful event that overwhelms a person’s usual ability to cope should be considered as critical incident.

**Post-traumatic stress disorder**

Many people have both an initial reaction and a delayed reaction to a critical incident. Post-traumatic stress is a normal reaction, in a normal person, to an abnormal event. It is a survival mechanism that is activated within our bodies to protect us from the negative affects of past experiences that overwhelmed our body’s natural ability to cope.

Post-traumatic stress disorder (PTSD), on the other hand, goes well beyond this normal reaction. PTSD was first described...
POST-TRAUMATIC STRESS  continued from page F19

in the third version of the Diagnostic and Statistical Manual (DSM-III) in 1980. According to the diagnostic criteria, symptoms must be present for more than one month. They must also cause significant distress or impairment in social, occupational, or other important areas of functioning.

Symptoms include intrusive thoughts about the event, avoiding the place or stimuli associated with the trauma, and a heightened sense of arousal. The traumatized person may remain jumpy or moody for extended periods of time. These symptoms result from the violation of the trauma victim’s worldview. The world has changed and no longer seems safe and secure.

For example, a firefighter who narrowly escapes after being trapped in a burning building during an attempted rescue may continue to relive the event mentally and emotionally. He may have difficulty responding to future calls, especially if they involve similar situations. Failure to rescue the person he was trying to save could add an additional layer of complexity to the event. In this case, the firefighter may also experience flashbacks that include the cries of the trapped person, and he may suffer other stress-related symptoms, such as survivor guilt, self-blame, uncertainty, or insomnia. PTSD can also be caused by more common situations. For example, three years ago, a severe hailstorm caused major damage to my home and the homes of hundreds of others in our town. During the storm, I went into my daughter’s bedroom to check on her. She was awake, but hiding under the covers, trembling, and noticeably scared. My wife and I tried to comfort her. Although the storm passed, my daughter’s experience of it did not. For nearly a year afterwards, my daughter needed nightly reassurance before going to bed. Fortunately, her fears were eventually laid to rest. She still remembers that storm and talks about it occasionally when other storms come up, but she no longer suffers from the physical, cognitive, emotional, or behavioral symptoms associated with storms that she once did.

Post-trauma do’s and don’ts
People who have experienced a traumatic event often demonstrate some changes in behavior. The sidebar offers suggestions for people who have experienced a traumatic event and reduce the probability of long-term stress reactions.

<table>
<thead>
<tr>
<th>Don’t</th>
<th>Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink alcohol excessively.</td>
<td>Get enough rest.</td>
</tr>
<tr>
<td>Use drugs or alcohol to numb consequences.</td>
<td>Maintain a good diet and exercise program.</td>
</tr>
<tr>
<td>Withdraw from significant others.</td>
<td>Find time to talk to supportive peers and family about the incident.</td>
</tr>
<tr>
<td>Reduce leisure activities.</td>
<td>Take time for leisure activities.</td>
</tr>
<tr>
<td>Stay away from work.</td>
<td>Follow a familiar routine.</td>
</tr>
<tr>
<td>Increase caffeine intake.</td>
<td>Spend time with family and friends.</td>
</tr>
<tr>
<td>Have unrealistic expectations for recovery.</td>
<td>Attend meetings regarding this traumatic event.</td>
</tr>
<tr>
<td>Look for easy answers.</td>
<td>Create a serene scene to escape to either visually or literally.</td>
</tr>
<tr>
<td>Take on new major projects.</td>
<td>Take one thing at a time.</td>
</tr>
<tr>
<td>Pretend everything is o.k.</td>
<td>Expect the experience to bother you.</td>
</tr>
<tr>
<td>Make major changes if you don’t need to.</td>
<td>Seek professional help if your symptoms persist.</td>
</tr>
<tr>
<td></td>
<td>Seek medical assistance if your physical symptoms concern you.</td>
</tr>
</tbody>
</table>

James P. Marshall, Ph.D., LMFT

For more information, contact jamesm@ext.usu.edu