Children Who Fail at School But Succeed at Life

by Mark Katz, PhD

IT WAS A VERY SPECIAL PLACE. Or an awful place. A place where you learned about your greatest gifts and talents. Or your worst shortcomings. Where you came to see yourself as smarter than most. Or not very smart at all. A place where you found the confidence you needed to succeed in the world. Or where you learned that you’ll never amount to much of anything. It was a place where you saw firsthand the value of perseverance. Or the futility of perseverance. It was a very warm and friendly place. Or a very mean and nasty place. The place? School.

A number of people currently enjoy meaningful and successful lives, thanks in large part to their earlier school experiences. And a number of other people currently enjoy meaningful and successful lives, in spite of their earlier school experiences. Surprised? If so, you’re hardly alone.

Until recently, not much attention was paid to successful people who did poorly in school. Why not? One reason might be that few among us realized how many of them are actually out there. But another and even bigger reason might be that many of us doubted that it was actually possible. And those doubts are entirely understandable. After all, think of the thousands of hours people spent trying their hardest to help these failing children turn things around in school, sometimes with little or nothing to show for it. And if these children continued to struggle and fail in school with all this help and support, how could they ever succeed in the real world decades later without it?

So, what did we miss? Why were we so wrong about them? And how can we use these lessons learned to prevent others from having to endure the years of school failure they endured decades ago? We can use the answers to these questions and the lessons learned to change the odds for those who currently struggle much like they did decades ago, including those whose struggles have persisted beyond their school-age years.

Here are a few of the many lessons learned:

● It’s really true. “There’s never anything so wrong with us that what’s right with us can’t fix.” The opportunity to do what we love to do and also do well can reveal personal strengths and qualities that may have otherwise gone unnoticed. And this is as true for school-age children as it is for adults.

● To feel we belong and have something important to contribute is a universal need. For some, it’s a need that went largely unfulfilled until their adult years. Today, we’re much more aware of how to fulfill this universal need during our school-age years. There’s reason to believe that doing so can prevent a range of potentially serious school-related and later life problems.

● There are many different ways of being smart, some of which can’t be measured by how well one does in school. Knowing this and truly believing this can avoid personally humiliating experiences at school as well as in life.

● No matter how smart one might be in whatever areas, it does not make them wise. To be wise is to know how to use our strengths and our successful life experiences to serve not only our personal needs but the needs of others as well.

● How we perceive the differences and challenges that others endure, school-age children included, can determine how they perceive these same differences and challenges. This in turn can determine whether they come to see themselves as courageous and resilient or, conversely, as helpless and hopeless. You and I, therefore, have more influence than we may realize in determining who overcomes adverse childhood experiences and who succumbs.

• Expanding upon this last point, we now know how to create social climates where difference no longer signals danger. The problem is that we usually forget to do it, which can help explain why those thousands of hours of help, year after year, by dedicated and caring people trying to change troubled lives might not have produced the results that were hoped for. They were provided in places where feeling different felt very dangerous.

• People can grow quite adept at raising their personal expectations while simultaneously leveling their personal playing field. And the creative ways they learn to use tools, technologies, strategies, and available resources to navigate around learning, behavioral, and other challenges serves a testament to their resilient spirit.

• A number of those who overcome difficult childhood experiences have learned to transform the pain of their past into meaningful action on behalf of others. We’re now learning how to help struggling school-age children eventually learn to do the same.

• For a number of those who overcome a difficult past, their emotional self-regulation and self-control skills improved over time. Today, we have specific tools to help improve these same skills in young school-age children. And research suggests that improving these skills can potentially prevent wide ranging health, mental health, and life adjustment problems years down the road. Some experts in the field would actually consider this the short list.

• A range of specific contextual influences have helped a number of people access inherent resilient qualities not easily accessed during their earlier school-age years. These contextual influences seem entirely transportable to a school day. Thus, if effectively weaved into a typical school day, they may also help to prevent school failure and improve later life educational, mental health, and life adjustment outcomes.

• These same contextual influences may potentially also outweigh the harmful effects of exposure to several, if not most, of the adverse childhood experiences that the Adverse Childhood Experiences (ACE) Study results link to serious later life medical problems. Weaving these contextual influences in and around a school day may not only improve educational, mental health, and life adjustment outcomes down the road. They may also prevent serious medical problems down the road as well.

• It’s impossible to predict what will become of us in the future based upon what may have happened to us in the past. It’s among the mysteries in life that makes one a believer in second, third, and fourth chance opportunities, and in knowing that lives can change for the better at any point in time, sometimes in response to completely unanticipated and unpredictable events. Experts who study resilience through the lifespan refer to these life changing experiences as turning points.

• Regarding this last point, those who consistently reach out to help improve the life of a struggling child are often unaware that they may represent an eventual turning point in that child’s life—a turning point that the child may not be fully aware of until years down the road.

• Those who, in time, “beat the odds” can usually name one or more people in their lives that helped to change the odds, proof perhaps that our greatest source of strength is each other.

A clinical and consulting psychologist, Mark Katz, PhD, is the director of Learning Development Services, an educational, psychological, and neuropsychological center in San Diego, California. As a contributing editor to Attention magazine, he writes the Promising Practices column and serves on the editorial advisory board. He is also a former member of CHADD’s professional advisory board and a recipient of the CHADD Hall of Fame Award.

Mark Katz, PhD, will present a institute focusing on information contained in his new book at CHADD’s Annual International Conference on ADHD in Costa Mesa, California.
Child Abuse and Mental and Physical Health in Adulthood: Findings from a Nationally Representative Canadian Sample

Tracie O. Afifi, PhD

Associate Professor
CIHR New Investigator (2013-2018)
Associate Editor, Child Abuse & Neglect

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Rady Faculty of Health Sciences
University of Manitoba
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- Canadian Institutes of Health Research (CIHR)
- Research Manitoba
- Statistics Canada
- Manitoba Research Data Centre (Dr. Ian Clara)
Learning Objectives

To further our understanding of child abuse in Canada by...

1. Providing recent estimates of the prevalence of child abuse and the co-occurrence of different types of child abuse in Canada;

2. Determining the relations between several types of child abuse and mental and physical health conditions in Canada using nationally representative data; and

3. Examining the relationships between individual- and relationship-level factors and better mental health outcomes among respondents with and without a child abuse history.
Background

- Compared to other parts of the world (e.g., United States, United Kingdom, the Netherlands, and Mexico), the number of child maltreatment studies conducted in Canada is far fewer.

- Prior to 2012, the data used to study child maltreatment were less diverse.

1. Afifi, T.O., 2011 CJPH
Background

• Prior to 2012, nationally representative data on child maltreatment from the general population in Canada did not exist.

• Prior to 2012, data sources included:
  ▫ Reported cases of child maltreatment
  ▫ Community samples
  ▫ Hospital data
  ▫ Clinical samples
  ▫ School-based samples
  ▫ Provincial survey from Ontario

Afifi, T.O., 2011 CJPH
Canadian Community Health Survey (CCHS) – Mental Health

- Nationally representative cross-sectional survey with a focus on mental health

- Data collected from January 2012 to December 2012
  - Overall household-level response rate: 79.8%
  - Household and person response rate: 68.9%

- Sample (included the 10 provinces)
  - Study sample: $N = 25,113$ (Age 15 years and older)
Canadian Community Health Survey (CCHS) – Mental Health

• Why was this survey important?

• It was the first nationally representative survey in Canada to include measures of experiences of child abuse.

• This means for the first time we were able to estimate the prevalence of child abuse in Canada.

• Those asked the child abuse questions were 18 years and older.
  • Study sample: $N = 23,395$ (Age 18 years and older)
What is Child Maltreatment?

- Physical abuse
- Exposure to intimate partner violence (IPV)
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Physical punishment
Canadian Community Health Survey (CCHS) – Mental Health

- Physical abuse
- Exposure to IPV
- Sexual abuse

Childhood Experiences of Violence Questionnaire (CEVQ)

Based on items from previous surveys

CCHS 2012

- Physical abuse: Before the age of 16...

  1) How many times did an adult slap you on the face, head or ears or hit or spank you with something hard to hurt you?
CCHS 2012

- Physical abuse: Before the age of 16...

1) How many times did an adult slap you on the face, head or ears or hit or spank you with something hard to hurt you?
   a) Never
   b) 1 or 2 times
   c) 3 to 5 times
   d) 6 to 10 times
   e) More than 10 times
CCHS 2012

• Physical abuse: Before the age of 16...

1) How many times did an adult slap you on the face, head or ears or hit or spank you with something hard to hurt you?

   a) Never
   b) 1 or 2 times
   c) 3 to 5 times
   d) 6 to 10 times
   e) More than 10 times
Physical abuse: Before the age of 16...

1) How many times did an adult push, grab, shove, or throw something at you to hurt you?
CCHS 2012

Physical abuse: Before the age of 16...

1) How many times did an adult push, grab, shove, or throw something at you to hurt you?
   a) Never
   b) 1 or 2 times
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Physical abuse: Before the age of 16...

1) How many times did an adult push, grab, shove, or throw something at you to hurt you?

- a) Never
- b) 1 or 2 times
- c) 3 to 5 times
- d) 6 to 10 times
- e) More than 10 times

If the answer is e), the response is YES.
Physical abuse: Before the age of 16...

1) How many times did an adult kick, bite, punch, choke, burn you, or physically attack you in some way?
• Physical abuse: Before the age of 16...

1) How many times did an adult kick, bite, punch, choke, burn you, or physically attack you in some way?
   a) Never
   b) 1 or 2 times
   c) 3 to 5 times
   d) 6 to 10 times
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a) Never

b) 1 or 2 times

c) 3 to 5 times

d) 6 to 10 times

e) More than 10 times
CCHS 2012

- Physical abuse: Before the age of 16...
- Yes to one or more of the three physical abuse items would indicate yes to any physical abuse.
CCHS 2012

- Sexual abuse: Before the age of 16...

  1) How many times did an adult force you or attempt to force you into any unwanted sexual activity, by threatening you, or holding you down or hurting you in some way?
• Sexual abuse: Before the age of 16...

1) How many times did an adult force you or attempt to force you into any unwanted sexual activity, by threatening you, or holding you down or hurting you in some way?

   a) Never
   b) 1 or 2 times
   c) 3 to 5 times
   d) 6 to 10 times
   e) More than 10 times
CCHS 2012

**Sexual abuse: Before the age of 16...**

1) How many times did an adult force you or attempt to force you into any unwanted sexual activity, by threatening you, or holding you down or hurting you in some way?

   - a) Never
   - b) 1 or 2 times
   - c) 3 to 5 times
   - d) 6 to 10 times
   - e) More than 10 times

   NO

   YES
• Sexual abuse: Before the age of 16...

1) How many times did an adult touch you against your will in any sexual way? By this, I mean anything from unwanted touching or grabbing to kissing or fondling.
• Sexual abuse: Before the age of 16...

1) How many times did an adult touch you against your will in any sexual way? By this, I mean anything from unwanted touching or grabbing to kissing or fondling.

a) Never
b) 1 or 2 times
c) 3 to 5 times
d) 6 to 10 times
e) More than 10 times
CCHS 2012

- **Sexual abuse: Before the age of 16...**
  
  1) How many times did an adult touch you against your will in any sexual way? By this, I mean anything from unwanted touching or grabbing to kissing or fondling.

  a) Never  

  b) 1 or 2 times  

  c) 3 to 5 times  

  d) 6 to 10 times  

  e) More than 10 times
CCHS 2012

• Sexual abuse: Before the age of 16...

• Yes to one or both of the two sexual abuse items would indicate yes to any sexual abuse.
CCHS 2012

- Exposure to Intimate Partner Violence: Before the age of 16...

1) How many times did you see or hear any one of your parents, step-parents or guardians hit each other or another adult in your home?
CCHS 2012

• Exposure to Intimate Partner Violence: Before the age of 16...

1) How many times did you see or hear any one of your parents, step-parents or guardians hit each other or another adult in your home?

a) Never
b) 1 or 2 times
c) 3 to 5 times
d) 6 to 10 times
e) More than 10 times
Exposure to Intimate Partner Violence: Before the age of 16...

1) How many times did you see or hear any one of your parents, step-parents or guardians hit each other or another adult in your home?

- a) Never
- b) 1 or 2 times
- c) 3 to 5 times
- d) 6 to 10 times
- e) More than 10 times

NO

YES
What is the Prevalence of Child Abuse in Canada?
Childhood Maltreatment and Mental Health in Adulthood

Murray Stein, MD, MPH
Distinguished Professor, Department of Psychiatry and Department of Family Medicine and Public Health, University of California San Diego; Staff Psychiatrist, VA San Diego Healthcare System
Scope of the Problem

• 1 in 4 adults report having been physically abused as a child

• 1 in 5 women and 1 in 13 men report having been sexually abused as a child

http://www.who.int/mediacentre/factsheets/fs150/en/
accessed 5-9-2017
Childhood Maltreatment and Adult Mental Disorders

• Nationally representative NZ sample
  – Aged 16-27 years (n = 1413)
  – Retrospective and prospective ascertainment
  – Link to national child protection database

• Maltreatment associated with increase in all lifetime mental disorders
  – No difference in magnitude of retrospective vs. prospective associations

Childhood Maltreatment and Brain Structure and Function
(One Data Bite [Byte?])
Severity of childhood maltreatment correlates with right middle/superior frontal gyrus gray matter volume

Fonzo GA et al., Psychiatry Res 2013
Severity of childhood maltreatment correlates with ventral anterior cingulate activation while processing angry faces

Fonzo GA et al., Psychiatry Res 2013
Childhood Maltreatment and Suicidality
In the US in 2013, suicide accounted for 41,149 deaths.

Source: CDC

Table 5. Interaction Effects of Child Abuse Exposure and DRT on Past-Year Suicide-Related Behaviors Among CAF Regular Forces Personnel

<table>
<thead>
<tr>
<th>Interaction Effects</th>
<th>Past-Year Suicidal Ideation</th>
<th>Past-Year Suicide Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRT</td>
<td>1.4 (1.0-1.8)</td>
<td>1.7 (1.1-2.7)</td>
</tr>
<tr>
<td>Model 2&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child abuse exposure</td>
<td>2.2 (1.6-2.9)</td>
<td>2.7 (1.7-4.3)</td>
</tr>
<tr>
<td>Model 3&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRT</td>
<td>1.3 (0.97-1.8)</td>
<td>1.7 (1.1-2.6)</td>
</tr>
<tr>
<td>Child abuse exposure</td>
<td>2.1 (1.6-2.9)</td>
<td>2.6 (1.6-4.2)</td>
</tr>
<tr>
<td>Model 4&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRT × child abuse exposure</td>
<td>1.2 (0.7-2.2)</td>
<td>0.8 (0.3-2.2)</td>
</tr>
</tbody>
</table>

Abbreviations: CAF, Canadian Armed Forces; DRT, deployment-related trauma.

<sup>a</sup> Adjusted for age, sex, marital status, educational level, income, and military rank.

<sup>b</sup> Adjusted for the same variables as models 1 and 2 with the addition of DRT and child abuse exposure in the same model.

<sup>c</sup> Adjusted for the same variables as model 3 with the main effects of DRT and child abuse exposure in addition to the interaction term for DTR × child abuse exposure.
Administration & Funding

• Supported by NIH Cooperative Agreement U01MH87981.

• Funds provided by the Department of the Army ($50M) & National Institute of Mental Health (NIMH: $15M).

• Army STARRS is being conducted by a consortium of investigators — from the Uniformed Services University of the Health Sciences (USUHS), the University of California-San Diego (UCSD), Harvard Medical School (HMS), & the University of Michigan (UM) — in collaboration with the NIMH.
  – Co-PIs: R. Ursano (USUHS) & M. Stein (UCSD)
  – Site-PIs: R. Kessler (HMS) & S. Heeringa (UM)
  – Collaborating NIMH Scientists: L. Colpe & M. Schoenbaum
  – Consulting Army Scientists: K. Cox & S. Cersovsky

• Army STARRS in-theater research was conducted under a protocol reviewed and approved by the U.S. Army Medical Research and Materiel Command (MRMC) Institutional Review Board, and in accordance with the approved protocol.
Army STARRS study components:

1. Historical Data Study

2. New Soldier Study (N ~ 50,000)
   -- Includes blood for DNA and neurocognitive assessment (subsamples)

3. All Army Study (including clinical calibration study)
   -- Cross-sectional surveys of representative samples of all Soldiers in Army (CONUS, OCONUS including combat zones)

4. Soldier Health Outcomes Study
   A. Case-control study of suicide attempters (SHOS-A)
   B. Case-control study of completed suicides (SHOS-B)

5. Pre/Post Deployment Study
   -- includes blood for DNA and RNA
Childhood Maltreatment and Lifetime Suicidal Behaviors Among New Soldiers in the US Army: Results From the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)

Murray B. Stein, MD, MPH\textsuperscript{a,b,c,\ast}; Laura Campbell-Sills, PhD\textsuperscript{a}; Robert J. Ursano, MD\textsuperscript{d}; Anthony J. Rosellini, PhD\textsuperscript{e}; Lisa J. Colpe, PhD, MPH\textsuperscript{f}; Feng He, MS\textsuperscript{b}; Steven G. Heeringa, PhD\textsuperscript{g}; Matthew K. Nock, PhD\textsuperscript{h}; Nancy A. Sampson, BA\textsuperscript{e}; Michael Schoenbaum, PhD\textsuperscript{f}; Xiaoying Sun, MS\textsuperscript{b}; Sonia Jain, PhD\textsuperscript{b}; and Ronald C. Kessler, PhD\textsuperscript{e}; on behalf of the Army STARRS Collaborators

J Clin Psychiatry 2017 (in press)
Methods

• Cross-sectional survey data from US Army basic trainees 2011-2012
  • $N = 38,237$
• Retrospective self-report of childhood abuse and neglect
  • Latent class analysis $\rightarrow$ 5 profiles
• Discrete-time survival analysis
  • Estimate associations of maltreatment profiles with suicidal behaviors
    • Assessed with modified Columbia Suicide Severity Rating Scale
  • Adjusting for sociodemographic factors and mental disorders

Stein MB et al., *J Clin Psychiatry* 2017
Childhood Maltreatment Profiles (NSS)

Stein MB et al., J Clin Psychiatry 2017
# Childhood Maltreatment and Lifetime Suicidality

<table>
<thead>
<tr>
<th></th>
<th>Ideation AOR (95% CI)</th>
<th>Plan AOR (95% CI)</th>
<th>Attempt AOR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No maltreatment</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Episodic emotional maltreatment</td>
<td>3.10 (2.88-3.35)</td>
<td>3.75 (3.13-4.49)</td>
<td>3.60 (2.85-4.54)</td>
</tr>
<tr>
<td>Frequent emotional and physical maltreatment</td>
<td>3.87 (3.37-4.46)</td>
<td>6.45 (4.9-8.51)</td>
<td>6.17 (4.70-8.09)</td>
</tr>
<tr>
<td>Frequent emotional, physical and sexual maltreatment</td>
<td>4.93 (3.85-6.33)</td>
<td>10.77 (7.31-15.86)</td>
<td>15.95 (10.70-23.77)</td>
</tr>
</tbody>
</table>
Bullying and Suicidal Behaviors
Associations Between Peer Victimization and Suicidal Ideation and Suicide Attempt During Adolescence: Results From a Prospective Population-Based Birth Cohort

Marie-Claude Geoffroy, PhD, Michel Boivin, PhD, Louise Arseneault, PhD, Gustavo Turecki, MD, PhD, Frank Vitaro, PhD, Mara Brendgen, PhD, Johanne Renaud, MD, FRCCP, Jean R. Ségui, PhD, Richard E. Tremblay, PhD, Sylvana M. Côté, PhD

Peer Victimization and Suicidality

- Prospective population-based birth cohort
  - Quebec Longitudinal Study of Child Development
- Self-report of suicidality and victimization experiences at ages 13 and 15

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total 13 y</th>
<th>Total 15 y</th>
<th>Females 13 y</th>
<th>Females 15 y</th>
<th>Males 13 y</th>
<th>Males 15 y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal ideation, % (n)</td>
<td>4.5 (56)</td>
<td>5.9 (86)</td>
<td>5.3 (35)</td>
<td>8.6 (65)</td>
<td>3.7 (21)</td>
<td>3.0 (21)</td>
</tr>
<tr>
<td>Suicide attempt, % (n)</td>
<td>2.4 (30)</td>
<td>2.8 (40)</td>
<td>2.7 (18)</td>
<td>4.5 (34)</td>
<td>2.1 (12)</td>
<td>0.9 (6)</td>
</tr>
<tr>
<td>Peer victimization, % (n)</td>
<td>21.0 (258)</td>
<td>17.4 (251)</td>
<td>16.7 (111)</td>
<td>17.5 (132)</td>
<td>25.8 (147)</td>
<td>17.2 (119)</td>
</tr>
</tbody>
</table>

Note: n = 1,234 at 13 y and n = 1,446 at 15 y.

*Based on maximum available sample.*
# Peer Victimization and Suicidality

## Table 2: Cross-Sectional Associations of Peer Victimization by Suicidality Outcomes (n = 1,168)

<table>
<thead>
<tr>
<th></th>
<th>Peer Victimization</th>
<th>Suicidality Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes % (n)</td>
<td>No % (n)</td>
</tr>
<tr>
<td>Suicide ideation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 y</td>
<td>11.6 (30)</td>
<td>2.7 (26)</td>
</tr>
<tr>
<td>15 y</td>
<td>14.7 (37)</td>
<td>4.1 (49)</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 y</td>
<td>5.4 (14)</td>
<td>1.6 (16)</td>
</tr>
<tr>
<td>15 y</td>
<td>6.8 (17)</td>
<td>1.9 (23)</td>
</tr>
</tbody>
</table>

Note: Model 1 is adjusted for sex. Model 2 is additionally adjusted for socioeconomic status (13 or 15 y); family structure (biological/blended/single; 13 or 15 y) and functioning (13 or 15 y); hostilereactive parenting (13 or 15 y); intelligence (10 y); and maternal lifetime suicidal ideation/suicide attempt. Model 3 is additionally adjusted for depression (12 y); opposition/defiance (6–12 y); inattention/hyperactivity (6–12 y) problems; p for sex interaction = .337 and .532 for suicidal ideation at 13 and 15 y, respectively; and .990 and .459 for suicide attempt at 13 and 15 y, respectively. OR = odds ratio.

*Based on maximum available sample; n = 1,234 at 13 y and n = 1,446 at 15 y.

Associations of childhood bullying victimization with lifetime suicidal behaviors among new U.S. Army soldiers


Depression and Anxiety, 2017
## Bullying and Suicidality

**Table 1** Weighted prevalence of lifetime suicidal behaviors by frequency of childhood bullying victimization

<table>
<thead>
<tr>
<th></th>
<th>Total Sample (N = 30,436)</th>
<th>Among Lifetime Ideators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ideation</td>
<td>Plan</td>
</tr>
<tr>
<td><strong>Physical Assault/Theft</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>10.5% (0.3%)</td>
<td>1.5% (0.1%)</td>
</tr>
<tr>
<td>Rarely or sometimes</td>
<td>23.3% (0.8%)</td>
<td>3.9% (0.3%)</td>
</tr>
<tr>
<td>Often or very often</td>
<td>34.4% (1.3%)</td>
<td>9.3% (0.8%)</td>
</tr>
<tr>
<td><strong>Bullying Comments/Behaviors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>8.8% (0.2%)</td>
<td>1.2% (0.1%)</td>
</tr>
<tr>
<td>One to four times</td>
<td>16.8% (0.5%)</td>
<td>2.6% (0.2%)</td>
</tr>
<tr>
<td>Five times or more</td>
<td>31.4% (0.9%)</td>
<td>6.8% (0.4%)</td>
</tr>
</tbody>
</table>

Notes: Values are weighted percentage (SE). For this table, response options for Physical Assault/Theft were collapsed into Never (n = 24,643), rarely or sometimes (n = 4,477), and often or very often (n = 1,316). Response options for Bullying Comments/Behaviors were collapsed into never (n = 20,210), one to four times (n = 6,115), and five times or more (n = 4,111).

Campbell-Sills et al., *Depression and Anxiety*, 2017
Bullying and Suicidality

• Bullying victimization in childhood associated with 50-70% higher odds of lifetime suicidal ideation or attempts among young adults
  – Compared to those with no bullying experiences
  – Exposure to the most persistent bullying associated with 2- to 4-fold increase in odds
    • Compared to those with no bullying experiences
• PAF suggests that ~ one-third of suicide plans and attempts might have been prevented had bullying not occurred

Campbell-Sills et al., Depression and Anxiety, 2017
Childhood Maltreatment and Risk of Major Depression or Generalized Anxiety Disorder
Childhood adversity, adult stress, and the risk of major depression or generalized anxiety disorder in US soldiers: a test of the stress sensitization hypothesis

G. Bandoli\(^1\)*, L. Campbell-Sills\(^2\), R. C. Kessler\(^3\), S. G. Heeringa\(^4\), M. K. Nock\(^5\), A. J. Rosellini\(^3\), N. A. Sampson\(^3\), M. Schoenbaum\(^6\), R. J. Ursano\(^7\), M. B. Stein\(^2,8,9\) and On behalf of the Army STARRS collaborators
Table 1. Weighted prevalence estimates (%; SE) of demographic characteristics from a sample of new soldiers surveyed in the Army STARRS New Soldier Survey (n=30436)

<table>
<thead>
<tr>
<th>Socio-demographic characteristics</th>
<th>Past 30 day major depressive episode</th>
<th>Past 30 day generalized anxiety disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n=1045)</td>
<td>No (n=29391)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes (n=1299)</td>
</tr>
<tr>
<td>Individual past 12-month stressful experiences*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death or a friend or family member</td>
<td>39.6 (2.1)</td>
<td>26.5 (0.3)</td>
</tr>
<tr>
<td></td>
<td>40.7 (1.9)</td>
<td>26.3 (0.3)</td>
</tr>
<tr>
<td>Separation or divorce</td>
<td>20.9 (1.5)</td>
<td>7.0 (0.2)</td>
</tr>
<tr>
<td></td>
<td>19.2 (1.3)</td>
<td>6.9 (0.2)</td>
</tr>
<tr>
<td>Spouse or partner cheated on you</td>
<td>29.3 (1.8)</td>
<td>10.9 (0.2)</td>
</tr>
<tr>
<td></td>
<td>27.7 (1.6)</td>
<td>10.8 (0.2)</td>
</tr>
<tr>
<td>Betrayal by someone else close to you</td>
<td>49.3 (2.3)</td>
<td>18.5 (0.3)</td>
</tr>
<tr>
<td></td>
<td>51.1 (2.1)</td>
<td>18.1 (0.3)</td>
</tr>
<tr>
<td>Ongoing arguments or break-up with friend or family member</td>
<td>52.3 (2.4)</td>
<td>19.1 (0.3)</td>
</tr>
<tr>
<td></td>
<td>52.4 (2.2)</td>
<td>18.8 (0.3)</td>
</tr>
<tr>
<td>Involved in a motor vehicle accident while you were driving</td>
<td>23.2 (1.6)</td>
<td>12.4 (0.2)</td>
</tr>
<tr>
<td></td>
<td>20.8 (1.3)</td>
<td>12.4 (0.2)</td>
</tr>
<tr>
<td>Caused an accident where someone else was hurt</td>
<td>11.6 (1.1)</td>
<td>4.4 (0.1)</td>
</tr>
<tr>
<td></td>
<td>9.7 (1.0)</td>
<td>4.4 (0.1)</td>
</tr>
<tr>
<td>Did not get promoted when you should have</td>
<td>18.9 (1.4)</td>
<td>8.7 (0.2)</td>
</tr>
<tr>
<td></td>
<td>17.4 (1.2)</td>
<td>8.7 (0.2)</td>
</tr>
<tr>
<td>Had trouble with the police</td>
<td>17.3 (1.4)</td>
<td>6.3 (0.2)</td>
</tr>
<tr>
<td></td>
<td>16.0 (1.2)</td>
<td>6.3 (0.2)</td>
</tr>
<tr>
<td>Spent time in jail, stockade, correctional custody, brig</td>
<td>7.5 (0.1)</td>
<td>2.1 (0.1)</td>
</tr>
<tr>
<td></td>
<td>5.7 (0.7)</td>
<td>2.1 (0.1)</td>
</tr>
<tr>
<td>Any other serious legal problem</td>
<td>7.2 (0.9)</td>
<td>1.4 (0.1)</td>
</tr>
<tr>
<td></td>
<td>6.2 (0.7)</td>
<td>1.4 (0.1)</td>
</tr>
<tr>
<td>Any other stressful event</td>
<td>45.8 (2.2)</td>
<td>15.2 (0.2)</td>
</tr>
<tr>
<td></td>
<td>48.2 (2.0)</td>
<td>14.8 (0.2)</td>
</tr>
<tr>
<td>Life-threatening illness of a friend or family member</td>
<td>39.0 (2.1)</td>
<td>21.2 (0.3)</td>
</tr>
<tr>
<td></td>
<td>38.2 (1.8)</td>
<td>21.1 (0.3)</td>
</tr>
<tr>
<td>Count: past 12-month stressful experiences (0–13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 stressors</td>
<td>15.9 (1.4)</td>
<td>38.7 (0.4)</td>
</tr>
<tr>
<td></td>
<td>13.7 (1.1)</td>
<td>39.0 (0.4)</td>
</tr>
<tr>
<td>1–2 stressors</td>
<td>25.3 (1.7)</td>
<td>38.8 (0.4)</td>
</tr>
<tr>
<td></td>
<td>26.4 (1.6)</td>
<td>38.9 (0.4)</td>
</tr>
<tr>
<td>3+ stressors</td>
<td>58.7 (2.6)</td>
<td>22.5 (0.3)</td>
</tr>
<tr>
<td></td>
<td>59.9 (2.3)</td>
<td>22.1 (0.3)</td>
</tr>
</tbody>
</table>

Bandoli G et al., *Psychol Med* 2017
Past 30-day Major Depressive Episode and Past 12-month Stressful Experiences

Fig. 1. Prevalence of 30-day major depressive episode by childhood maltreatment profile and level of past 12-month stressful experiences in a sample of 30,436 new soldier recruits in the Army Study to Assess Risk and Resilience. Weighted prevalence estimates are adjusted for age at survey, gender, education, race/ethnicity, and interaction term between childhood maltreatment and level of past 12-month stressful experiences.

Bandoli G et al., *Psychol Med* 2017
Childhood Maltreatment and Alcohol Use Disorder
Alcohol Misuse and Co-Occurring Mental Disorders Among New Soldiers in the U.S. Army

Murray B. Stein, Laura Campbell-Sills, Joel Gelernter, Feng He, Steven G. Heeringa, Matthew K. Nock, Nancy A. Sampson, Xiaoying Sun, Sonia Jain, Ronald C. Kessler, Robert J. Ursano, On behalf of the Army STARRS Collaborators

Alcohol Clin Exp Res 2017; 41:139-148
Childhood Maltreatment Profiles (NSS)

Stein MB et al., *J Clin Psychiatry* 2017
**Effect of maltreatment profile**

\[ \chi^2 = 248.95 \ p < .001 \]

<table>
<thead>
<tr>
<th>Maltreatment Profile</th>
<th>AOR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>No maltreatment</td>
<td>1.00</td>
<td>-</td>
</tr>
<tr>
<td>Episodic emotional</td>
<td>1.80</td>
<td>1.54-2.10</td>
</tr>
<tr>
<td>Freq. Emo/Physical</td>
<td>2.18</td>
<td>1.85-2.56</td>
</tr>
<tr>
<td>Episodic Emo/Sexual</td>
<td>2.50</td>
<td>1.92-3.25</td>
</tr>
<tr>
<td>Freq. Emo/Phys/Sexual</td>
<td>3.97</td>
<td>2.57-6.14</td>
</tr>
</tbody>
</table>
Potential depression and anxiety cases that could be prevented through child maltreatment reduction worldwide

“PAFs suggest that over one-half of global depression and anxiety cases are potentially attributable to childhood maltreatment.”

Li M et al., *Psychol Med* 2016
Summary

• Childhood maltreatment is pervasive and pernicious
• Most (maybe all) mental disorders are increased among adults who have experienced childhood maltreatment
  • More, and longer, is associated with worse outcomes
  • PAF are high, suggesting the prevention will be highly impactful
• Brain structure and function associated with childhood maltreatment
  • Much more work to be done
  • May help identify those at highest risk for poor outcome
  • May inform development of new therapies aimed at augmenting function in dysfunctional (emotion regulation and other) circuits
• Suicidal behaviors strong associated with childhood maltreatment
  • Important target for resource mobilization and intervention
Thanks to...

• The Army STARRS research team...
  – Nationally: Bob Ursano MD, Ron Kessler MD, Matt Nock PhD, et al...
  – Locally:
    • Sonia Jain PhD
    • Feng He
    • Shelly Sun
    • Laura Campbell-Sills PhD
    • Gretchen Bandoli PhD

• Collaborators outside of UCSD...
  – Jitender Sareen MD
  – Tracie Afifi PhD

• Imaging Research...
  – Martin Paulus MD
  – Greg Fonzo PhD
Questions?
Comments!
Child abuse and mental disorders in Canada

Tracie O. Afifi PhD, Harriet L. MacMillan MD, Michael Boyle PhD, Tamara Taillieu MSc, Kristene Cheung BA, Jitender Sareen MD


Competing interests: None declared.

This article has been peer reviewed.

Correspondence to:
Tracie Afifi, tracie.afifi@med.umanitoba.ca


ABSTRACT

Background: Nationally representative Canadian data on the prevalence of child abuse and its relation with mental disorders are lacking. We used contemporary, nationally representative data to examine the prevalence of 3 types of child abuse (physical abuse, sexual abuse and exposure to intimate partner violence) and their association with 14 mental conditions, including suicidal ideation and suicide attempts.

Methods: We obtained data from the 2012 Canadian Community Health Survey: Mental Health, collected from the 10 provinces. Respondents aged 18 years and older were asked about child abuse and were selected for the study sample (n = 23 395). The survey had a multistage stratified cluster design (household response rate 79.8%).

Results: The prevalence of any child abuse was 32% (individual types ranged from 8% to 26%). All types of child abuse were associated with all mental conditions, including suicidal ideation and suicide attempts, after adjustment for sociodemographic variables (adjusted odds ratios ranged from 1.4 to 7.9). We found a dose–response relation, with increasing number of abuse types experienced corresponding with greater odds of mental conditions. Associations between child abuse and attention deficit disorder, suicidal ideation and suicide attempts showed stronger effects for women than men.

Interpretation: We found robust associations between child abuse and mental conditions. Health care providers, especially those assessing patients with mental health problems, need to be aware of the relation between specific types of child abuse and certain mental conditions. Success in preventing child abuse could lead to reductions in the prevalence of mental disorders, suicidal ideation and suicide attempts.
Prevalence in Canada

- **32.1%** of the adult population in Canada has experienced child abuse.
  - physical abuse
  - sexual abuse
  - and/or exposure to IPV

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
Prevalence in Canada

- **32.1%** of the adult population in Canada has experienced child abuse.
- **26.1%** experienced physical abuse
- **10.1%** experienced sexual abuse
- **7.9%** experienced exposure to IPV

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
Prevalence in Canada

- **Women** were more likely than men to have experienced sexual abuse (14.4% v. 5.8%)

- **Women** were more likely than men to have experienced exposure to IPV (8.9% v. 6.9%)

- **Men** were more likely than women to have experienced physical abuse (31% v. 21.3%)

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
What is the Prevalence of Child Abuse in the Canadian General Population Compared to the Canadian Armed Forces?
Original Investigation

Association of Child Abuse Exposure With Suicidal Ideation, Suicide Plans, and Suicide Attempts in Military Personnel and the General Population in Canada

Tracie O. Afifi, PhD; Tamara Taillieu, MSc; Mark A. Zamorski, MD; Sarah Turner, BHS; Kristene Cheung, MA; Jitender Sareen, MD, FRCP-C

**IMPORTANCE** Recent evidence indicates a high prevalence of child abuse exposure in modern US veterans, which may explain in part their higher likelihood of suicide relative to civilians. However, the relationship between child abuse exposure and suicide-related outcomes in military personnel relative to civilians is unknown. Furthermore, the associations among deployment-related trauma, child abuse exposure, and suicide-related outcomes in military personnel have not been examined.

**OBJECTIVES** To determine whether child abuse exposure is more prevalent in Canadian Armed Forces (CAF) personnel compared with the Canadian general population (CGP); to compare the association between child abuse exposure and suicidal ideation, suicide plans, and suicide attempts among the CAF and CGP; and to determine whether child abuse exposure has an additive or interaction effect on the association of deployment-related trauma and past-year suicidal ideation and suicide plans among Regular Forces personnel.

**DATA, SETTING, AND PARTICIPANTS** Data were collected from the following 2 nationally representative data sets: the 2013 Canadian Forces Mental Health Survey (CFMHS) for the CAF (8161 respondents; response rate, 79.8%) and the 2012 Canadian Community Health Survey-Mental Health (CCHS-MH) for the CGP (23,395 respondents; response rate, 68.9% [of these, 15,981 age-matched participants were drawn]). Data were collected from April 15 to August 31, 2013, for the CFMHS and January 2 to December 31, 2012, for the CCHS-MH. Data were analyzed
Canadian Armed Forces

- 48% report experiencing child abuse

Canadian General Population

- 33% report experiencing child abuse

Afifi et al., 2016 JAMA Psych, 73, 229-238
What is the Prevalence of Experiencing More Than One Type of Child Abuse in Canada?
Research article

Relationship between child abuse exposure and reported contact with child protection organizations: Results from the Canadian Community Health Survey

Tracie O. Afifi a,b,*, Harriet L. MacMillan c,d, Tamara Taillieu e, Kristene Cheung f, Sarah Turner a, Lil Tonmyr g, Wendy Hovdestad g

a Department of Community Health Sciences, University of Manitoba, Canada
b Department of Psychiatry, University of Manitoba, Canada
c Department of Psychiatry and Behavioural Neurosciences, McMaster University, Canada
d Department of Pediatrics, McMaster University, Canada
e Department of Applied Health Sciences, University of Manitoba, Canada
f Department of Psychology, University of Manitoba, Canada
g Surveillance and Epidemiology Division, Public Health Agency of Canada, Canada
## Multiple Experiences of Child Abuse in Canada

<table>
<thead>
<tr>
<th>Child Abuse Experience</th>
<th>Whole Sample %</th>
<th>Men %</th>
<th>Women %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No child abuse</td>
<td>68.0%</td>
<td>66.1%</td>
<td>69.8%</td>
</tr>
<tr>
<td>Physical abuse only</td>
<td>16.8%</td>
<td>22.3%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Sexual abuse only</td>
<td>4.2%</td>
<td>1.7%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Exposure IPV only</td>
<td>1.4%</td>
<td>1.3%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Physical abuse &amp; sexual abuse</td>
<td>3.2%</td>
<td>2.6%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Physical abuse and exposure IPV</td>
<td>3.7%</td>
<td>4.0%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Sexual abuse &amp; exposure IPV</td>
<td>0.4%</td>
<td>0.04%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Physical abuse, sexual abuse, and exposure IPV</td>
<td>2.4%</td>
<td>1.5%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Multiple Experiences of Child Abuse in Canada

• Physical abuse often occurred alone rather than with other types of abuse
  • (16.8% vs. 9.3%)

• Exposure to IPV rarely occurred alone
  • (1.4% vs. 6.5%)

• Similar proportions of respondents experienced sexual abuse alone as with other abuse types
  • (4.2% vs. 6.0%).

What is the Relationship between Child Abuse Types and Adult Mental Conditions in Canada?

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
Child abuse and mental disorders in Canada

Tracie O. Afifi PhD, Harriet L. MacMillan MD, Michael Boyle PhD, Tamara Taillieu MSc, Kristene Cheung BA, Jitender Sareen MD


Abstract

Background: Nationally representative Canadian data on the prevalence of child abuse and its relation with mental disorders are lacking. We used contemporary, nationally representative data to examine the prevalence of 3 types of child abuse (physical abuse, sexual abuse and exposure to intimate partner violence) and their association with 14 mental conditions, including suicidal ideation and suicide attempts.

Methods: We obtained data from the 2012 Canadian Community Health Survey: Mental Health, collected from the 10 provinces. Respondents aged 18 years and older were asked about child abuse and were selected for the study sample (n = 23 395). The survey had a multistage stratified cluster design (household response rate 79.8%).

Results: The prevalence of any child abuse was 32% (individual types ranged from 8% to 26%). All types of child abuse were associated with all mental conditions, including suicidal ideation and suicide attempts, after adjustment for sociodemographic variables (adjusted odds ratios ranged from 1.4 to 7.9). We found a dose–response relation, with increasing number of abuse types experienced corresponding with greater odds of mental conditions. Associations between child abuse and attention deficit disorder, suicidal ideation and suicide attempts showed stronger effects for women than men.

Interpretation: We found robust associations between child abuse and mental conditions. Health care providers, especially those assessing patients with mental health problems, need to be aware of the relation between specific types of child abuse and certain mental conditions. Success in preventing child abuse could lead to reductions in the prevalence of mental disorders, suicidal ideation and suicide attempts.
Child Abuse and Mental Conditions in Canada

- **Mental Disorders** (Lifetime)
  - Based on the Composite International Diagnostic Interview (CIDI) and DSM-IV-TR criteria
    - Depression, bipolar disorder, generalized anxiety disorder (GAD), alcohol abuse/dependence, drug abuse/dependence

- **Self-Reported Mental Health Conditions** (Current)
  - Long-term health condition diagnosed by a health professional lasted or expected to last 6 months or more
    - Obsessive-compulsive disorder (OCD), panic disorder, PTSD, phobias, attention deficit disorder (ADD), eating disorders, learning disability

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
Child Abuse and Mental Conditions in Canada

- **Suicidal Ideation**
  - Asked if respondent ever seriously thought about committing suicide or taking his or her own life
    - a) Yes
    - b) No

- **Suicide Attempts**
  - Asked if respondent had ever attempted suicide or tried to take his or her own life
    - a) Yes
    - b) No

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
Summary of Findings

- When adjusting for sociodemographic variables, all types of child abuse were associated with increased odds of all mental conditions.

- There was a general trend of increasing number of child abuse types experienced corresponding with greater odds of mental conditions, indicating a dose–response relationship.

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
Child Abuse and Mental Conditions in Canada

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332

Adjusted Odds Ratios (AOR-1)

- Depression: 2.9
- Bipolar Disorder: 3.6
- GAD: 2.7
- Alcohol Abuse/Dependence: 2.5
- Drug Abuse/Dependence: 3.4

AOR-1 (odds ratios adjusted for age, sex, visible minority status, Canadian born status, education, income, marital status and province)
Child Abuse and Mental Conditions in Canada

Adjusted Odds Ratios (AOR-1)

<table>
<thead>
<tr>
<th>Condition</th>
<th>No Child Abuse</th>
<th>Any Child Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCD (Ref Group)</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>Panic Disorder (Ref Group)</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>PTSD (Ref Group)</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td>Phobias (Ref Group)</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>ADD (Ref Group)</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Eating Disorders (Ref Group)</td>
<td>4.7</td>
<td></td>
</tr>
<tr>
<td>Learning Disability (Ref Group)</td>
<td>1.7</td>
<td></td>
</tr>
</tbody>
</table>

AOR-1 (odds ratios adjusted for age, sex, visible minority status, Canadian born status, education, income, marital status and province)

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
Child Abuse and Mental Conditions in Canada

Suicidal Ideation

Suicide Attempts

AOR-1 (odds ratios adjusted for age, sex, visible minority status, Canadian born status, education, income, marital status and province)

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
Child Abuse and Mental Conditions in Canada

Afifi, T.O. et al., 2014, CMAJ, 186, E324-E332
What is the Relationship between Child Abuse Experiences and Adult Physical Health in Canada?

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18.
Child abuse and physical health in adulthood

by Tracie O. Afifi, Harriet L. MacMillan, Michael Boyle, Kristene Cheung, Tamara Taillieu, Sarah Turner, and Jitender Sareen

Abstract

**Background:** A large literature exists on the association between child abuse and mental health, but less is known about associations with physical health. The study objective was to determine if several types of child abuse were related to an increased likelihood of negative physical health outcomes in a nationally representative sample of Canadian adults.

**Data and methods:** Data are from the 2012 Canadian Community Health Survey—Mental Health (n = 23,395). The study sample was representative of the Canadian population aged 18 or older. Child physical abuse, sexual abuse, and exposure to intimate partner violence were assessed in relation to self-perceived general health and 13 self-reported, physician-diagnosed physical conditions.

**Results:** All child abuse types were associated with having a physical condition (odds ratios = 1.4 to 2.0) and increased odds of obesity (odds ratios = 1.2 to 1.4). Abuse in childhood was associated with arthritis, back problems, high blood pressure, migraine headaches, chronic bronchitis/emphysema/COPD, cancer, stroke, bowel disease, and chronic fatigue syndrome in adulthood, even when sociodemographic characteristics, smoking, and obesity were taken into account (odds ratios = 1.1 to 2.6). Child abuse remained significantly associated with back problems, migraine headaches, and bowel disease when further adjusting for mental conditions and other physical conditions (odds ratios = 1.2 to 1.5). Sex was a significant moderator between child abuse and back problems, chronic bronchitis/emphysema/COPD, cancer, and chronic fatigue syndrome, with slightly stronger effects for women than men.

**Interpretation:** Abuse in childhood was associated with increased odds of having 9 of the 13 physical conditions assessed in this study and reduced self-perceived general health in adulthood. Awareness of associations between child abuse and physical conditions is important in the provision of health care.

**Keywords:** Child abuse, chronic disease, health status, obesity, smoking.
Child Abuse and Physical Health in Canada

- **13 Self-Reported Physical Health Conditions** (Current) Long-term health conditions diagnosed by a health professional lasted or expected to last 6 months or more
  - asthma
  - arthritis (excluding fibromyalgia)
  - back problems (excluding fibromyalgia and arthritis)
  - high blood pressure
  - migraine headaches
  - chronic bronchitis/emphysema/chronic obstructive pulmonary disease (aged 35+)
  - diabetes
  - epilepsy
  - heart disease
  - cancer
  - stroke
  - bowel disease (Crohn’s disease, ulcerative colitis, irritable bowel syndrome, bowel incontinence)
  - chronic fatigue syndrome

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18
Child Abuse and Physical Health in Canada

• All types of child abuse were associated with an increased likelihood of having a physical health condition.

• All types of child abuse were associated with increased odds of obesity in adulthood
  - Physical abuse (AOR = 1.2; 95% CI = 1.1 to 1.4)
  - Sexual abuse (AOR = 1.4; 95% CI = 1.1 to 1.6)
  - Exposure to IPV (AOR = 1.3; 95% CI = 1.1 to 1.6)

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18
Child Abuse and Physical Health in Canada

- Child Abuse
  - Increased likelihood
    - after adjusting for SES variables, smoking, and obesity

- Arthritis
- Back problems
- High blood pressure
- Migraine headaches
- Chronic bronchitis/emphysema/COPD
- Cancer
- Stroke
- Bowel disease
- Chronic fatigue syndrome

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18.
Child Abuse and Physical Health in Canada

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18
Child Abuse and Physical Health in Canada

Adjusted Odds Ratio (AOR-1)

<table>
<thead>
<tr>
<th>Condition</th>
<th>No (Reference Group)</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>1.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Arthritis</td>
<td>1.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Back Problems</td>
<td>1.0</td>
<td>1.6</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>1.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Migrane</td>
<td>1.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Chronic Bronchitis</td>
<td>1.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.0</td>
<td>1.2</td>
</tr>
</tbody>
</table>

* Indicates statistical significance.

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18
Child Abuse and Physical Health in Canada

Adjusted Odds Ratio (AOR-1)

<table>
<thead>
<tr>
<th>Condition</th>
<th>No (Reference Group)</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy</td>
<td>1.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>1.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Cancer</td>
<td>1.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Stroke</td>
<td>1.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Bowel Disease</td>
<td>1.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Chronic Fatigue Syndrome</td>
<td>1.0</td>
<td><em>2.6</em></td>
</tr>
<tr>
<td>Any Physical Health Condition</td>
<td>1.0</td>
<td><em>1.4</em></td>
</tr>
</tbody>
</table>

* indicates statistical significance.

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18
Child Abuse and Physical Health in Canada

- Several explanations for the relationship between child abuse and poor physical health are possible:
  - Infants who experience abuse have high hormonal reactivity to stress (Jaffee et al., 2014; Bugental et al., 2003).
  - The link between child abuse and physical health may also reflect physiologic responses to violence. Exposure to abuse may affect the hypothalamus-pituitary adrenal axis, leading to excess secretion of cortisol and consequent physiological responses such as increased heart rate and blood pressure (Sachs-Ercsson et al. 2009; Shonkoff et al. 2009; Kendall-Tackett et al., 2009; Tarullo et al., 2006; McCrory et al., 2010).
  - Neuroimaging and neurochemical and proton spectroscopy data has indicated that individuals exposed to abuse and violence have acute, subacute, and chronic changes in the brain, particularly related to the hypothalamic-pituitary-adrenal axis (Keeshin et al., 2012).

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18
Child Abuse and Physical Health in Canada

Several explanations for the relationship between child abuse and poor physical health are possible:

- Child abuse can also alter patterns of sleep, which may worsen physical symptoms (Chapman et al., 2011).

- As well, child abuse and neglect are associated with alterations in the immune system—markers of systemic inflammation appear to be more common among children and adults exposed to maltreatment (Coelho et al., 2014; Matthews et al., 2014).

- Indirect pathways between child abuse and physical health may also exist through mental conditions or physical co-morbidities.

- Individuals exposed to maltreatment in childhood may have emotional, cognitive, and behavioural responses such as substance abuse and overeating, which may be another pathway to health problems (Sachs-Ericsson et al., 2009; Kendall-Tackett et al., 2009).

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18
Child Abuse and Physical Health in Canada

• Health care providers may have a limited awareness of the role of child abuse in relation to physical health conditions.

• From a public health perspective, it is increasingly recognized that prevention of child abuse has major implications for reduction in mental health problems, but it is also possible that reducing child abuse may lead to better physical health outcomes.

Afifi, T.O. et al., 2016, Health Reports, 27, 10-18
Resilience and Child Maltreatment
Resilience Following Child Maltreatment: A Review of Protective Factors

Tracie O Afifi, PhD; Harriet L MacMillan, MD

Objective: Child maltreatment is linked with numerous adverse outcomes that can continue throughout the lifespan. However, variability of impairment has been noted following child maltreatment, making it seem that some people are more resilient. Our review includes a brief discussion of how resilience is measured in child maltreatment research; a summary of the evidence for protective factors associated with resilience based on those studies of highest quality; a discussion of how knowledge of protective factors can be applied to promote resilience among people exposed to child maltreatment; and finally, directions for future research.

Method: The databases MEDLINE and PsycINFO were searched for relevant citations up to July 2010 to identify key studies and evidence syntheses.

Results: Although comparability across studies is limited, family-level factors of stable family environment and supportive relationships appear to be consistently linked with resilience across studies. There was also evidence for some individual-level factors, such as personality traits, although proxies of intellect were not as strongly related to resilience following child maltreatment.

Conclusions: Findings from resilience research needs to be applied to determine effective strategies and specific interventions to promote resilience and foster well-being among maltreated children.

Resilience Following Child Maltreatment: A Review of the Protective Factors

- Much of the current child abuse and resilience literature is limited by:
  - Non-representative samples
    - Clinical/treatment-seeking or at-risk samples
  - Limited assessments of child maltreatment
    - One type of child abuse
  - Limited assessments of resilience or mental health
    - Symptoms of depression
    - Psychological well-being only
  - Limited assessments of protective factors and factors less amendable to change
    - Mostly individual-level factors

Afifi & MacMillan, 2011
Child Maltreatment and Resilience

- **Family-Level Protective Factors**
  - Stable family environment
  - Supportive relationships

- **Individual-Level Protective Factors**
  - Personality traits (locus of control)

Individual- and Relationship-Level Factors Related to Better Mental Health Outcomes following Child Abuse: Results from a Nationally Representative Canadian Sample

Facteurs individuels et relationnels liés à de meilleurs résultats de santé mentale suite à la violence faite aux enfants : résultats d’un échantillon national canadien représentatif

Tracie O. Afifi, PhD\(^{1,2}\), Harriet L. MacMillan, MD, FRCPC\(^{3,4}\), Tamara Taillieu, MSc\(^5\), Sarah Turner, MSc\(^1\), Kristene Cheung, MA\(^6\), Jitender Sareen, MD, FRCPC\(^{1,2,6}\), and Michael H. Boyle, PhD\(^3\)
Background

- Mental health is defined by the World Health Organization (WHO) as not just the absence of mental disorders, but also the presence of well-being.

World Health Organization, 2005
Background

• This perspective on mental health has been further developed in the work of Corey Keyes and the complete state mental health model.

• Mental health is the absence of mental disorders and the presence of mental well-being and functioning.

• **Well-being and functioning** includes constructs such as
  o Happiness
  o Interest and satisfaction with life
  o Being embedded in a community
  o Confidence in managing daily responsibilities
  o Expressing ideas
  o Making worthwhile contributions to society.

Keyes, 2005; 2006; 2007; 2009 Westerhof & Keyes, 2010
Similarly, it may be important to expand our thinking beyond mental disorders and also include suicidal thoughts.

Having a mental disorder increases the odds of suicidal ideation, but it is also possible to have such thoughts without meeting criteria for a mental disorder.

Sareen et al., 2005
# Measuring Mental Health

## Table 1. Three-Factor Model for Computing Mental Health.

<table>
<thead>
<tr>
<th>Scores on MHC-Sf</th>
<th>No Past-Year Suitical Ideation</th>
<th>Past-Year Suitical Ideation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Past-Year Mental Disorder</td>
<td>Past-Year Mental Disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Past-Year Mental Disorder</td>
</tr>
<tr>
<td>Flourishing</td>
<td>Good Mental Health</td>
<td>Moderate Mental Health</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate Mental Health</td>
<td>Moderate Mental Health</td>
</tr>
<tr>
<td>Languishing</td>
<td>Poor Mental Health</td>
<td>Poor Mental Health</td>
</tr>
</tbody>
</table>

Afifi et al., 2016
Measures

- Individual-level protective factors:
  - Highest educational attainment
  - Household annual income
  - Marital status
  - Physical health condition diagnosed by a health care professional
    - 13 self-reported conditions assessed
  - Physical activity
    - Moderate to vigorous physical activity in the past 7 days (yes or no)
  - Coping skills
    - Self-perceived ability to handle unexpected and difficult problems
    - Self-perceived ability to handle day-to-day demands of their life

Afifi et al., 2016
Measures

- **Relationship-level protective factors:**
  - Quality of friend and family relationships (Social Provisions Scale)
    - **Attachment**
      - Emotional closeness
    - **Guidance**
      - Advice or information
    - **Social integration**
      - As sense of belonging to a group
    - **Reliable alliance**
      - Assurance that others can be counted on in times of stress
    - **Reassurance of worth**
      - Recognition of one’s competence

Afifi et al., 2016
Mental Health

Prevalence of overall mental health in the total sample.

- Good = 67.1%
- Moderate = 28.6%
- Poor = 4.3%

Afifi et al., 2016
Mental Health

**Without a Child Abuse History**
- Good = 72.4%
- Moderate = 25.1%
- Poor = 2.5%

**With a Child Abuse History**
- Good = 56.3%
- Moderate = 35.6%
- Poor = 8.1%

Afifi et al., 2016
What are the relationships between individual- and relationship-level factors and better mental health outcomes among respondents with and without a child abuse history.

Afifi et al., 2016
Better mental health for those with a child abuse history was related to:

- Higher educational attainment
  - Compared to less than high school (reference group)

- Higher income
  - Compared to less than $30,000 (reference group)

- Being married/common-law
  - Compared to being separated/widowed/divorced (reference group)

Afifi et al., 2016
Sociodemographic Variables Related to Better Mental Health for those with a Child Abuse History

<table>
<thead>
<tr>
<th>Variable</th>
<th>Poor Mental Health</th>
<th>Moderate Mental Health</th>
<th>Good Mental Health</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education: University Degree</td>
<td>1.0</td>
<td><strong>2.01</strong></td>
<td>*<strong>4.08</strong></td>
<td>7.79</td>
</tr>
<tr>
<td>Income: $80,000 or more</td>
<td>1.0</td>
<td>*<strong>3.36</strong></td>
<td>*<strong>7.79</strong></td>
<td></td>
</tr>
<tr>
<td>Marital Status: Married/common law</td>
<td>1.0</td>
<td><strong>2.02</strong></td>
<td>*<strong>2.34</strong></td>
<td></td>
</tr>
</tbody>
</table>

Afifi et al., 2016
Individual-Level Factors: Physical Health

Better mental health for those with a child abuse history was related to:

- No physical health condition
- Having moderate to vigorous physical activity

Afifi et al., 2016
Physical Health Variables Related to Better Mental Health for those with a Child Abuse History

No Physical Health Condition

- Poor Mental Health: 1.0
- Moderate Mental Health: 2.27
- Good Mental Health: 3.23

Moderate to Vigorous Physical Activity

- Poor Mental Health: 1.0
- Moderate Mental Health: 1.47
- Good Mental Health: 1.93

*p<0.05, ** p<0.01, *** p<=0.001

Afifi et al., 2016
Individual-Level Factors: Positive Coping Skills

- Better mental health for those with a child abuse history was related to:
  - Good to excellent ability to handle unexpected problems
  - Good to excellent ability to handle day-to-day demands

Afifi et al., 2016
Relationship-Level Factors: Quality of Relationships

Positive Coping Skills Related to Better Mental Health for those with a Child Abuse History

Afifi et al., 2016
Better mental health for those with a child abuse history was related to higher scores on:

- Attachment
- Guidance
- Reliable alliance
- Social integration
- Reassurance of worth

Afifi et al., 2016
Quality of Relationships Related to Better Mental Health for those with a Child Abuse History

Afifi et al., 2016
Better Mental Health among those With and Without a Child Abuse History

• Sociodemographic characteristics and individual-level factors moderated the relationship between child abuse and overall mental health.

• Specifically, the impact of higher income, being married, and having good to excellent ability to handle unexpected problems on better mental health was significantly larger among respondents with a child abuse history compared to those who were not abused.

Afifi et al., 2016
Limitations of these Studies

- Due to the cross-sectional and retrospective nature of the data, inferences regarding causation cannot be made.

- The data were all self-reported.

- The assessment of sexual abuse in the CCHS 2012 may not have been adequate to capture all sexual abuse experiences that would be harmful and/or considered illegal.

- Measures of emotional maltreatment and neglect were not included.

- Several child and family characteristics were not available in the data such as family poverty, parental substance abuse, and parental mental health problems.

- Other individual- and relationship-level factors were not included and community-level factors were not assessed.
Summary of the Findings

• 32% of the adult population in Canada has experienced child abuse.

• Child abuse has robust associations with all mental conditions including suicide ideation and attempts.

• Experiencing abuse in childhood was associated with increased odds of having 9 of the 13 physical conditions in adulthood.
Summary of Findings

According to our findings, better mental health outcomes following child abuse may be more likely if the individual is able to:

- **stay in school** for longer
- obtain a **well-paying job**
- be **physically active**
- have the ability to **handle unexpected problems and day-to-day demands**
- have **good quality relationships** with friends and family

Afifi et al., 2016
Conclusions

- Child abuse is an important public health problem globally, including in Canada.

- All health care providers should be aware of the relation between child abuse and mental and physical health conditions.

- Success in preventing child abuse could lead to reductions in these conditions.
Conclusions

- Prevention of child abuse remains a priority.

- These studies identify areas that could be targeted for interventions to improve mental health following maltreatment.

- Next steps include developing and testing the effectiveness of intervention strategies to help improve mental health following maltreatment and prevent child abuse.
Moving Forward

• We need to continue to invest in nationally representative data on child maltreatment in Canada and in other countries.

• We need to add measures of neglect and emotional maltreatment to all surveys assessing child maltreatment.

• We need to also assess child and family characteristics such as family poverty, parental substance abuse, and parental mental health problems.

• We need to assess child abuse along with indicators of health, education, justice, sexual orientation, and gender-identity.
Well-Being & Experiences Study
The WE Study

Research Protocol Goals

- **Representative** sample
- **Generational** data
- Personal Health Identification Numbers (PHINs) to link data to the administrative data housed at the Manitoba Centre for Health Policy (MCHP) for adolescent and parent.
  - Health, education, housing, justice, family services, children in care, etc.
- **Longitudinal** waves into adulthood that will include data collection of adolescent offspring.
Thank you!

Questions?
References


References


- Walsh WA, Dawson J, Mattingly MJ. How are we measuring resilience following childhood maltreatment? Is the research adequate and consistent? What is the impact on research, practice, and policy? Trauma Violence Abuse. 2010;11(1):27-41.


References


References


References


References


Childhood Trauma in Relation to Adult Health & Resilience: Focus on Schizophrenia

Dilip V. Jeste, MD
Senior Associate Dean for Healthy Aging
Director, Stein Institute for Research on Aging
Distinguished Professor of Psychiatry and Neurosciences
University of California, San Diego
OUTLINE

• Literature Review
• UC San Diego Study
• Associations of Severity of Trauma
• Role of Resilience
• Implications for Interventions
ELEANOR ROOSEVELT (1884 – 1962): A PROBABLE VICTIM OF CHILDHOOD EMOTIONAL, PHYSICAL, & SEXUAL ABUSE

“I gain strength, courage and confidence by every experience in which I must stop and look fear in the face.”

I say to myself, “I’ve lived through this and can take the next thing that comes along.”
SCHIZOPHRENIA

• A serious mental illness, labeled by some as “cancer of the mind”
• Etio-pathology unclear; Postulated “2-hit hypothesis” with genetic predisposition + early childhood brain injury or damage
• Onset of illness usually between 15 and 30 years of age
• Chronic, often life-long, disease with psychotic relapses
• Antipsychotic medications reduce psychotic symptoms but do not affect underlying pathology; Psychosocial interventions improve functioning to some extent
“Besides the psychic disorders, there are also in the physical domain a series of morbid phenomena to record.”

--- Emil Kraepelin, 1913
ACCELERATED PHYSICAL AGING IN SCHIZOPHRENIA?

- Various diseases of aging (diabetes, metabolic disorders, heart disease) occur in younger adults with SZ
- 2-12 times higher mortality and 15-to-20-year shorter lifespan
- Earlier onset of aging-associated pathological changes – e.g., insulin resistance, immune activation, inflammatory syndrome, larger brain ventricles

LITERATURE ON CHILDHOOD TRAUMA IN PSYCHOTIC DISORDERS

• Meta-analyses and epidemiological studies point to an association between childhood trauma and psychosis (broadly defined ranging from subclinical psychotic symptoms to psychotic disorders); Relationship appears to be dose-dependent (Bendall 2008, Clarke 2012, Morgan 2007, Trotta 2015)

• Childhood abuse more prevalent in psychotic disorders compared to mood or anxiety disorders (Larsson 2013, Matheson 2013)

• Childhood abuse – more likely in women than in men with psychotic illness (Shah 2014)
LITERATURE ON CHILDHOOD TRAUMA IN SCHIZOPHRENIA

• Emotional neglect most common form of adversity (Larsson 2013)
• Abuse associated with poor premorbid social functioning, increased clinical symptoms, thought disorder, lifetime suicide attempts, anxiety, personality disorder, impaired quality of life, and depression (Andrianarisoa 2016, Shah 2014)
• Abuse associated with positive symptoms (Gallagher 2013, Heins 2011, van Dam 2014)
• Neglect associated with negative symptoms (Gallagher, 2003)
• Elevated IL-6 and TNF-alpha in SZ with trauma compared to SZ without trauma (Dennison 2012)
LIMITATIONS OF THE LITERATURE

- Variable (sometimes small) sample sizes
- No control groups in some studies
- Variability in the measures used for assessing childhood adversity
- Little information provided on non-psychiatric clinical characteristics of participants (e.g., physical health)
- Only a few studies of biomarkers
UC SAN DIEGO STUDY

• > 100 outpatients with schizophrenia and > 100 demographically comparable healthy subjects

• Use of Childhood Trauma Questionnaire (CTQ), a well established, reliable, and validated measure of childhood trauma

• Comprehensive psychiatric, physical, and positive psychological characterization of the study participants

• Assessment of biomarkers of aging related to inflammation, oxidative stress, and insulin resistance

• This report is based on baseline cross-sectional data, but the subjects are being followed longitudinally
OUTLINE

• Literature Review
• UC San Diego Study
• Associations of Severity of Trauma
• Role of Resilience
• Implications for Interventions
NIMH-FUNDED UC SAN DIEGO STUDY OF ACCELERATED BIOLOGICAL AGING IN SCHIZOPHRENIA (SZ)

- 140 outpatients with SZ and 120 non-psychiatric comparison subjects aged 26-65 years, recruited using structured multi-cohort longitudinal design
- Mean age 50 years; 45% women; majority Caucasians
- Patients performed worse on measures of psychopathology, lifestyle, physical health (obesity, diabetes, cardiovascular function), cognitive performance, and biomarkers of aging related to inflammation, oxidative stress, and insulin resistance

OTHER RELEVANT MEASURES

• 36-item MOS-SF-36 scale with physical and mental component scores
• 10-item Connor-Davidson Resilience Scale
• 5-item Life-Orientation Test-Revised for Optimism
• Scales for Satisfaction with life, Perceived stress, Depression, Anxiety
• Physical health: Medical comorbidities, BMI, Waist circumference, Blood pressure
• Biomarkers: Inflammation (cytokines and chemokines), Oxidative stress (F2-isoprostanes), and Insulin resistance (HOMA-IR)
OUTLINE

• Literature Review
• UC San Diego Study
• Associations of Severity of Trauma
• Role of Resilience
• Implications for Interventions
RESILIENCE

• Trait or Process or Outcome?
• **Definition:** Ability to adapt positively to adversity, or to recover readily from adversity
• **Assessment:** Connor-Davidson’s and other scales
• **Different levels:**
  1. “Survival” after a major adversity
  2. Bouncing Back: Return to pre-adversity level
  3. Post-traumatic Growth: Becoming stronger after recovering from adversity, to cope with future adversities, and even prevent ones from occurring
WHY IS RESILIENCE IMPORTANT?

• In physically ill patients, resilience is associated with medically desirable behaviors (self-care, treatment, & exercise adherence), and better health outcomes (emotional health & well-being, less pain, and better physical health), and greater longevity

• People in their 90s, who endorsed higher levels of resilience, had a 43% higher likelihood of living to 100 years compared to their peers with lower levels of resilience

  (Lamond et al., 2008; Shen & Zeng, 2010; Stewart & Yuen, 2011)
OUTLINE

• Literature Review
• UC San Diego Study
• Associations of Severity of Trauma
• Role of Resilience
• Implications for Interventions
INTERVENTIONS TO ENHANCE RESILIENCE

• Master Resilience Training for the armed forces
• Stress Management and Resilience Training (SMART)
• Mindfulness-Based Stress Reduction
• (Novel Biological interventions such as Training to modulate one’s own brain activity with real-time fMRI-based neuro-feedback)
• (Loprinizi et al., 2011; Rose et al., 2013; Creswell et al 2012; Caria et al 2007)
RESILIENCE PRESCRIPTION: 10 STEPS

1. Positive attitude (Optimism)
2. Cognitive flexibility:
   • Reframe, assimilate, accept, recover
   • Failure is an essential ingredient for growth
3. Personal moral compass (a set of core beliefs)
4. Role model: Imitation is a powerful mode of learning
5. Face your fears:
   • Fear is normal
   • Facing fears can increase self-esteem

(Southwick and Charney, 2012)
RESILIENCE PRESCRIPTION: 10 STEPS

6. Develop active coping skills

7. Establish and nurture a supportive social network:
   • Very few can “go it alone”
   • Considerable emotional strength accrues from close relationships with people and organizations

8. Attend to physical well-being: Exercise

9. Training: Discipline & practice

10. Recognize, utilize, and foster your strengths:
    • Engaging character strengths to cope with stress

(Southwick and Charney, 2012)
ILLUSTRATIVE RESILIENCE INTERVENTION

• 64 college students randomly assigned to the intervention or wait-list control

• 4-week resilience intervention (four 2-hour sessions) with psychoeducational components, aspects of Cognitive Behavior Therapy, rational-emotive therapy, and internal family systems therapy

• The intervention group had significantly higher scores on the Connor-Davidson Resilience Scale, as well as better coping skills and protective factors, along with less depression and perceived stress compared to the wait-list control group

(M. Steinhart & C. Dolbier, J Am College Health, 56:445-454, 2008)
ACKNOWLEDGEMENTS

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Thank You!

www.aging.ucsd.edu
Children Who Fail at School
But Succeed at Life

Advances in Our Understanding of
Human Resilience and of the Limits of
Emotional Endurance

Mark Katz, Ph.D.

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Children Who Fail at School But Succeed at Life

• Part I: Introduction: Why Do People Keep Asking the Wrong Question?

• Part II: Advances in Our Understanding of Human Resilience and of the Limits of Emotional Endurance

• Part III: “To Have Erroneous Perceptions and to Reason Correctly From Them”

• Part IV: What Can Be
Part I: Introduction

Why Do People Keep Asking the Wrong Question?
Resilience Through the Life Span

• Why is it that some people exposed to multiple childhood risks and adversities “beat the odds” and manage to go on to lead meaningful and productive lives?

• Why is it that others succumb then rebound decades later?

• Is it because those who “beat the odds” are more resilient?

• Are we sure?

• Might some who succumb to adversity be every bit as resilient as those who endure, or even more so? (Might some adults?)

• Have we been focusing on the wrong question?
Resilience Through the Life Span

• What could cause otherwise resilient people to succumb to childhood risks and adversities?

• And why do a number then rebound decades later?

• Resilience Through the Life Span Project

• Current focus: People who fail at school but succeed in life
PART II

Advances in Our Understanding of Human Resilience,

And of the Limits of Emotional Endurance
Resilience Through the Lifespan

- Resilience: strength under adversity

- Emmy Werner – following children exposed to 4 or more risks, now in their 40s. Significant # who succumbed through age 18 rebounded by their early 30s. Still doing well in their 40s.
Are There Limits to Emotional Endurance?
Long Term Multiple Risk Exposure

• Risks can co-occur

• “A man with one watch always knows what time it is, a man with two is never really sure.”

• Risks can co-occur and can also persist (ACES can co-occur and can also persist)

• Protective processes that can offset multiple prolonged risk exposure (Werner and Smith, 2001)
Protective Influences

Events, Experiences, Conditions That Can Outweigh or Neutralize the Effects of Exposure to Known Risk Factors
Protective Processes That Researchers Feel Can Offset the Effects of Multiple Childhood Risks  
(Werner et al, 2001)

1. Experiences That Reduce the Impact of Prevailing Risks:
   A. Learning to see adversities in a new light
   B. Reducing the amount of exposure to the risks of adverse conditions (role of context); buffers

2. Preventing a Chain Reaction of Negative Life Events; Creating Safety Nets

3. Experiences That Promote a Sense of Mastery (Mastery to meaning connection)

4. Opening the Door to Turning Point Experiences or Second Chance Opportunities
Resilient Children Who “Beat the Odds,”
Resilient Children Who Succumb

• To repeat - What could cause otherwise resilient people to succumb to childhood risks and adversities?

• Answer: A few entirely understandable yet erroneous perceptions -

• Erroneous perceptions that over-ride protective processes that for some could outweigh exposure to multiple risks and adversities
Part III

“To Have Erroneous Perceptions and to Reason Correctly From Them”
“To Have Erroneous Perceptions and to Reason Correctly From Them”

“What is Madness? To Have Erroneous Perceptions and to Reason Correctly From Them”

Voltaire
“To Have Erroneous Perceptions and to Reason Correctly From Them”

- Paradoxically uneven learning, behavioral and emotional profiles (sometimes observed in children exposed to multiple risks and advers)

- Can lead caring people with the best of intentions to a series of entirely understandable yet erroneous perceptions regarding their uneven profiles

- 5 erroneous perceptions

- 5 alternative perceptions - may allow access to protective processes
Erroneous Perception #1

- Anyone capable of performing exceptionally well on intellectual, creative or artistic tasks that most others find very difficult, is necessarily capable of performing equally well or better on academic or behavioral tasks that most others find very easy. It’s all simply a matter of trying harder.
Perception #1

• It’s indeed possible that some people can be capable of doing difficult things easy yet find easy things difficult for reasons that can have nothing to do with laziness or a person’s moral character.

• This profile is common among children/youth/adults who experience various learning disabilities/differences.
Erroneous Perception #2

• Anyone who knows what they’re supposed to do in a given situation can be expected to predictably, consistently and independently do what they know, one hundred percent of the time.

• It’s all about willpower.
Perception #2

• It’s entirely possible for someone to know what to do yet have difficulty consistently, predictably and independently doing what they know, in part, because they call into play different skills (Barkley, 2010; Goldstein 2001).

• Learning/behavioral profile is consistent with individuals (children, youth, adults) with executive function challenges
Examples of Mental Processes
Under the EF Umbrella

• Self-Control – Behavioral Inhibition

• Emotional Self-Regulation

• Organization, Time Management, Planning (OTMP) (Howard Abikoff et al., 2014)

• Mental Flexibility

• Self-Monitoring

• Working Memory
The Role of Executive Function (Cont)

• What can cause EF challenges?

  Learning/behavioral profile
  (neurodevelopmental profile)

  Prolonged traumatic stress exposure
  (Perry, 2002)

  Both, in combination

  Other conditions?
Interpersonal Trauma and Executive Functioning

• Among those suffering the effects of traumatic stress, neuroimaging studies reveal decrease in activation in brain regions associated with executive functioning (van der Kolk, 2006).
Erroneous Perception #3

• The single measure of human intelligence is school performance. Those who do very well in school, therefore, are very smart, and those who don’t do very well in school, therefore, are not.
Perception #3

There are many different ways of being smart, some of which can’t be measured by how well one does in school.

Knowing this and truly believing this can avoid personally humiliating experiences at school as well as in life
Erroneous Perceptions #4 & 5

• Erroneous Perception # 4 –

  – Individuals, school age children included, can be expected to think and act the same way in situations they perceive as safe, friendly and within their ability to control as they do in situations they perceive as dangerous, threatening and beyond their ability to control.
Erroneous Perception #5

Believing as we do in erroneous perception #4, it follows that resilience and success are one and the same. Those who succeed at school are resilient. Those who fail are not, logically speaking.
• Resilience and context are inseparable

• In an environment that you perceive as dangerous and threatening, it makes no sense, from a survival point of view, to appear conspicuously vulnerable

• Contextual blind spots
The Limits to Emotional Endurance

• Powerlessness in the context of prolonged inescapable stress

• For some, humiliation in the context of inescapability

• Can misperceptions result in believing that our challenges (adversities) as permanent, pervasive and personal?
Perception #4

Resilient people, school age children included, sometimes think and act differently in places they find threatening and dangerous as opposed to places they find warm and friendly, particularly when those threatening and dangerous places are also perceived as stigmatizing, inescapable and beyond their ability to control or influence.
Perception #5

It’s these contextual influences that can determine whether we endure in the face of adversity or are stretched to our limits of emotional endurance, which helps to explain why some of the most resilient people we will ever have the pleasure of meeting may struggle significantly just to get through a typical day, school-age children included.
Part IV

What Can Be
Changing the Odds

- Perceptions > processes > practices

- New perceptions = greater access to protective processes and practices that can foster them
Can You Guess?

• It can make you look virtue-less or virtuous, utterly blind or remarkably kind.

• It’s character’s best friend, or sometimes its worst enemy.

• And while few things are more important in improving the quality of our lives and curing our major social ills, in the final analysis, it may also be impossible to measure.

• What is it?
Contextual Influences

• Contextual influences – a framework for helping to access protective processes and selecting programs and practices that strengthen them

• Reminds us of our contextual blind spots and our need to navigate around them

• Reminds us of our context sensitive ways and our capacity for contextual thinking
Contextual Influences

- Contextual influences linked directly to protective processes that can potentially offset multiple childhood risk exposure (Werner et al 2001)

- (contextually expressed protective processes)

- See attached figure
Contextual Influences That Can “Change the Odds”

- **Social Context** = The ability to successfully seek out, change and/or accommodate to social contexts where we enjoy socially valued roles and responsibilities, and the opportunity to contribute significantly.

- **Life experiences – In Context** = Learning to see strengths, challenges, and adverse experiences in a hopeful new light.

- **Relationships – In Context** = While resilience is typically viewed through the lens of individual journeys, research suggests that our greatest source of strength may actually be each other.
Social Context

• Creating a social climate where we feel we belong and have something important to contribute

• Meaningful roles and responsibilities (examples)

  “There’s never anything so wrong with us that what’s right with us can’t fix.”

• More labels, not less
Social Context

• How do you change a social climate?
  – Buy-in
  – Focusing on strengths
  – Making a significant contribution
  – Legitimizing, validating differences
  – Modeling
  – Interventions at the point of performance
  – The role of bystanders
Social Context: Changing Bystander Behavior

- Key ingredient in changing the social climate of a classroom and of a school
- Key ingredient in preventing and reducing bullying
- Key ingredient in preventing stigma
- Can be key ingredient in helping those impacted by stigma to overcome its effects
- Public awareness is one thing, taking action on behalf of others is quite another
- Creating a context (social climate) where what we believe in is more powerful than what we are afraid of
Changing Bystander Behavior

"In the end we will remember not the words of our enemies but the silence of our friends."

Martin Luther King, Jr.
Changing Bystander Behavior

“There is something you must always remember. You are braver than you believe, stronger than you seem, and smarter than you think. But the most important thing is, even if we’re apart… We’ll always be with you.”

A.A. Milne (Winnie The Pooh)
Life Experiences – In Context
Learning to See Abilities/Challenges in a New Light

• Taking threat and danger out of difference

• Access to a language (vocabulary; mindset) that allows us to interpret experiences in a new light.

• Connecting with others who endured similar risk exposure and who are doing well
Life Experiences – In Context
Learning to See Abilities/Challenges in a New Light

• Writing strengths based, trauma informed reports

• Ongoing project
  (www.learningdevelopmentservices.com
  Click Book icon, click ongoing projects
  or e-mail markkatzphd@gmail.com)
• Can assessment results be a vehicle for highlighting our unique strengths and that provide a new way to understand struggles and differences?
Life Experiences – In Context
Learning to See Abilities/Challenges in a New Light

• Brainology
  Carol Dweck, Ph.D. www.mindsetworks.com

• Shut Up About Your Perfect Kid
  www.shutupaboutyourperfectkid.com

• Active Minds  www.acrtiveminds.org

• WhyTry Program www.whytry.org

• Eye to Eye  www.eyetoeyenational.org
Life Experiences – In Context
Learning to See Abilities/Challenges in a New Light

• It’s not how smart are we, but rather, how are we smart

• Howard Gardner, Ph.D. - Diverse intellectual strengths
  • linguistic
  • logical-mathematical
  • musical
  • kinesthetic
  • spatial
  • naturalist
  • interpersonal
  • intrapersonal
Life Experiences - in Context
Mastery to Meaning Connection

- Not only can new beliefs lead to new successful actions (new meaning – new mastery), but new successful actions (new mastery) can also lead to new beliefs (new meaning)

- Meaning to Mastery

- Mastery to Meaning
A Sense of Mastery

- The belief that our actions control our outcomes. If we try hard, learn from our mistakes, we’ll reach the goals we set out to achieve.

- A sense of mastery is learned

- Not be confused with self-esteem
A Sense of Mastery Vs Self-Esteem

• VCU Study - College students obtaining a grade of C or below on midterm exam randomly assigned to two groups, one that received weekly self-esteem enhancing messages, another (the control group) that received neutral messages.

• Students receiving weekly self-esteem boosters received lower grades on their final exam. In fact, grades were even lower than those they received on their midterms.

• Says social psychologist Roy Baumeister, “It’s possible to learn how to feel better about doing worse.” (Baumeister & Tierney, 2011)
Life Experiences – In Context: Mastery to Meaning Connection

• A sense of mastery requires an ability to see mistakes/setbacks as learning experiences

• Mistake jar; Struggle jar – Who had a great struggle today? (Carol Dweck, Ph.D)

• “Oh, Well” - Teaching, practicing, celebrating replacement behaviors

• “What does it mean to be smart?” Valuing effort – as opposed to praising intelligence (Carol Dweck, Ph.D.)
Life Experiences – In Context: Mastery to Meaning Connection

- Teacher coaches the child/youth before class about questions that will be asked during class. The child/youth gets to answer them correctly in front of other students.

- A couple of times a week, the parents/caregivers get a “great news” postcard/e-mail/text letting them know about their child’s accomplishments/successes.

- Parents/caregivers send postcard/e-mail/text to teachers thanking them for all they’re doing to help their child.
Life Experiences – In Context: Mastery to Meaning Connection

• Self Monitoring Strategies

• Peer organizer/coach meets for a few minutes before and after school - before school goes over “to-do” list, helps organize; after school checks to see if homework was turned in, assignments written down and right books coming home
Life Experiences – In Context: Mastery to Meaning Connection

• **Structure, brevity, variety** (Clare Jones, 2004; 2000)
  
  – *Structure* = consistent routine, specific daily schedules - visual, reviewed (changing appearance to keep interest), well defined transitions (with extra cues when necessary)

  – *Brevity* = brief activities - breaking long multi-step tasks into smaller solvable chunks (modifying seatwork, long term projects, etc)

  – *Variety* = introducing novelty into activities, combating problems resulting from repetition, boredom, stimulation seeking behavior
Life Experiences – In Context: Mastery to Meaning Connection

• Replenishing our Executive Function Fuel Tank

• Self-Regularity Strength is a Limited Resource Pool
  – the more you tax emotional self-regulation/self-control the more you deplete the resource; why after a day of school or work, person can feel depleted.
  – Need to replenish this fuel tank.

• What works
Fostering a Sense of Mastery:
Improving Emotional Self-Regulation

• Before school and after school aerobic exercise opportunities

• Aerobic exercise – studies show that it improves attention, self-control, among other areas.

• “A bout of exercise is like taking a little bit of Prozac and a little bit of Ritalin.”

        John Ratey, M.D.
Mastery to Meaning Connection

• Raising the bar and leveling the playing field

• Helpful technologies to level the playing field
  – Pulse Smartpen  www.livescribe.com
  – Audio Note
  – Google Read and Write
  – Dragon Naturally Speaking
  – Virtual Reading Coach  www.mindplay.com
  – Watchminder  www.watchminder.com
  – Audiobooks  www.rfbd.org  www.learningally.org
Mastery to Meaning Connection: Programs and Practices (short list)

• PAX Good Behavior Game
  www.goodbehaviorgame.org

• BOKS – Building Our Kids Success
  www.bokskids.org

• Irvine Paraprofessional Program (IPP)
  www.learningdevelopmentsservices.com (click What’s New – see promising practices articles)
“Safety nets - For children/youth at risk for serious emotional, behavioral, learning and later life adjustment problems, can simply going to school each day actually protect them from these negative outcomes years down the road?

– Schools can be protective
– After school time can be protective
– Neighborhoods can be protective
Relationships – In Context

• Connecting to those who legitimize rather than stigmatize

• Hope is contagious - Naomi Tannen

• Translating the pain of our past into meaningful action on behalf of others
Translating the Pain of Our Past Into Meaningful Action on Behalf of Others

• After overcoming the stigma associated with their own differences, a growing number of young people are stepping forward to help others learn to do the same.

  – High school students who started a club on campus to stamp out stigma

  – Young adults who spent years in foster care mentoring children currently experiencing feelings similar to those they experienced years ago

  – Older students with learning and other challenges mentoring younger students with similar challenges
Relationships - in Context

• Ongoing project exploring how young people are translating the pain of their past into meaningful action on behalf of others

(see website – ongoing projects or e-mail markkatzphd@gmail.com)
Relationships – In Context: Preventing/Reducing “Compassion Fatigue”

- Exhaustion – emotional, physical or both
- Signs, symptoms known to vary from person to person
  - Feeling a sense of futility or a sense of hopelessness that better days lie ahead
  - Questioning our abilities or even our worth
  - Losing patience and our ability to control our emotions
Relationships – In Context: Preventing/Reducing “Compassion Fatigue

Remembering our ABC’s*

• A = Awareness
• B = Balance
• C = Connections

How to work in the field of mental health without losing our mental health
Relationships – In Context:  
A Closer Look at Turning Points

• Individuals, who as children and teenagers succumbed to adversity, but who, in adulthood, are doing well:

• Life experiences they cited as important turning points (Werner and Smith, 2001):
  – Marriage or entry into a long term committed relationship
  – The birth of a first child
  – Establishing themselves in a career or a job
Relationships – In Context:
A Closer Look at Turning Points

- Life experiences they cited as important turning points: continued
  - Obtaining further education, such as through a community college
  - Joining the armed forces as a way to gain educational or vocational skills
  - Becoming active in a church or religious community
Two Questions:

– Can you think of turning points in your life where your life began to change for the better?

– When you think of your turning points, are there any people who come to mind, people who you feel a debt of gratitude to for these turning points?
Our greatest source of strength = each other.
Children Who Fail at School But Succeed a Life

• We are more resilient than we realize

• There are limits to emotional endurance even for the most resilient among us, school-age children included

• You and I have more influence than we realize in determining who endures and who succumbs
• The meaning we attach to the adversities of others can influence the meaning they attach to these same adversities.

• And the meaning they attach to adversity and life’s challenges can determine whether they see themselves as resilient and courageous or as helpless and hopeless. This is especially true during their younger years.

• It takes a lot of strength and courage to learn to see life’s adversities in a new light. But for even the most resilient among us, it may not always be possible when too many others can only see them in a very old light.
Multiple childhood risk exposure seems in many instances to translate into paradoxically uneven learning and behavioral profiles.

Paradoxically uneven learning and behavioral profiles can, in turn, translate into entirely understandable yet erroneous perceptions on the part of loving parents, caring teachers, and expert healthcare professionals.

Entirely understandable yet erroneous perceptions can translate into equally understandable interventions that can unfortunately lead to disappointing results.
Children Who Fail at School But Succeed a Life

• If we replace a few erroneous perceptions regarding commonly observed uneven learning and behavioral profiles with new, empirically validated ones, it can potentially allow access to protective processes that can over-ride the effects of exposure to multiple childhood risks and adversities.

– An important and overlooked first step in changing the odds for struggling school-age children. And this includes children at risk for a range of later life problems.

• New meaning new mastery; new mastery new meaning
Children Who Fail at School But Succeed a Life

• “There anything so wrong with us that what’s right with us can’t fix.”

– Those who rise above adverse childhood experiences are living proof that our strengths are more than capable of over-riding whatever lifelong weaknesses we might be struggling with. It all depends on what we choose to focus on.
Children Who Fail at School But Succeed at Life

• We are very context sensitive beings, say neuroscientists.
  – We act, think, and feel one way in situations that frighten us, another way in situations that welcome us.
  – And rather than seeing this as a weakness or liability or character flaw, neuroscientists see it as one of our greatest strengths.
We see our context sensitive strengths at work among those enjoying lives well-lived, despite previous years of school failure.

- We see context sensitive strengths at work socially (externally), emotionally, psychologically, spiritually (internally), and relationally.
Children Who Fail at School But Succeed a Life

• While our differences can render us at a serious disadvantage at one stage of our life, they may provide us at an advantage at another stage.

• Life outcome can be very different than tx outcome
Children Who Fail at School But Succeed a Life

• To feel we belong and have something important to contribute is a universal need.

  – For some, it’s a need that went largely unfulfilled until their adult years.

  – Today, we’re much more aware of how to fulfill this universal need during our school-age years.

  – There’s reason to believe that doing so can prevent a range of potentially serious school-related and later life problems.

  – Meaningful roles and responsibilities, more labels, not less
Children Who Fail at School But Succeed a Life

• There are many different ways of being smart, some of which can’t be measured by how well one does in school.

• Knowing this and truly believing this can avoid personally humiliating experiences at school as well as in life.
Children Who Fail at School But Succeed a Life

- No matter how smart one might be in whatever areas, it does not make them wise.

- To be wise is to know how to use our strengths and our successful life experiences to serve not only our own personal needs but the needs of others as well.
A number of those who overcame difficult childhood experiences have learned to transform the pain of their past into meaningful action on behalf of others.

We’re now learning how to help struggling school-age children eventually learn to do the same.
Children Who Fail at School But Succeed a Life

• For a number of those who overcame a difficult past, their emotional self-regulation and self-control skills improved over time.

• Today, we have specific tools to help improve these same skills in young school-age children. And research suggests that improving these skills can potentially prevent wide ranging health, mental health, and life adjustment problems years down the road.

• Some experts in the field would actually consider this the short list.
Children Who Fail at School But Succeed a Life

• People can grow quite adept at raising their personal expectations while simultaneously leveling their personal playing field.

• And the creative ways they learn to use tools, technologies, strategies, and available resources to navigate around learning, behavioral, and other challenges serves a testament to their resilient spirit.

• Transactive memory
Children Who Fail at School But Succeed at Life

• Resilience and context are inseparable

• In an environment that we perceive as threatening and dangerous, it makes no sense, from a survival point of view, to appear conspicuously vulnerable

• Some of the most resilient people we will ever have the pleasure of knowing have to work very hard just to get through a normal day, school-age children included
Children Who Fail at School But Succeed a Life

- We know now that children who succumb to adversity can, in time, rise above a difficult past and eventually go on to lead meaningful and productive lives.

- What’s more, we now know this to be the case for children who succumb to a range of different adverse childhood experiences, beyond those leading to school failure.

- Regardless of the nature or degree of adversity, in the final analysis, our greatest source of strength may be each other.
Children Who Fail at School But Succeed at Life

Are there things that count that can’t be counted?

And do the things we count, count?
Final Thoughts

• It’s impossible to predict with absolute certainty any one person’s life course.

• It’s among the mysteries in life that makes one a believer in turning point experiences, in second, third, and fourth chance opportunities, and in knowing that lives can change for the better at any point in time, sometimes in response to completely unanticipated and unpredictable events.

• Which, in a way, is another way of saying that when it comes to overcoming life’s adversities, there are things that count that can’t be counted. And not everything we count, counts.
FROM ADVERSITY TO RESILIENCE: BEING A TRAUMA INFORMED SYSTEM

Kimberly Giardina, Deputy Director
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May 17, 2017
Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach, July 2014
CHARACTERISTICS

System

• A balance between competence and kindness across policies, practice, language, environment, and inclusion of client partners

Services

• Services are collaborative, integrated and person-centered.

Workforce

• The workforce leadership and all levels of staff recognizes the need for wellness (e.g., self-care strategies infused in professional and personal activities goals and outcomes).
2010: Begin Training staff in Signs of Safety Practice model and Participation in National Child Traumatic Stress Network Trauma-Informed Practice Breakthrough Collaborative begins

2012-current: Development, Training, and Implementation of Safety Enhanced Together Practice Framework

2016-current: Safety-Organized Practice model is implemented in Policy

2011-2012: Resources begin to be created for parents and caregivers including a brochure around understanding child trauma and “All About Me” forms for parents to provide key information about their children to caregivers to try to reduce trauma when removed

2014-current: San Diego joins the California Well-Being Demonstration Project (Title IV-E Waiver)

2015: San Diego implements Pathways to Well-Being
SAFETY ENHANCED TOGETHER: VISION

Every child grows up safe and nurtured.
<table>
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<th>PRIORITY</th>
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<th>STATISTICS</th>
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| 1.       | Safely stabilize and preserve families; and if that is not possible... | • About **82%** of all referrals do not require intervention.  
• Nearly **43%** of the cases opened each year are voluntary cases and the children are not removed from the home. **60%** of these voluntary cases successfully stabilize and preserve the family. |
| 2.       | Safely care for children and **reunify children to their families of origin**; and if reunification is not possible... | • Over **55%** of children removed reunify with their family. |
| 3.       | Safely support the development of **permanency and lifelong relationships** for children and youth. | • Over **78%** of children removed **find permanency** either with their family of origin or a new family. |

Data as of June 2016
## SAFETY ENHANCED TOGETHER: CORE VALUES

| Relationships with children, youth, and families are the foundation | Shared responsibility with community partners |
| Collaborative partnerships with kinship and resource families | A strong working relationship with the legal system |
| Helping children and youth achieve their full potential and develop lifelong relationships | A workplace culture characterized by reflection, appreciation and ongoing learning |
HHSA’S JOURNEY TO BECOMING A TRAUMA INFORMED SYSTEM

2010: Futuring Session for Living Safely component of Live Well San Diego

2011: CWS begins TI initiative to improve services for children and families served

2012: BHS conducts assessment of TI competencies among Agency staff and contractors

2014: Agency commits to becoming a TI system in order to build a better service delivery system

2015: Agency policy signed; Programs conducts initial scan towards becoming a TI system

TI = Trauma Informed
TRAUMA INFORMED SYSTEM PRINCIPLES

- Understanding trauma and its impact to individuals, staff and the community
- Promoting safety
- Ensuring cultural competence and responsiveness
- Supporting consumer control, choice and independence
- Sharing power and governance such as including staff and clients in the review and creation of policies and procedures
- Integrating services along the continuum of care
- Believing that establishing safe, authentic and positive relationships can be healing
- Understanding that recovery is possible for everyone
Minimizes risk of re-traumatizing individuals and/or families

Services are characterized by being:

- Recovery/Resiliency oriented
- Integrated, and
- Ecologically sound
PROCEDURES

- Each region and division will develop and implement an annual action plan applicable to their respective programs and services that support the HHSA trauma informed systems approach. To every extent possible, actions shall be integrated with

  - Live Well San Diego
  - HEART Customer Service Initiative
  - Diversity and Inclusion
  - County Strategic Plan
Each region and division shall:

- Conduct and/or review annual scan to identify targets or goals which are achievable within a fiscal year toward becoming and remaining a trauma informed system.
- Identify priority objectives for implementation in the fiscal year.
- Develop an action plan to achieve the identified objectives. Implement the action plan and monitor progress of objectives.
- Report progress of objectives to the Agency Director annually via the region/division’s assigned CAO Staff Officer, specifically, fulfillment and maintenance of this policy.
LIVE WELL SAN DIEGO

Trauma Informed

HEART

Live Well Communities

Diversity & Inclusion
TISI TEAM

- **Purpose** - The Team reviews and approves tools and materials to support implementation of department Trauma Informed Action Plans.

- **Members** - Each department has a representative on the TISI Team.

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Trauma Informed System Integration: Building a Better Service Delivery System Improving the Culture Within
EXAMPLES OF HHSA TRAUMA INFORMED PRACTICES

POLICY
• Developed Safety Enhanced Together (SET) practice framework to strengthen families

PRACTICE
• Integrated Trauma Informed Principles with Customer Services initiative HEART and HR threat assessment trainings and practice

LANGUAGE
• Included expectation that BHS contractors apply trauma lenses to all facets of their services

CLIENT/STAFF ENGAGEMENT
• Obtain community feedback for Cultural Broker (a trauma informed program to reduce the number of African American children who are over-represented in CWS)

ENVIRONMENT
• Conducted assessment of new/existing facilities to promote a sense of well-being
FOR CHILDREN AND FAMILIES
- Safety-Organized Practice
- All About Me Form
- Pathways to Well-Being
- Child and Family Teams
- Trauma informed foster parent training
- Caring for Babies
- Family Visit Coaching
- Permanent Connections
- CSEC Survivor Advocates

FOR STAFF
- Trauma Informed Training for Staff
- Employee Assistance Program – getting creative
- Group supervision
- Social Worker Safety
QUESTIONS/COMMENTS

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