Understanding Mental Health in the Juvenile Justice System: Assessment, Understanding, and Intervention

Michael Wolff, PsyD, ABPdN

Goals

- The workshop will review several key risk factors confronting juveniles involved in the legal system.
- Prevalence rates of abuse, traumatic brain injury, and other life attributes influencing brain health.
- Better understand of the brain and how targeted assessment can be used to better understand how these challenges
- Recognizing the areas of vulnerability
  - anticipating the patterns of behavior
  - differential reaction vs intent,
  - and to target interventions that can hopefully address long term outcomes.
- Mutlistystemic influences contribute to behavioral vulnerability – What can be done?

Statistics

- 1.3 million cases were processed in juvenile courts in 2010
  - 25% persons offenses
  - 37% property offenses
  - 12% drug offenses
  - 26% various public order offenses
- In 2012 - 910,000 arrests of youth under 18
- 80% of cases are initiated by referral from law enforcement
- 20% of cases have pretrial detention stay

National Center for Juvenile Justice's Court Statistics 2010

Youth Involved per 1000

- 87.6 African American
- 36.4 White youth
- 36.6 American Native American
- 11.6 Asian
- Hispanic cases were not reported in study

- 66% of males and 74% of females met the diagnostic criteria for a mental health disorder

Journal of Correctional Health Care 2015, Vol. 21(1) 35-44

- In 85% of cases where there was a mental health referral, the mental health referral preceded the first arrest
  - In only 15% of cases did the first DJJ referral occur before the first mental health referral.

Journal of Emotional and Behavioral Disorders 2014, Vol. 22(1) 3–15

- 44 % of youth were concurrently receiving community mental health services

Child Adolesc Soc Work J (2014) 31:369–392

Roughly – 22-30% of juveniles may not be receiving Mental Health Services but be in need prior to offense

Learning Disabilities

- Adolescents with learning disabilities two to three times greater risk of being involved in offending activities
  - Adolescents with learning disabilities were found to be at an increased risk of being arrested while in school, as well as within one year after they finished school

Child Adolesc Soc Work J (2014) 31:369–392

- This pathway, often called the school-to prison pipeline, may be funneling adolescents with learning disabilities disproportionately to the system

(Federal Advisory Committee on Juvenile Justice 2010)

Traumatic Brain Injury

- Studies vary – I have read anywhere between 30-85% of youth involve have experienced a TBI
  - A recent study: Eight-two percent of those interviewed reported experiencing at least 1 TBI

    The Journal Of Head Trauma Rehabilitation, 30(2), 106-115
  - As compared to 30% in a meta-analysis reviewing 9 other studies between the US and UK

    Child Neuropsychology (2013), 19 (3), 225-234

Abuse

- Victims of physical, sexual, psychological abuse or neglect. In fact, when identifying such histories, between 26 and 60 % of formally juvenile court-involved adolescents have been found with these maltreatment histories

  Child Adolesc Soc Work J (2014) 31:369–392
- Youth who had been in CPS were approximately 50% more likely than those who had not been in CPS to commit a second crime.

  Journal of Emotional and Behavioral Disorders 2014, Vol. 22(1) 3–15
- Rates of PTSD in juvenile justice-involved youth are estimated between 3%-50%

  2010, National Council of Juvenile and Family Court Judges

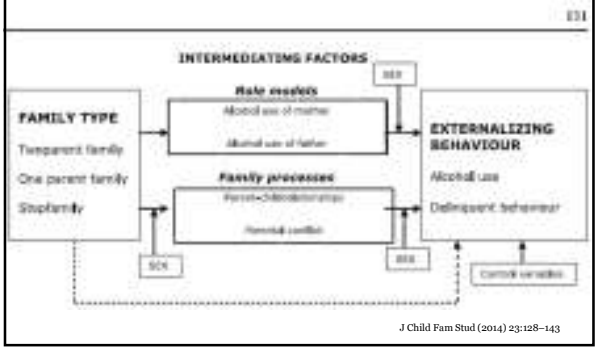
- Males are at more risk when in a single parent family.
- Females are at high risk in stepparent families where sexual abuse risk is elevated.

Family Risk

The following factors increase risk for offending and antisocial behavior:

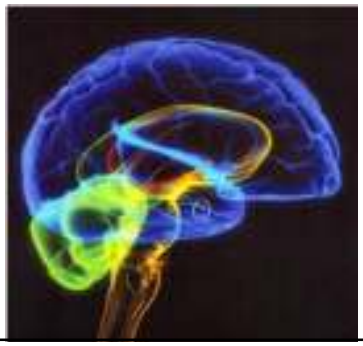
- Large number of children
- Poverty
- Younger and more Poorly Educated parents
- Divorce, remarriage, substance using parents
- Families with poor communication, supervision, disciplinary practices, and cohesion

Conceptual Model: Risk



J Child Fam Stud (2014) 23:128–143

The Dynamic Brain



Brain Development

- The Beginning of Brain Development Starts Before the Beginning!
  - During Pregnancy

    Nutrition
    - Poor prenatal nutrition can reduce brain and central nervous system growth.

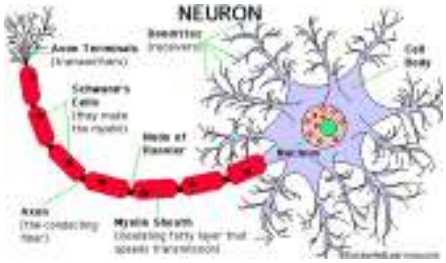
    Alcohol/Drug Exposure
    - Alcohol and Drug exposure can also lead to permanent changes/damage

    Stress Levels
    - In the 2nd and 3rd trimester, the brain will be more apt to learn aggression or hostile language when there is abuse/neglect experienced by the mom

    Parent Illness
    - Central nervous system health, medical vulnerabilities

Beginning the Process: Brain Development – Some Facts

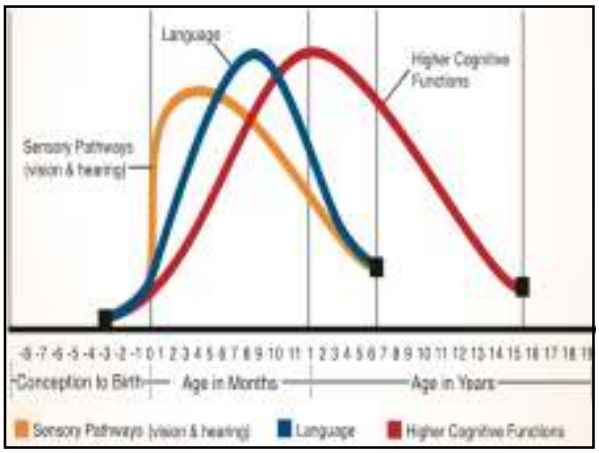
- Brain cell formation (neurons) is nearly complete before birth
  - But brain maturation will continue through young adulthood creating and specializing synaptic connections



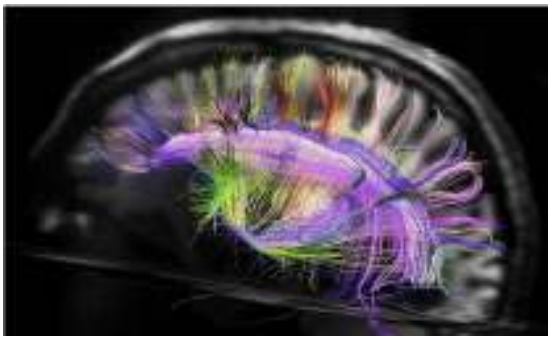
Neuronal tube development

- There may be as many as 100 billion neurons
- During the 1st month of life, these neurons may make 50 trillion to 1 quadrillion connections a single cell may connect with 15,000 other cells
- Average adult brain weighs 3-pounds
- If an infant's body grew at a comparable rate to the brain's growth, its weight would increase from 8.5 pounds at birth to 170 pounds at one month old.

http://www.neurology.org/content/vol66/issue3/images/data/339/DC1/Video.mov



Orderliness of Axonal Connections



Brain Maturation: Adolescence

- Frontal Lobe white matter
  - Peaks at 12 yrs for frontal and parietal lobes
  - Peaks at 16 yrs for temporal lobe
    - Last systems to develop are first to degenerate in disorders such as Alzheimer's
- Deep gray matter nuclei (esp. caudate)
  - Lose volume in puberty
- Basal Ganglia, temporal lobe structures (amygdale and hippocampus)
  - Increases in volume through childhood and adolescence

Neuroplasticity

- Dendritic spines seem to determine the synapse numbers. And, it is suggested that up to 70% of the brain's synapses on these spines change every day (Dr. Fred Travis, 2009)

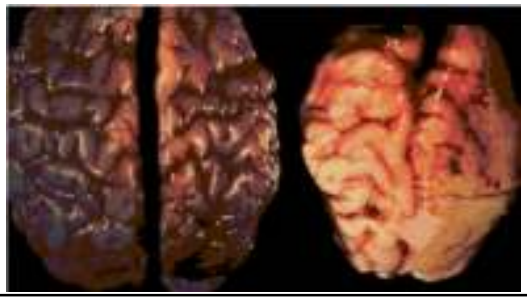
Brain Development
Non-optimal Circumstances

But what happens with abuse or trauma?

- The brain changes in response to these conditions
  - Tissue can die
  - The brain can fail to develop the density or number of connections typically seen
  - There can be damage or injury to the tissue
- Regardless of cause, the brain is able to learn and adapt through compensatory stress mechanisms
  - These adaptations may become maladaptive

Brain of baby with no exposure to alcohol

Brain of baby with heavy prenatal exposure to alcohol



Non-Optimal Prenatal Conditions

- Poor prenatal nutrition
  - Can reduce brain and central nervous system growth
  - As important as avoiding alcohol and drugs. Yet, both are leading causes of Cognitive Impairment
- Prenatal exposure to violent language:
  - The brain starts learning before birth
  - In the 2nd and 3rd trimester, there is new research to suggest that the brain will be more apt to learn aggression or hostile language when there is abuse/neglect experienced by the mom. These have been referred to as Vowel Magnets

What this Pre and Immediately Postnatal Understanding Means

- It is important for budding parents to think about the tone, type, and cadence of speech while engaging the fetus – even before it is a newborn
- Even though it does not seem like it, listening to music, reading, singing, talking to the neonate, etc. can be very beneficial for brain development

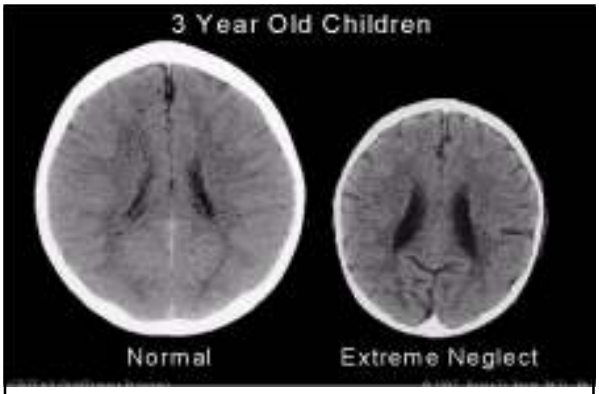
What about too much TV?

- Having infants/toddlers watch television can result in:
  - A 10 percent increase in likelihood of being picked on by classmates
  - A 13 percent decrease in physical activity on weekends
  - A 9 percent increase in soft drink consumption
  - A 5 percent increase in body mass index (a ratio of a person's height and weight that is considered to be an indicator of body fat percentage).
  - (recommended children under 2-yrs old watch no television and over age 2- no more than 2-hrs a day)

Understandable Terms: Avoid This

Child Abuse and Neglect Statistics

- 58% of children age 0-3 have serious physical health problems
- 51% through age 5 at-risk on developmental screenings
- 27% under 2 ½ years old at least 2 standard deviations below age expectation on Bayley Scales
- 23% deficient in sensory integration functioning



Example or developmental disorder affecting social/emotional and general cognitive development with severe neglect sensory deprivation:
Images reproduced from Bruce Perry, M.D., Ph.D. Baylor College of Medicine.

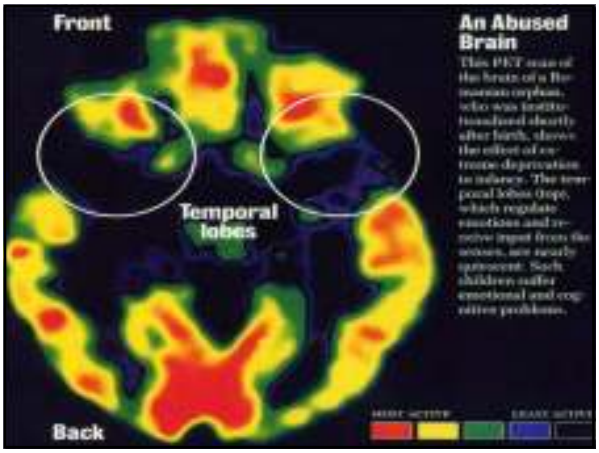
Developmental Overpruning

- Toxic effect of overwhelming stress on the young brain.
  - Can lead to excessive cell death which can deteriorate the neocortical limbic connections in particular

Effects of Abuse and Neglect

Abuse
- Exposure to swearing in-utero, more predisposed later
- Violence from parents (modeling, witnessing traumatic, + genetic predisposition for anger management issues if a parent has anger problem)
- Increased adrenaline levels when scared

Neglect (attachment issues/RAD/ODD/Conduct Disorder/Sensory integration)
- Lack of stimulation, sensory atrophy, predictability
- Nutritional deficiencies
- Over 500,000 children per year suffer "neglect"
- A host of neurochemical and neuroarchitectural abnormalities noted
- Height and weight 30-40th percentile but head circumference at 10th percentile
- 11.5% of those with chaotic neglect and 64.7% of those with global neglect had enlarged ventricles or cortical atrophy on CT/MRI scans

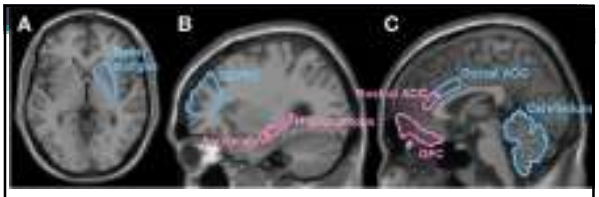


Pediatric and toddler injuries

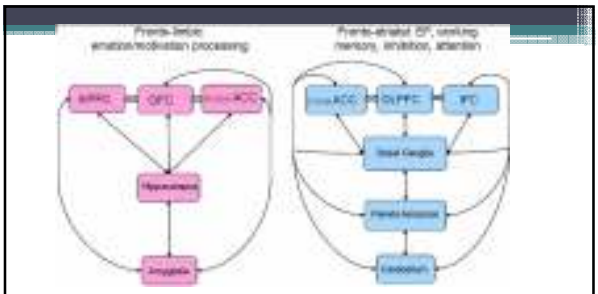
- In children aged <2 years, physical abuse is the most common cause of serious head injury.
  - Shaken baby syndrome (SBS) is characterized by retinal hemorrhage, subdural or subarachnoid hemorrhage, and little evidence of external trauma.
- In children aged 3 years and older, falls and motor vehicle, bicycle, and pedestrian accidents are responsible for most traumatic brain injuries.
  - Remember – with TBI there is often frontal involvement and can be temperament and personality change

- "the impact of child…abuse is highly variable. Some children show no detectable negative effects; others show highly adverse reactions with severe psychiatric symptomatology"
  Saywitz, p1040
  - Abused children exhibit *more* symptoms than non-abused children
  - No one symptom characterizes the majority of abused children, and there is no evidence of one cohesive syndrome resulting from abuse
  - The experience of the abuse itself makes an independent contribution to the later symptoms, along with the child's vulnerability and resilience

- Abnormalities occurred predominantly in the left side of the frontal, temporal, or anterior regions for physically and/or sexually abuse subjects..
- Children who had been psychologically abused or neglected but not physically or sexually abused were found to have abnormalities in the left side of the temporal region only.
- Increased dependence on the right frontal lobes may, in turn, lead to increased perception and expression of negative emotion and may facilitate unconscious storage of painful childhood memories
- Effects of abuse are pervasive and long-lasting
- Not limited to the neighborhoods, clinics, or areas where you would 'expect' to see it



- Anatomical brain regions implicated in maltreated subjects based on structural and functional imaging studies, overlaid on a high resolution structural MRI image. Regions highlighted in pink correspond to fronto-limbic areas involved in emotion and motivation processing and regions highlighted in blue to fronto-striatal brain regions involved in executive functions, working memory, inhibition and attention. Panel (A) shows an axial view containing the basal ganglia and panels **(B,C)** are sagittal views highlighting the hippocampus, amygdala and DLPFC and ACC, OFC, and cerebellum, respectively.

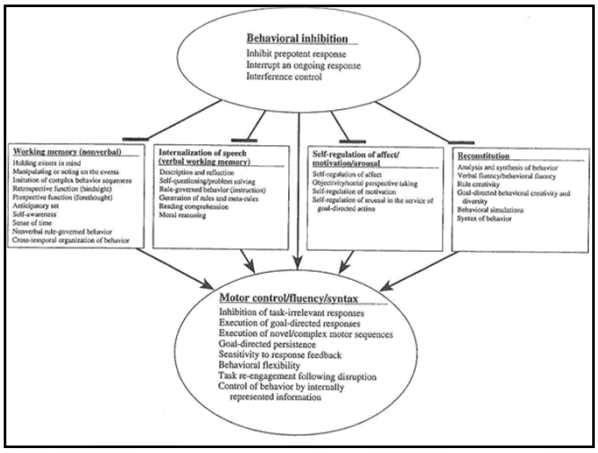


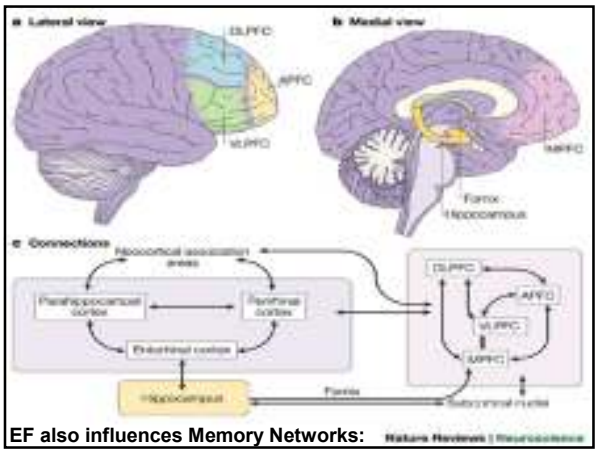
- Deficits of fronto-limbic regions and networks have most consistently been associated with childhood abuse. However, there is some evidence from more recent studies, including whole brain imaging analyses, for deficits in fronto-striatal and fronto-cerebellar networks.

Hart, H. & Rubia, K. (2012) Neuroimaging of child abuse: a critical review. Frontiers in Human Neuroscience, 6, 1-24.

Prefrontal Cortex

- Inhibitory behaviors and integration speech/motor activity with sensory input (EF)
  - Attention, working memory
- Exposure to stress → enhanced dopamine turnover (dysregulation) → paranoia and hypervigiliance
- Catecholaminergic system: key in stress adaptation
  - Elevated plasma cortisol levels, reduced NK cell activity, increased norepinephrine and glucocorticoid levels
- Executive functioning Deficits





EF also influences Memory Networks: Nature Reviews | Neuroscience

Amygdala

- Provides emotional importance to stimuli
  - Perceives fear, sets off cascade that leads to hyperarousal
  - Important in formation of emotional memory
- High levels of emotional arousal → aroused amygdala → autonomic and behavioral reaction to stress
- "State-dependent memories may result in trauma-induced neurotransmitters, amygdala activation, and the development of abnormal neural pathways" (Weber, 119)

Corpus Callosum

- Stress can impact hemispheric integration
  - Not communicating can become a protection mechanism against becoming overwhelmed
  - Preserving linguistic consciousness
- EEG abnormalities show greater left-sided dysfunction may be associated with abuse
  - Enhanced perception of and reaction to negative affect
  - 'Preferential' storage of negative or traumatic memories

Hippocampus

- Memory function, spatial learning, behavior inhibition
  - Implicated in anxiety and panic disorders
  - Known to decrease in volume with abuse
- May become overactive with abuse
  - "When repetitively stressed and highly emotionally aroused, [it] appears to become so aroused that it is essentially deactivated" (Joseph, p528)
- Stress → damage to hippocampal neurons →deficits in memory

Emotional Trauma and Brain Function

- Inescapable stress produces a variety of behaviors in animals including
  - Abnormal alarm states and altered sleep patterns
  - Aggression and sensitivity to stress
  - Deficits in learning and memory
  - Withdrawal.
- Memory and learning challenges can be pervasive weaknesses following chronic childhood stress
- Chronic emotional stress changes chemical performance and structural areas of the brain

Body and Mood Connection

- Lowered immune system response
- Increased risk of:
  - Alcohol and/or drug use
  - Cancer and ulcers
  - Body weight changes
  - Peripheral nervous system disorders, etc.
- Suicide
- Higher rates of psychopathology

Emotional Trauma and the Brain

- Smaller, more reactive amygdala
- Reduction in grey matter and brain volume negatively correlated with abuse
- Reactivity or lesions in the septum pallucidum
- Hippocampus is very sensitive to stress
- Hypothalamic-pituitary-adrenal axis dysregulation
  - Pituitary often becomes hypo-responsive
  - Adrenal glands often become over-activated

Infant and Toddler Effects

- Cognitive:
  - Mental retardation
  - Speech and language delays
  - Lack of curiosity
- Social/Emotional:
  - Inappropriate attachment
  - Immature play
  - Inappropriate reactions to social interaction
- Physical:
  - Growth retardation
  - Brain damage, sensory loss, brain stem compression
  - Epilepsy, cerebral palsy, coma, paralysis
  - Poor muscle tone, motor control
  - Delays in gross and fine motor coordination

Preschool and School Age

- Cognitive:
  - Delayed speech, poor articulation, pronunciation, and/or grammar
  - Cognitively delayed
  - Short attention span, unable to concentrate, no interest in objects
- Physical:
  - Small in stature
  - Sickly, frequently ill
  - Poor muscle tone, coordination, fine and gross motor skills
- Social/Emotional:
  - Inappropriate attachment and reaction to others
  - Social immaturity
  - Detached, isolated, withdrawn
  - Poor self-esteem, confidence
  - Flat affect, passive
  - Suspicious of adults
  - "Parenting" role
  - Over-seeking approval
  - Impulsive, outbursts
  - Lack initiative, give up easily

Adolescents

- Physical:
  - Sickly, chronically ill
  - Sensory, motor and perceptual delays
  - Delayed puberty
- Cognitive:
  - No operational thinking, immature logic or hypothetical thinking,
  - Academic challenges
- Social/Emotional:
  - Mistrust of adults
  - Avoid relationships
  - Anxiety, depression, withdrawal, aggression
  - Inability to regulate emotions
  - Poor self-image
  - No future plans, faith in the future
  - Limited concern for others

Effects of Abuse

- Physical and/or sexual abuse in children
  - Predominantly produces abnormalities in left side of frontal, temporal, or anterior regions
- Psychologically abused/neglected children
  - Not physical or sexually abused
  - Abnormalities in the left side of the temporal region only
- Increased dependence on the right frontal lobes may, in turn, lead to increased perception and expression of negative emotion and may facilitate unconscious storage of painful childhood memories

The Limbic System

- Stimulates emotions vital for self-preservation and survival
- Late maturing, Impacts behavior, memory, emotional states, and learning
- Includes the hippocampus, cerebral cortex, and amygdala
- Arousal mechanisms of SNS, endogenous opioid system, and HPA Track show abnormalities with trams

Cortisol

- Product of the stress-response system
  - Released by hypothalamus, pituitary, and adrenal glands
- Linked to thymus shrinkage, cell death, hippocampal atrophy, weaker immune system
- Serves to manage out-of-control stress-response before worse damage occurs

Stress-response Systems

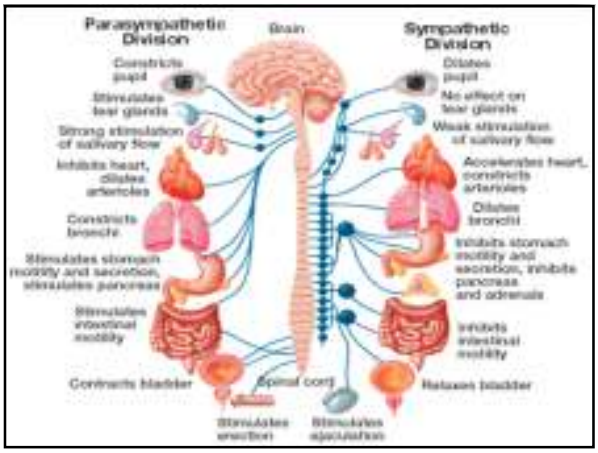
- Often produce anxiety, hyperactivity, impulsivity, hypertension, dysphonia, sleep problems, tachycardia
  - Not all, some, some of the time
- Basal homeostatic level for abused children is not 'normal', they may demonstrate exaggerated reactivity due to constant anxiety
- Higher levels of catecholamine, norepinephrine, and dopamine levels found in abused children

Sympathetic Nervous System

- Helps the body cope with external stimuli and functions during stress (triggers the flight or fight response)
  - Vasoconstriction – increase in blood pressure
  - Increased heart rate
  - Increased respiratory rate
  - Cold, sweaty palms
  - Pupil dilation

Parasympathetic Nervous System

- Works to save energy, aids in digestion, and supports restorative, resting body functions.
  - Decrease in heart rate
  - Increased gastro intestinal tract tone and peristalsis
  - Urinary sphincter relaxation
  - Vasodilation – decrease in blood pressure



So – What Should We Do

Clinical Neuropsychology

- A subdiscipline of psychology specializing in assessment and treatment of brain injury or neurocognitive deficits.
  - What distinguishes a clinical neuropsychologist is an extensive knowledge of the brain, including an understanding of areas such as: neuroanatomy, neurobiology, pharmacology, neurodevelopmental disorders, illness, and injury.

Neuropsychological Evaluation

- This is the testing process and report focused on understanding brain-related cognitive, learning, behavioral and emotional disorders that emphasizes functioning - documenting and making recommendations to moderate areas of concern.

Areas Possible to Assess

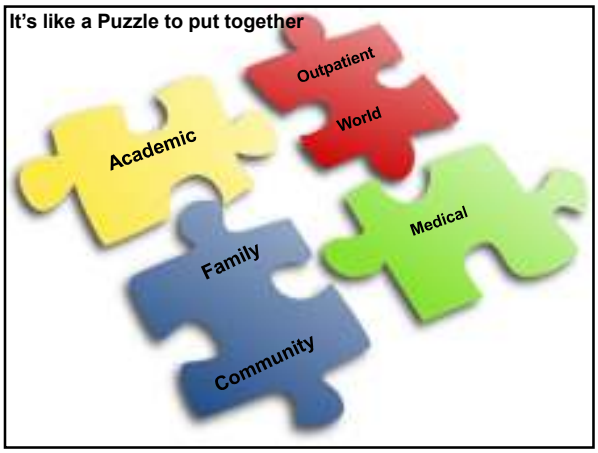
- Intelligence
- Attention
- Memory
- Language
- Sensory perceptual and motor functions
- Auditory and visual processing
- Academic skills
- Behavior, emotions, and personality
- Executive skills
  - Concept formation and problem solving
  - Planning and organization
  - Speed of Processing
  - Cognitive Flexibility
  - Ability to Self-Correct
  - Follow Through
  - Coping with Change

And, what do neuropsychologists do again?

- We endeavor to help –
  - We try to understand how the brain is functioning in light of the knowledge we can "drudge up"
  - Try to understand how this brain functioning might be contributing to behavior and emotional risk
  - Putting this together, we can then make recommendations
- What we need, so we can put it together:
  - History
  - Records
  - Interviews
  - Observations
  - Test Data
  - Social Context – family, gang involvement
  - Academic Context
  - Legal Factors

And, we prefer a clear question

- We typically want to know – what we are being asked to answer.
  - The more specific the question, the more accurately we can focus our battery to answer
    - Does the client have the ability to make decisions?
    - Is there a learning disability?
    - What are the influences of a brain injury?
    - Does the individual seem to be responding to attention medication?
  - But most of the time we get, "What is going on and what do we do?"



- It is not always easy to understand or explain
  - For example – there are 100's of things that can cause an attention or behavioral problem, ADHD or Oppositional Defiant Disorder are only two options. But, headaches, poor nutrition, loneliness, learning disabilities, head injury, depression, anxiety, physical pain, working with a frustrating co-worker every day, etc. may also be causes.
- Mislabel the pieces =
  - Misinformed treatment
  - Poly-pharmacological approach without direct impact and potentially worsening matters
  - Ineffective Therapy approaches
  - The family and systems give up – incarceration or longer placement times

Role of the Professional

Can anything be done?

- We hope so – most of our jobs rely on it.
  - If you work for the court or residential – you might keep your jobs, because we will have to put these individuals some place.
  - But in reality, the answer is Yes – we can do a lot and nothing should be taking for granted. All of us play a role. Degree's do not matter as long as we are trying to work together Cohesively and toward common goals. Opinions need to be respected, adjustments made, and we need to challenge ourselves as much as we challenge those we work with to "get better."

The Michigan Pothole Analogy

- We navigate the complex roads to reach our desired location(s) any given day. Everything can be moving along smoothly, but hitting one pothole can change your heart rate, mood, and possibly cause serious damage, even though "it was just a pothole."
- This is similar to an injury or developmental problem in the brain, sometimes even minor changes can result in significant impairment, but sometimes major issues are not as severe.
- This would be similar to listening to the radio for the traffic report; if you are aware there is an accident backing things up, you have the option to choose a new path. In the meantime and without your awareness, others are working to manage the accident, so that it can hopefully be correct by the time you need to return home.
- This is very similar to how the brain functions when it is dealing with the world

Assessment

- Interventions are based on understanding the child's abilities
  - Important to understand factors that are maintaining the child's behaviors
  - Childhood experiences alter how the brain functions
  - Behaviors can be reaction to early experiences, not rational
- Create a hypothesis for symptom etiology
  - Visceral response to childhood trauma
  - Cognitive or developmental challenges
  - Cultural and social motivators
  - Basic needs not met – e.g. nutrition, safety, etc.

- Developmental neural plasticity in the process of the central nervous system making changes over time-depending upon the types of pressures the individual might confront.
- A more scientific definition is: "Neural plasticity is the ability of the CNS to change and adapt in response to environmental cues, experience, behavior, injury, or disease. Neural plasticity can result from a change in function within a particular neural substrate in the CNS through alternations in synaptic strength, neuronal excitability (increasing the neurons [cells in the brains] response pattern), neurogensis (new cell development), or cell death" (Brosh & Barkai, 2004).

Some Forms of Neuroplasticity

- Re-Organization – other areas assuming functioning on another area
- Redundancy
- Compensation – teaching the brain new tricks to accomplish the same task

Neuroplasticity

- The potential for change is based on the premise that brain pathways can be strengthened through repetition
  - Similar to building muscle strength with repetition
  - e.g. writing with non-dominant hand
- Repetition is fostered by developing appropriate skills, and provides structure, consistency, and routine

Developing Effective Skills

- Effective life skills do not develop automatically
- Appropriate skills must taught, modeled, and reinforced
- Absence of these skills does not create a vacuum, but can mean that ineffective/inappropriate skills have been developed instead
  - Results in strengthening of brain pathways associated with ineffective behaviors and weakening desired pathways
  - Do not only have to teach new patterns, but extinguish existing ones

Skill Development

- Critical skill deficits are commonly associated with areas of the brain most affected by trauma and neglect
- Language/communication
  - Reflective listening
  - Reading
  - Nonverbal language
- Executive functioning
  - Problem solving
  - Impulse control
  - Social perspective taking
- Emotion regulation
  - Breathing/relaxation
- What are skills/strategies for each area?

Skill Development

- Skills must be explicitly taught, modeled, and reinforced
- The child must identify value to learning the skills
  - Reach goals
  - Social acceptance
  - Valued as part of self, family, or culture
  - Other?

Changing the World View

- Child becomes reactive, behaviors don't necessarily make sense
- Emotionally driven
- Act on what feels right rather than what is effective or right
- Focused on immediate needs over long term needs
- Seek pleasure versus happiness/fulfillment
- Develop a "Wise Mind" that considers both emotion and intellect

Ineffective Coping due to Skill Neglect

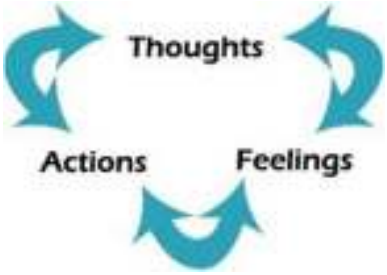
- Failure to develop appropriate skills leads to inability to meet needs effectively
- The world feels out of control, unpredictable, and unfair
- Views the world concretely
  - Might not understand abstract concepts
  - Does not see how actions will affect others
  - Becomes angry when people do not react as expected
- Child responds by attempting to meet needs through avoidance or overt force
- Can occur inadvertently, not only through trauma or neglect

Mental Health

- Depression
- Anxiety
- Anger
- Aggression
- Over time can yield cognitive changes and personality patterns
- Mood and behavior issues are often driven by fear – activation of sympathetic nervous system

Other Diagnoses

- Bipolar
- Reactive Attachment Disorder
- Oppositional Defiant and Conduct Disorder
- Antisocial Personality or Sociopathic Tendencies
- Intermittent Explosive Disorder
- ADHD
- And multiple combinations of the above



Goal Setting

- Develop realistic goals
- Recognize the difference between dreams and goals
- Write down goals
- Identify steps to reach goals
- Review regularly

Behavior Modification

- Punishments are defined as an intervention that reduces the likelihood that a particular behavior will occur again in the future. If grounding a child who has run away from home leads to him running away from home again, the running away behavior might have been reinforced and not punished.
- Effective behavior modification requires understanding what motivates him and makes sense to him, not what makes sense to others. Parents often become frustrated when their attempts at punishment lead to increased behavior problems, and consequently blame the child. This is actually an opportunity for further exploration and identifying what motivates that particular child.
- Punishment tends to be less effective method of behavior change than reinforcement. Rather than focusing on decreasing particular behaviors, it is often more effective to focus on increasing desired behaviors that are mutually exclusive of those that might be considered problematic.

Activities

- Promote activities that encourage and model cooperation, teamwork, responsibility, problem solving, and solution focused thinking and will provide an opportunity for learning skills that are underdeveloped
- Collaborative Problem Solving

Medications

- Can be helpful to "take the edge off" symptoms
- Not as effective for children where environment and/or experience is playing a significant role in maintaining the symptoms
- Side effects can counteract some of the positive aspects of medications
- E.g. psychostimulants might increase irritability, mood stabilizers can slow cognitive processes

Daily Interventions

- Nutrition
- Exercise
- Sleep
- Safety
- Love and validation
- Toileting

Working with Caretakers

- Don't have to directly discuss the specifics of the abuse to be helpful
- Anxiety and avoidance: gradual exposure and desensitization, relaxation training, interruption and replacement of thoughts
  - Helps regain control of thoughts and feelings
- Depressive symptoms: coping-skills, correction of distortions
- Behavior issues: behavior-management strategies

Interventions

- There are many different play models/sand tray work
- Parent Management Training, etc.
- Focus of any of these
  - Let child experience in safety
  - Correct compassionately without reaction or abuse
  - Structure, routine, stability

Challenging to treat

- Symptoms can change abruptly – I love you, I hate you
- Symptoms can develop prior to 4-months of age and may persist if consistent family or adoptive family providing caretaking
- Overmedication is common in attempts to manage behavior, but habituation to medication can be fast leading to complex medication regimes, side effects, etc.
- Never know what to trust and the other shoe always feels like it is about to fall.

Keep in Mind

- Most of these children, adolescents and adults don't plan to or want to act they way they do – they may genuinely not know why they react the way they do

That is the MAIN POINT – the behavior is REACTIVE
It doesn't make sense for you, them, or most of us

Treatment:

- Understand functional and cognitive strengths and weaknesses
  - Try to provide more opportunities for them to build on successes and limit challenging weaknesses
- Be consistent in your reactions and remain stable
- Be careful how many people allowed in their lives to have a caretaker role

- For a website to add a different perspective on how to address challenging, behavior, http://www.thinkkids.org/ is a strong perspective with a different focus to address behavior.
- This is an excellent website and approach that helps us to better understand the impact of brain processing and ADD on these types of students. The approach used is described in the book, *Treating Explosive Kids: The Collaborative Problem Solving Approach*. As applied to challenging kids, the model sets forth two major tenets: first, that these challenges are best understood as the byproduct of lagging cognitive skills (rather than, for example, as attention-seeking, manipulative, limit-testing, or a sign of poor motivation); and second, that these challenges are best addressed by teaching children the skills they lack (rather than through reward and punishment programs and intensive imposition of adult will).

BRAINS

Call us at 616-365-8920

3292 N Evergreen Drive NE
Grand Rapids, MI 49525

www.brainspotential.com
Facebook: BRAINS Potential
Pinterest: https://www.pinterest.com/brains0131/

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