

# The Use of School-Based Mental Health Services to Promote Psychosocial Well-Being and Academic Success among Vulnerable Children

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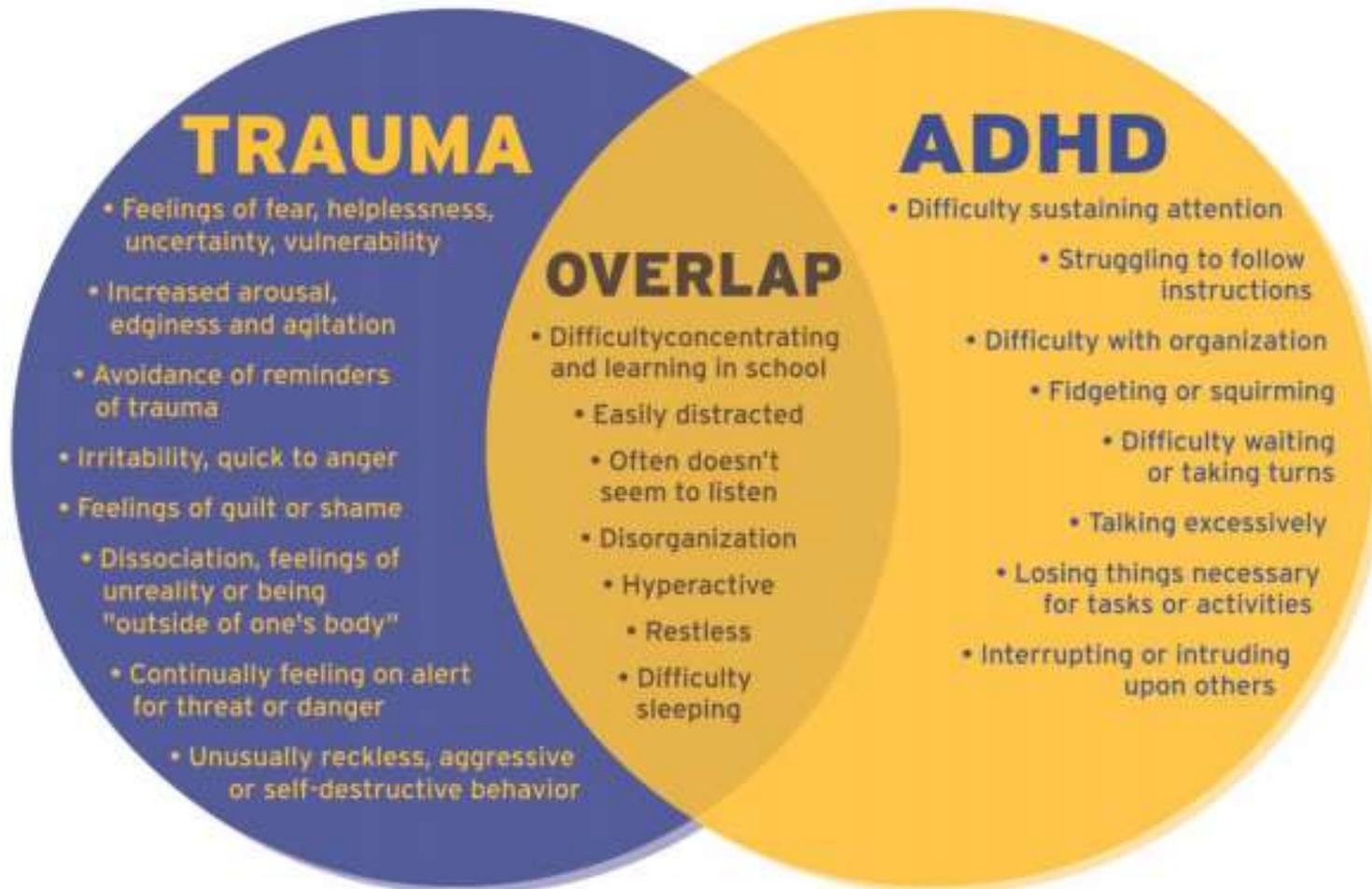
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# Describe this Child

- Difficulty concentrating and learning in school
- Easily distracted
- Often does not seem to listen
- Disorganized
- Hyperactive
- Restless
- Irritable- quick to anger
- Reckless, aggressive and self-destructive behaviors
- Increased arousal, edginess and agitation
- Difficulty sleeping

# Symptoms Overlap



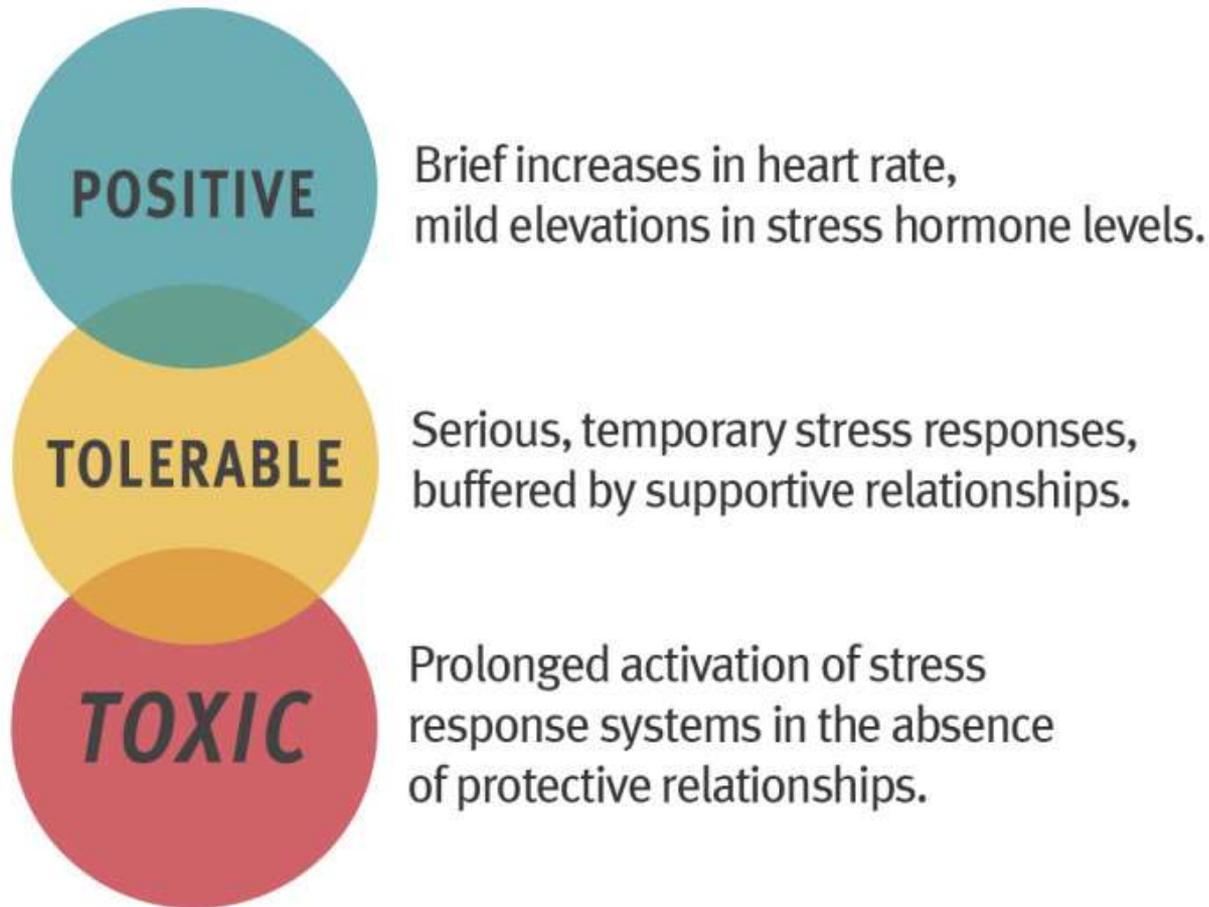
# Common childhood stressors

- Transitions to new environment
- Separations from trusted people
- Worries about school/grades (performance anxiety)
- Worries about parental health and well-being
- Family stress
- New situations:
  - Home
  - Siblings
  - Schools

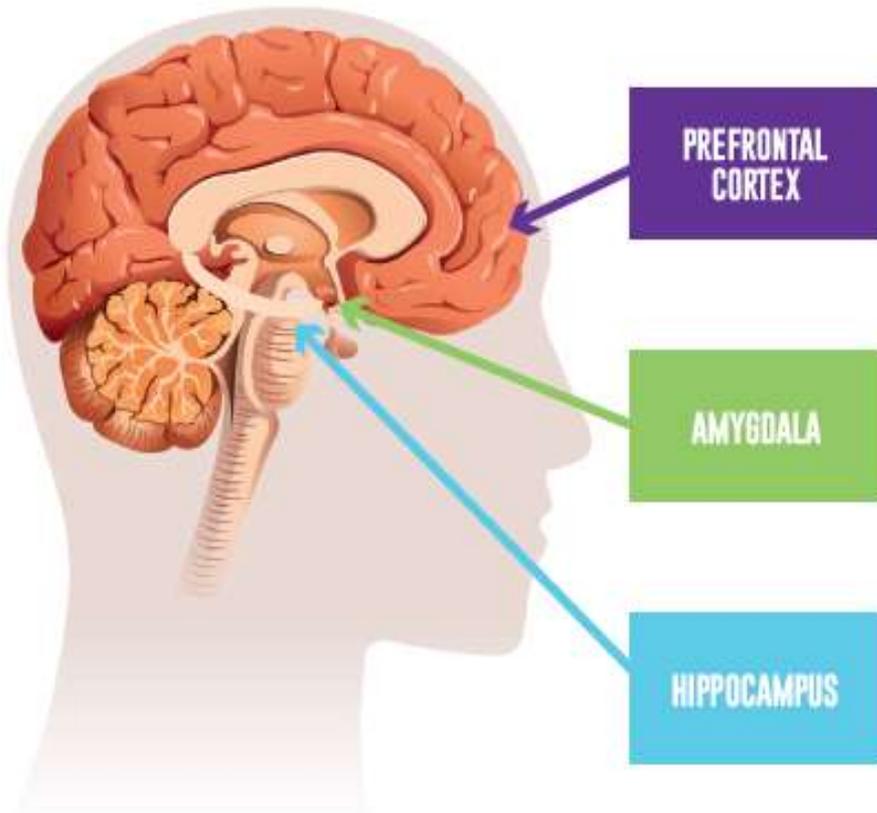
# Latino children stressors

- Immigration
- Acculturation/adaptation
- Perceived discrimination
- Racism
- Limited language proficiency
- Documentation status
- Fear of deportation or family separation
  - Underreporting of incidences of domestic violence
  - Substance abuse
  - Educational and healthcare system
    - Will not enroll children in school because of fear
    - Will not take children to seek healthcare

# Toxic Stress



# Toxic Stress



Areas responsible for:

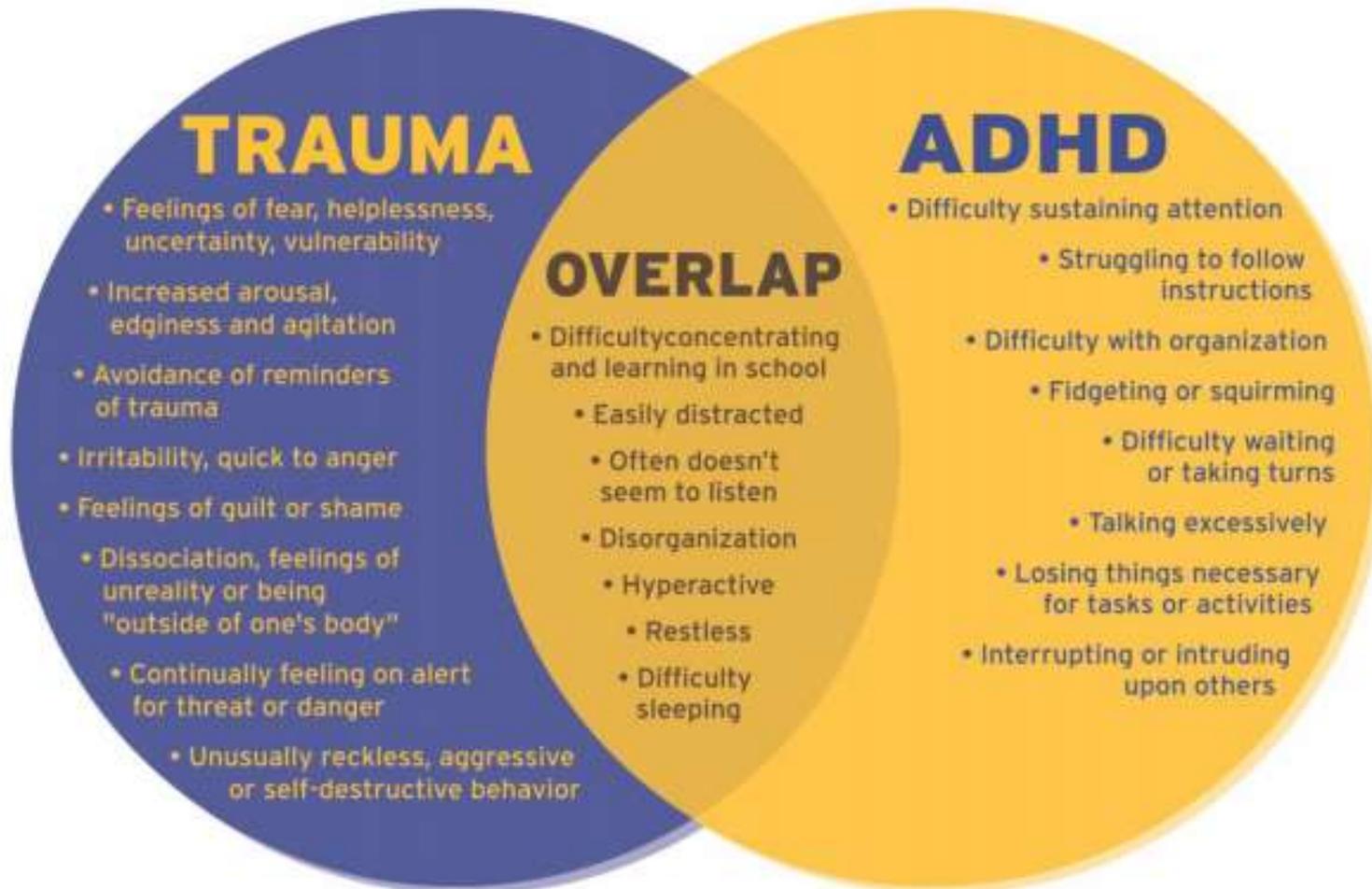
- Learning
- Decision-making
- Emotions

# Toxic Stress and Trauma

## Trauma

- ❖ Affects children's social, emotional, behavioral, cognitive, and general health functioning
- ❖ Impacts parenting capacity – for example, living in constant fear limits parents' ability to provide a feeling of safety for children within the home
- ❖ Can impede children's academic success
- ❖ Can negatively influence behaviors in school

# Symptoms Overlap



# “Omar”

- 14 year old newcomer from Guatemala
- Average academic performance
- Classroom behavior
  - Inattention
  - Distractibility
  - Aggressive behaviors

# “Elena”

- 13 year old newcomer from Guatemala
- Average academic performance
- Classroom behavior
  - Inattention
  - Conflictual peer relations
  - Moody

# What their Teachers Did Not Know

- Elena and Omar were forced to flee their home under threats of violence
- Elena was sexually assaulted
- Father was killed
- Elena and Omar crossed the boarder alone

# Outward Expressions of Similar Experiences

Omar	Elena
Externalized behavior	Internalized behavior
Identified initially as requiring services	Later identified
More noticeable and disruptive	Less disruptive, more “typical”

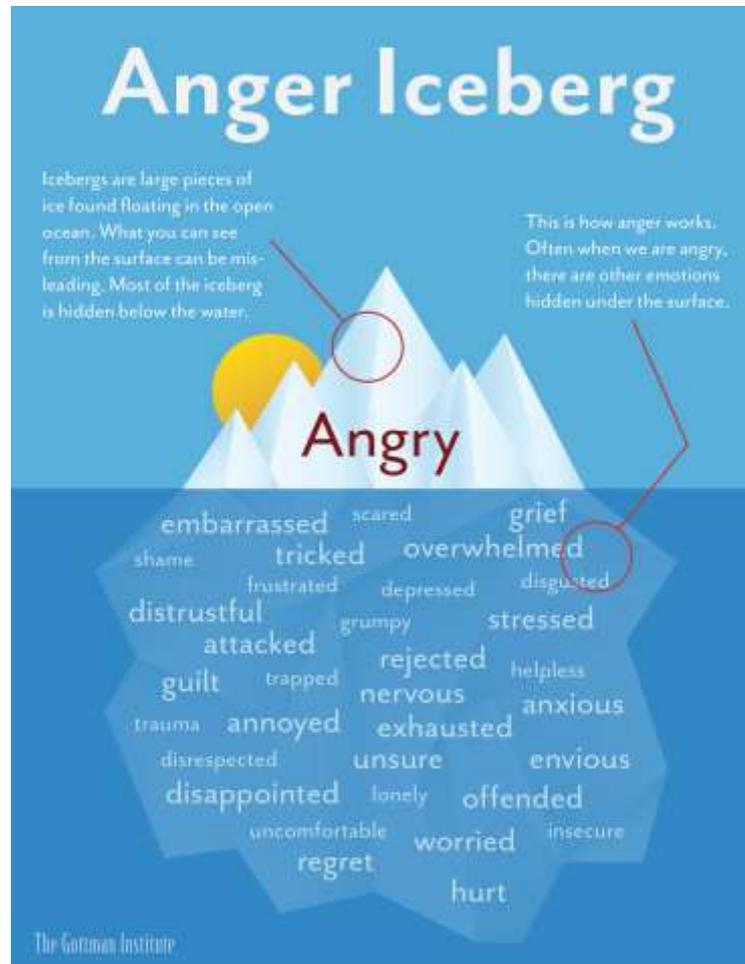
# An Illustration

- Omar and Elena were riding the bus home from school
- A male student passed by Elena, brushing her shoulder
- Elena told Omar
- Omar was involved in a physical altercation with the student
- Omar receives disciplinary action

# What the Administrators Did Not Know

- Elena was triggered by the unwanted and unexpected touch
- She sought protection and comfort in telling her brother
- Omar's responsibility had been to protect his sister
- Omar also was triggered and reacted aggressively toward the other student

# Tip of the Iceberg



# Response to Therapy

- Better understanding of their trauma have led improvement in their behaviors:
  - Omar is less disruptive
  - Elena is getting along better with her peers
    - Less “moody”
  - Both of their grades have been better
    - Inattention and focus have improved
  - School personnel is more sensitive to their trauma

# Exposure to trauma impacts children in many ways

- ❖ Have generalized reaction of terror/fear
- ❖ Can experience grief responses
- ❖ Secrecy - others do not know about it
- ❖ Feel a lack of safety
- ❖ Feel powerless
- ❖ Often times, trauma is not language-based, but a sensory experience (mid-brain)

# Research has shown the following:

## **Children experience a wide range of negative outcomes – increased internalizing and externalizing behaviors**

- ❖ More depressive symptomology
- ❖ More anxiety and worry
- ❖ More prone to anger (can often be destructive)
- ❖ Higher level of behavior problems
- ❖ Interpersonal problems
- ❖ Trauma symptoms – nightmares, flashbacks, hyper-arousal, exaggerated startle responses, emotional withdrawal
- ❖ Sometimes meet criteria for PTSD diagnosis

# Continuation of research findings:

## There are:

- ❖ Developmental issues –manifestations of symptoms vary due to age differences
- ❖ Gender contrasts – girls tend to display more internalizing behaviors and boys more externalizing behaviors – this shifts as boys and girls get older
- ❖ Themes of trauma: lack of safety, worry, hurt, fear, anger/revenge, victim thinking, loss of future orientation (focused on the here and now, so very difficult to think about academics and future success in schooling)

# Developmental/age differences in reactions to trauma:

## Toddlers

- ❖ They may experience: excessive irritability, regression in behaviors and developmental milestones (i.e., sleep, toilet training), difficulty understanding their own feelings, experience attachment issues
- ❖ They may have temper tantrums and aggression, crying and resisting comfort, anxiety
- ❖ Trauma undermines child's developmental need for safety and security

# Continuation of age differences:

## School aged children

- ❖ Have symptomology that is more behavioral - problems at school, social difficulties, PTSD, lower self-esteem
- ❖ May also have physical symptomology – psycho somatic – headaches, asthma, insomnia, enuresis, nightmares
- ❖ Experience their academics, social success, and self-concept being negatively affected
- ❖ Are at risk for bullying or to be bullied, have peer difficulties
- ❖ Experience sadness, anxiety, and depression

# Continuation of age differences:

## Adolescents

- ❖ Experience poor intimate relationships, avoidance attachment style, lack of trust, sadness, depression
- ❖ Have coping mechanisms that may be to tune out, disengage, try drugs and/or alcohol (these may be perceived as defiant behaviors or “not caring” – instead of trauma reactions)
- ❖ Have higher rates of delinquency

# Mind/Body Skills

- ❖ Trauma is driven by feelings and sensations, **NOT** rational thinking
- ❖ Mitigating factors
  - Increasing protective factors through therapy, a strong relationship with and attachment to a caring adult is critical
  - Increasing resilience – positive relationships with peers and siblings for support
  - Increasing locus of control
  - Increasing self-esteem

# Mental Health and school success

- We know that if children have good mental health they are better able to succeed academically. This is critical, and mental health professionals are able to help children in this capacity. However, it is necessary to be culturally competent in this work.

# Mental Health providers play a key role in schools

IF MH PROVIDERS ARE CULTURALLY COMPETENT AND HAVE AWARENESS AND KNOWLEDGE THEY CAN:

- ❖ Help staff understand cultural differences
  - By having knowledge and empathy
  - Avoiding misperceptions
  - Not pathologizing behaviors, must have an understanding of cultural context
  - Examples of differences: value placed on education versus work, spirits, herbs, etc.

# Continuation of Mental Health providers play a key role in schools

- ❖ Educate staff on particular stressors Latino/a students face:
  - Anxiety – can provide strategies/interventions for staff
  - Depression
  - Secrecy and shame – keep it inside and will not necessarily have external behaviors
  - Fear of deportation of family members (multi-faceted)
  - Language barriers
  - Family not able to navigate educational system
  - Family not able to help with homework or school related things

# THANK YOU!

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