

The Impact and Influence that Protective Factors and Trauma-Informed Care have on Building Resilience Among those that have endured Adverse Childhood Experiences: A School Functioning and Adult Mental Health Review

by

Christopher, C, Hague

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Abstract

This paper outlines and describes the implications that ACEs have on student functioning as well as the impacts ACEs have on one in later life. Research indicates that one's mental health as well as ones physical and social life are inhibited greatly because of ACEs. The ramifications of ACEs are also intergenerational and as such the impact that ACEs have on one family member have a strong likelihood of impacting the wellbeing of the next generation.

Nevertheless, this paper also aims to highlight and bring hope to those that aim to support children who have endured ACEs. Research indicates that protective factors, specifically a person who aims to support one who has experienced ACEs when conducted from a Trauma-Informed lens, can change the trajectory of a child's life. Trauma Informed Practice if done effectively can allow students to experience their trauma safely and can create neurological changes that can disrupt patterns of behavior that have been hurtful for the student's development. Essentially Trauma-Informed Care and Practice have the potential to create a lasting impact on the student's life and can help that student build resilience despite the harmful impacts of ACEs. Therefore, I recommend that Trauma-Informed Programs be placed in schools to address the diverse needs of students impacted by ACEs to improve their resilience capacity as students which will then impact their resilience capacity in later life.

Keywords:

Adverse Childhood Experiences (ACEs), Protective Factors, Trauma-Informed Care, Trauma-Informed Practice, Resilience, Person-Centered Therapy, Countertransference, Dialectical Behaviour Therapy (DBT).

Chapter 1: Introduction

Introduction

As a Case Manager of at-risk students, I am often confronted with the task of supporting students who are suffering from a very broad spectrum of intensive behavior and mental health needs. From my observations it appears that there are two very distinct categories of behavior and mental health needs which I aim to support. Some of my students exhibit extroverted behaviors such as bullying, peer victimization, and physical and emotional violence. My other students exhibit more inverted struggles such as depression, anxiety, Post Traumatic Stress Disorder, and the early stages of borderline and other personality disorders. This is not to say that any given student cannot move from an extraverted bullying to an introverted place of anxiety, what I am referring to in each of these two categories is the baseline behavior on which my students struggle.

Consistent with both types of student's baseline behaviours is their relationship to Adverse Childhood Experiences and the impact that ACEs have on student functioning based upon the literature reviewed in this paper. Everyone of my twenty-six students has endured no less than four ACEs. The baseline intensive behaviors and or mental health struggles my students exhibit are in consequence to the ACEs they have endured. The concern as it relates to this paper is with students functioning, specifically what educators and educational support staff can do to help support the specific and varying needs of students who have endured ACEs. In chapter one I will discuss the impact that ACEs have on student functioning I will then discuss how one's resilience capacity from ACEs can begin to form through connectedness to the school and or groups at school.

Background Information

ACEs and Student Functioning

Research indicates that ACEs have a malignant impact on student functioning in schools. Specifically, bullying and harassment, peer victimization, violence, depression, and anxiety. The consequence of these behaviors and mental health concerns, which are impacted by ACEs, significantly increase the risk of school engagement, drop-out, suicide, suicide ideation and drug use when compared to students who have not endured ACEs (Bae, 2020, p. 1; Foster, 2020, p. 662; Jia, 2020, p. 1).

Research indicates that depression, drug use and antisocial behavior have a synergistic connection when compared against the child's ACEs. Drug use and antisocial behavior are defensive mechanisms that the student creates for him or herself because of ACEs and are used to help the impacted student protect themselves from the compounded negative impacts that ACEs have had on their development. These behaviors then have a negative impact on depressive symptomatology which then further the cycle that ACEs have on the student (Shilling et al., 2007, Morrow et al., 2018; Jia et al., 2020) Consistent with the research conducted in this paper is that suicidality, suicide ideation, student disengagement and drop out are also linked to a lack of feeling connected to the school. Research indicates that a school that cultivates a culture where students can feel connected even students who have endured ACEs school attendance and engagement increase (Jia et al., 2020; Bethell et al., 2014; Morrow et al., 2018).

Research indicates that delinquent behaviour, specifically violence, peer victimization and carrying weapons to school are onset by ACEs. When these students conduct this behaviour, they are at a higher risk of suspension, expulsion, and legal ramifications which concern theft and the destruction of property. The results of these behaviors are also consistent with an increased risk of failure to complete high school and or drop out (Foster et al., 2020;

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Morrow et al., 2018). However, research also indicates that if educators and or support staff can impact a student where they can begin to gain academic success the risk of failure to complete high school and or drop out decreases, yet delinquent acts remain similar. Research also indicates the importance of keeping a child in school despite his or her delinquent acts as feeling connected to a safe place can be preventative of future social maladjustments such as an increase in deviant behavior which could lead to incarceration (Bae et al., 2020; Foster et al., 2020; Morrow et al., 2018).

Research also suggests that those that have endured ACEs have an increased probability of school disengagement due to the adverse effects of chronic illness. Yet those that struggle with chronic health related illness because of ACEs showed a greater school engagement when supported by educational staff. What appears to be evident in the research reviewed is that matters of one's resilience from the adverse effects of chronic illness are impacted despite ACEs when one feels connected and supported (Bethell et al., 2106). It appears that the effects of ACEs specifically those that impact school functioning can be mitigated through feeling connected to a school and the educational staff that provide the care for those that have been impacted by ACEs. It also appears that one's resilience capacity to overcome drop-out, school disengagement, peer victimization and violence increases because of ACEs improves if the school and school staff find ways to connect to the specific needs of the student.

Connectedness and Resilience

Research indicates that feeling connected to a school or a group at a school has an impact on a student's resilience when confronted with the effects of ACEs. Yet, what is also consistent with research found are similarities on how feeling connected impacts their person. Research indicates that within groups at school it is the information provided, the sense of

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belonging that is communicated in the group and the creation of hope that is fostered in a group setting that has the greatest impact on one's resilience when confronted with the effects of ACEs. Data indicates that positive increases are associated with student academic self efficacy, building a stronger self concept and identity because of developing resilience through connectedness in groups (Wiley, 2019, p. 913; Mann, 2015, p. 117).

Establishing a sense of belonging is central to the functioning of the human organism. To feel connected with others relaxes our central nervous system and allows us to operate with a greater receptive acceptive capacity than when we feel isolated. It is typical for the traumatized brain to be rigid as a matter of protecting one's own organism and will often create a narrative of cognitive dissonance as a by-product of his or her traumatic experience. Yet when one feels a sense of connectedness, despite traumatic experiences in childhood one's cognition becomes more pliable and fluid which allows access to new neural pathways for more optimal cognitive functioning. Essentially the brain when it feels connected feels safe and when one feels safe more cognitive pathways are opened and it is during this moment of reception and the acceptance of new information that even those who have endured terrible traumas can build a stronger resilience capacity (Greenburg, 2012, p. 1; Joseph, 2014, p. 708).

As identified by literature those that have endured ACEs may suffer from various psychological traumas. However, literature also indicates that resilience capacity can be built among those that have endured ACEs through connectedness with the school or a group at a school. Yet the question (s) remains, what does this look like? What is required from the facilitators of groups that aim to create connectedness and what is done in these groups that helps support some of our most vulnerable students in a sustainable way? What does the structure look like in these groups to help us understand what practices might be most effective? What do I need to be mindful of as it concerns practices that might harm students?

Purpose and Significance

The purpose of this capstone is to explore research on the impact of ACEs in schools or in students and propose recommendations for the development of Trauma Informed Practice based programs in schools that can be facilitated by educator and or counsellors to help improve student resilience among those that have endured ACEs. The research objectives are as follows: Understand the mental, physical, and social implications for ACEs; Identify strategies to support connectedness and resilience in children and youth and provide recommendations as to how educators and or counsellors can begin to create Trauma Informed Programs that help meet the specific needs of those that have endured ACEs.

Essentially and what is perhaps of most importance to my area of study concerns matters of social justice, specifically inequities faced by those that have endured ACEs. Healthy opportunities afforded to the broader school demographic when compared to those that have endured ACEs indicates quite a broad and extremely dichotomous divide. The aim for us as educator is to facilitate connected learning environments that meet each student where they are at to support their development as young people. However, if attention is not given to students who have endured ACEs, specifically programming that aims on bridging the gaps in school connectedness to help strengthen these students' resilience, we are essentially contradicting our mandate as professional educators and are widening the inequities faced by our most at-risk demographic.

If we can find a way to effectively implements individualized trauma informed programs, we are not only strengthening the resilience capacity of our at-risk students we are also strengthening the culture of inclusive learning at our schools. My hope is that my research leads me and others to a place where we can begin to objectively look at our school culture and the needs that exist within it and ask ourselves how we are supporting our at-risk students and what

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can we do to implement specific trauma informed practice that help meet these students needs?

If this question is asked by our educational assistants, our custodial staff, our teachers, and our administrators I am hopeful that we will arrive at a place where we start to evaluate more critically the concerns of school inequity faced by those that have endured ACEs.

Outline of the Remainder of the Paper

The functionality of building a resilience capacity among those that have endured ACEs through programs that build connectedness is a complicated process. In Chapter 3 I will make recommendations how a program like this should look based upon the evidence of ACEs and school functioning and the impact that connectedness has on resilience. I will also incorporate evidence from Chapter 2 to highlight the specificity of Trauma Informed Care and Trauma Informed Practices and how these impacts the functionality of building resilience in a connection-based program for those that have endured ACEs.

Chapter 2: Literature Review

Introduction

In this chapter I will begin by discussing the framework of Adverse Childhood Experiences (ACEs) and the impacts that they have on the mental, physical, and social well-being of the person effected. I will then discuss resilience and the impacts that Trauma Informed Care and Trauma Informed Practices have on building a greater resilience capacity among those that have endured ACEs. Lastly, I will discuss the importance of building emotional safety in a Trauma informed Care and Trauma Informed Practice among those that have endured ACEs.

Adverse Childhood Experience Framework

Adverse Childhood Experiences, or ACEs are defined in this paper as, potentially traumatic events that occur in childhood such as physical or emotional violence like neglect, witnessing violence in the home or community, having a family member die by suicide or attempt to die by suicide, household substance misuse, mental health problems and family member incarceration (Brown 2009, p. 389). The implications that ACEs have on the developing brain during childhood can have adverse effects in adulthood, specifically: depression, anxiety, post traumatic stress and toxic stress and other varied psychopathological mental health concerns. Physical health concerns such as chronic health conditions, specifically hypertension and blood clotting and other physical illnesses onset by heart related concerns are impacted by ACEs. ACEs also have negative effects on social factors such as homelessness, incarceration, and effects due to lack of education and the negative implications that have on one's career prospects and socioeconomic status. The impacts of ACEs can also contribute to a continued life cycle of intergenerational trauma due to unresolved strained family dynamics (Brown et al., 2009).

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The significance of ACEs transcends cultural and ethnic differences and has had an impact on a global scale. Research suggests that over one-half of global depression and anxiety cases are potentially attributed to self-reported child maltreatment. A 10-25% reduction in maltreatment has the potential to prevent 31.4-80.3 million depression and anxiety cases worldwide (Li 2016, p. 717). The literature reviewed in this paper indicates a strong connection between ACEs and negative mental health, physical health and psychosocial outcome and will be addressed in dialog with the research conducted. In this paper I will evaluate the impact and influence that protective factors and a trauma informed practice have on building a resilience capacity among those that have endured ACEs.

ACE Implications on Mental Health in Adulthood

Research appears to indicate that individuals who endure four or more ACEs are at the greatest risk not only of potential mental health outcomes but also physical health and psychosocial. When one has less than two ACEs they are at modest risk for physical inactivity, overweight or obesity and diabetes. When one has two to three ACEs there is a moderate risk from smoking heavy alcohol use, cancer, heart disease and respiratory disease. When one has three to six ACEs there is a strong correlation to sexual risk taking, mental health concerns, drug usage and interpersonal and self-directed violence (Hughes 2017, p. 356). What is consistent in the data analyzed is that in the absence of protective factors, the impact of ACEs appears to have more significant impacts on one's mental health compared to those who endured ACEs and had protective factors. For the purposes of this literature review protective factors can be classified as a child's access to a safe neighbourhood, supportive neighbours, a minimum of four neighbourhood amenities, a well-kept neighbourhood, no household smoking, a minimum five meals per week and most importantly a parent who can talk to the child. (Robles 2019, p. 144). Protective factors will be discussed at further length later in this literature review, I emphasize it now as the data that I found as it concerned ACE's implications on mental health was almost entirely negatively impacted by the absence of protective factors. Therefore, for the

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purposes of research and observation the findings in the following are representative of a data set that is either missing protective factors as a confounding variable or is representative of data that highlights ACEs in the absence of protective factors.

Research has found that depression as well as the absence of maternal and paternal love is a strong predictor of suicidality. In addition to depression being a predictor of suicidality ACEs also appear to connect to suicidality (Hardt 2011, p. 119). Suicidality for classification purposes in this literature review also needs to be observed separately from Non-suicidal Self Injury (NSSI) as suicidality precludes the intention of suicidality where as NSSI does not; however, both are potential by-products of ACEs. Findings suggest that childhood emotional abuse was positively associated with NSSI, and this association caused identity confusion. Research indicates that rumination can be onset by emotional abuse stemming from ACEs, specifically, “rumination intensified the association between childhood emotional abuse and identity confusion, as well as the association between childhood emotional abuse and NSSI” (Gu 2020, p. 106). An important distinction in the findings here is that NSSI findings had a correlation to a specific ACE (emotional abuse) where suicidality did not.

Toxic stress, or stress that has manifested from ACEs to adulthood, is consistent with the impact of multiple ACEs, specifically if one has endured more than four ACEs. Without community advocacy and support the vicarious impacts of emotional neglect, caregiver substance abuse and or mental illness and physical violence indicates that in adulthood one is far more likely to experience toxic stress than one who has endured ACEs with community advocacy (Ellis 2019, p. 88). The impact that protective factors have on those that have endured ACEs or even multiple ACEs appears to have a positive impact on mental health aversions in adulthood onset by ACEs, specifically depression, anxiety, suicidality, non-suicidal self injury, and toxic stress.

Findings indicate that those that have endured ACEs have a greater likelihood of sustaining Post Traumatic Stress Disorder, Complex Post Traumatic Stress Disorder, and a

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dissociative subtype of PTSD (Frewen 2019, p.10) than those that have endured stressful events in adulthood but have not experienced ACEs. However, the positive implications that protective factors have on those that suffer from PTSD, Complex PTSD, and a dissociative subtype of PTSD in adulthood because of ACEs appear to impact one's resilience. However, research indicates that emotional regulation through therapeutic practice is the best way to offset PTSD, complex PTSD, and the dissociative subtype of PTSD with clients who have endured ACEs (Cloitre 2019, p. 1942). What is interesting here is that protective factors appear to have a positive impact on one's mental health resilience in adulthood despite ACEs, if these mental concerns are depression, anxiety, non-suicidal self injury, and suicidality by themselves and not coupled with PTSD (or subtypes). Therefore, it appears that if one suffers from PTSD (or PTSD subtypes) in adulthood because of ACEs, protective factors have a lesser effect on one's resilience (Cloitre et al., 2019).

ACE Implications on Physical Health in Adulthood

Research indicates a connection between physical health concerns in adulthood because of ACEs. However: high risk sexual activity and sexually transmitted disease, hypertension, stroke, high blood pressure and other heart related, and respiratory illnesses and substance misuse appear to be the most prevalent in research conducted. Variation of physical health outcomes because of ACEs was specific to the type of adverse childhood experience endured (Felitti 2019, p. 744; Putnam 2020, p. 106; Chanlongbutra, 2018, p. 1; Brown 2017, p. 211). It appears that exposure to childhood emotional, physical, or sexual abuse and domestic violence, especially if all four of these ACEs are present drastically increase the potential of high-risk sexual activity and disease in adulthood (Felitti et al., 2019). However, adverse effects of sexual abuse during childhood appears to have a disproportionately negative impact on adult health outcomes when compared against other social ACEs. Specifically, "Sexual abuse was malignantly synergistic, frequently pairing with other adversities, followed by physical abuse, neglect and domestic violence" (Putnam et al., 2020).

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Sociodemographic factors have a significant impact on adult physical health outcomes due to ACEs. Access to amenities in the community for recreation were impacted by sociodemographic factors. Limited access to community amenities for recreation coupled with ACEs put adults at an increased risk of heart disease, specifically heart attack and type two diabetes (Chanlongbutra et al., 2018). However, what is becoming a consistent theme in research reviewed is that protective factors, specifically helping support those that have endured ACE's gain access to recreation facilities helped offset concerning physical health implication in adulthood caused by ACEs.

Research also indicates that, "protective adult relationships moderate the relationship between ACEs and substance misuse, but not adolescent delinquency. Specifically, under low levels of protective adult relationships, cumulative ACEs are related to increased substance use among youth" (Brown et al., 2017). What is interesting here is that protective factors must be of a high level to impact substance abuse in adolescence because of ACEs; therefore, the quality of care provided by the adult protective relationship, has an impact on adolescence substance misuse stemming from ACEs. Also, it appears that protective adult relationships, even ones that give a high level of care and support do little to impact the behaviors, specifically delinquency of youth because of ACEs (Brown et al., 2017).

Social Implications of ACEs in Adulthood

The impact that ACEs have in adults extends beyond mental and physical health and into the psychosocial aspects of the individual as well as intergenerational dynamics. Findings suggest that ACEs impact individual well-being in low socioeconomic status above and beyond the effects of demographic risk of poverty (Giovanelli 2020, p. 1418). Research also indicates that those with a higher ACE score (four and greater) were more likely to report high school non-completion and living in a household below the poverty level (Metzler, 2017, p. 141). It appears that the social impacts of ACEs affect high school completion and the compounded negative impacts that this has on the person economically which then influences their well-being

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in adulthood. What also appears to be consistent with data reviewed was the compounded impacts of intergenerational trauma caused by ACEs, specifically the impact that maternal disconnection has on the next generation (Giovanelli et al., 2020; Metzler et al., 2017; Doi 2020, p. 104). Research indicates that, “adolescents of mothers who experience parent loss were more likely to report lower self-rated academic performance. Maternal ACEs, and especially maternal parent loss, were associated with lower self-rated academic performance in adolescent offspring” (Doi 2020, p. 104). The maternal connection to ACEs appears to be linked to unresolved trauma, specifically the adverse impacts of losing a parent. This trauma then appears to impact the next generation, specifically their schooling which then impacts their socioeconomic status and eventually their wellbeing (Doi et al., 2020). These unresolved intergenerational traumatic events and their concerning nature are echoed by Family Psychologist Dr. Murray Bowen. Bowen stated that, “a given level of differentiation is passed from generation to generation in families through the operation of emotional triangles and unresolved fusion within the original dyad will continue intergenerationally” (McCollum 1986, p. 25). Research did not directly indicate that fusion between mother and child was a reason for the systemic impacts that ACEs have intergenerationally; however, I find it interesting that parental loss, specifically loss of the mother, has the potential to impact one's socioeconomic status and well-being in adulthood if that trauma is unresolved.

Protective factors also appear to be a significant contributor in offsetting the negative social effects that ACEs have in adulthood. Research indicates that preventing early adversity may impact health and life opportunities that reverberate across generations, these factors include residing in a safe neighbourhood, attending a safe school and parental monitoring of friends and activities. However, the strongest protective factor for children who have endured ACEs is a parent that can talk to the child empathetically, specifically the mother (Metzler, et al., 2017; Moore, 2016, p. 299). Essentially what appears to be evident in the research provided is that a preventative factor in helping one who has endured ACEs is connecting and supporting

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that person's mother. What I find interesting here is that the protective factor of a strong supportive adult in the absence of a supporting parent has shown to limit the impacts that ACEs can have on one in adulthood. Further research needs to be done on the specificity of the relationship between mother and parental loss so we can find more efficient ways to support the family in need and limit the impact that this relationship has on ACEs intergenerationally.

ACEs and the effects that they have in adulthood are very dynamic in nature and appear to be connected to mental illness. Findings suggest that ACEs have a strong connection to homeless adults and mental illnesses especially dissociative disorders (Liu, 2020, p. 807). Disassociation is a maladaptive and defensive strategy to help manage the life circumstances of being homeless. Research also indicates that, sexual abuse, physical abuse, and family mental health problems were all positively associated with dissociative symptoms among homeless adults (Tyler, 2004, p. 355). Nevertheless, helping homeless adults who suffer from mental illness because of ACEs can be supported by helping them build resilience. Research indicates that resilience protects against adverse childhood experience associated with poor mental health outcomes in adulthood, thereby serving as a potential interventional target in homeless populations (Liu, et al., 2020). It appears that helping those that are disassociating because of the impacts of ACEs and the difficult social circumstances of being homeless can, at least in part, be offset by helping them build a greater resilience capacity (Liu et al., 2020; Tyler et al; 2004). What I find interesting here is that the dissociative disorders stemming from ACEs in adulthood are like the mental health conditions of PTSD and PTSD subtypes, in that protective factors alone cannot offset the impact that ACEs have in adulthood.

Strengthening the Resilience Factor

What appears to be a theme in the research reviewed is the notion of resilience. Resilience is discussed at length in the context of an emerging capacity that one who has endured ACEs is striving to achieve or overcome. There appear to be five consistent themes that qualify one's emerging capacity in becoming resilient: surviving, thriving, perseverance,

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reconciling and integrating traumatic experiences into healthy identity development and advocating for oneself (Yoon 2020, p. 106). Research indicates that protective factors primarily act as external supports; however, the process that one becomes resilient through ACEs is a deeply internalized process. This is not to say that protective factors cannot contribute to resilience as this is not the case however research indicates that, the internalized process of trauma reconciliation and identity development is extremely psychopathological in nature and requires more than externalized systems of support (Yoon, et al., 2020; Bethell, 2017, p. 36; Banyard, 2017, p. 88; Pusch, 2017, p. 89).

Research indicates that at the center of well-being is nurturing relationships and resilience. To help support one who has endured ACEs become resilient in adulthood a relationship centered approach is essential as this approach does not just work with families and community members but also the trauma, stress to one's brain development and emotional regulation in consequence to ACEs (Bethell et al., 2017). Essentially resilience building among those that have endured ACEs is a trauma informed practice and the focus is to build strength through self regulation and the development of interpersonal skills to help the adult a healthier perception of the *self* (Banyard, et al., 2017).

Studies suggest that, "the association between ACEs and depression was stronger among individuals with low resilience relative to those with high resilience" (Pusch, et al., 2017). This evidence indicates that ACEs have a direct relationship with resilience outcomes and that low resilience among those that have endured ACEs are at higher risk of depression (Pusch, et al., 2017). Mood regulation is a method on how clinical counsellors and psychologists help those with depression. Depression because of trauma can have devastating impacts on the nervous system (Pusch, et al., 2017). Therefore, it appears that resilience training because of ACEs is based on trauma informed care which moves away slightly from protective factors which focus on information (ACE) to action (supports) to help one build a capacity for self regulation through depression (Leitch, 2017, p. 279).

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Consistent with trauma informed care among those that are suffering from dissociative disorders, PTSD and PTSD related subtypes because of ACEs are four themes that have shown to be most effective in treatment: cognitive rest restructuring and psychoeducation, a deliberate and continuing therapeutic relationship, relaxation and self-regulation and exposure via narrative experience (Gentry, 2017, p. 279; Leitch et al., 2017). What I find interesting here is that even though protective factors have limited impacts on dissociative disorders, PTSD and PTSD subtypes because of ACEs, building resilience through trauma informed practices appears to have a positive impact on one's well-being (Liu et al., 2020; Tyler et al; 2004; Gentry, et al., 2017; Leitch et al., 2017).

Trauma-Informed Care: Counselling Models

What appears to be evidence in research conducted between trauma informed care and resilience due to the impacts of ACEs is the benefits of Cognitive Behavior Therapy (CBT) (Deblinger 2011, p. 71; Fenn, 2013, p. 579; Jensen, 2014, p. 358). The aim of CBT is to help the client disrupt automatic negative thoughts by interrupting the thought to feeling to behavior continuum. Helping the client navigate a new internal narrative based on patterns of thinking which is derived from one's core beliefs of themselves, the world, and/or the future will help interrupt one's automatic negative thoughts which will then result in cognitive and behavioral change (Fenn, et al; 2013). However, research indicates that CBT as a modality must also accommodate a trauma narrative (TN) to build greater resilience capacity among those that have endured ACEs, specifically sexual abuse. CBT as a modality of Trauma informed practice is effective among persons who have experienced child sexual abuse. Data among those that have endured sexual abuse indicates that, "TN component seemed to be the most effective and efficient means of ameliorating parents' abuse-specific distress as well as children's abuse-related fear and general anxiety" (Deblinger et al., 2011). This finding indicates that a TN approach helps both the victim's parents and the victim themselves, specifically in areas of parental distress and child general anxiety. "TN-CBT was effective in improving participant

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symptomatology as well as parenting skills and the children's personal safety skills" (Deblinger, et al., 2011). What I find interesting here is that a narrative component in CBT is essential in helping the client build resilience from sexual abuse which is also consistent with research conducted concerning clients who suffer from dissociative disorders, PTSD, and PTSD subtypes (Gentry, et al., 2017; Leitch et al., 2017). However, there appears to be little research concerning the specific details of how those that suffer from dissociative disorders, PTSD and PTSD subtypes in adulthood because of sexual abuse benefit from a TN CBT approach; therefore, more research needs to be conducted in this area.

Research also indicates that a trauma focus on CBT as a modality helps those that have endured other forms of ACEs as well and helps for overall capacity when one exhibits symptoms of trauma as a child or adolescent (Jensen, et al., 2014). Early intervention through a trauma focused CBT with children and adolescents who have endured ACEs appears to be effective in helping build resilience (Jensen, et al., 2014). However, the likelihood of a child or adolescent advocating from themselves compared to an adult prior to trauma focused CBT is extremely rare and typically requires external support to advocate for their needs. Therefore, recognizing the signs and symptoms of cognitive trauma in a child is an important skill in getting the child the help they need to support early intervention strategies among those that have endured ACEs (Jensen, et al., 2014). Signs and symptoms include but are not limited to the following: feelings of hopelessness and/or sadness, appear to be stunned and disconnected from others, fear and anxiety, anger and mood swings, confusion and inability to self regulate (Jensen, et al., 2104). Research indicates that Trauma Informed Care (TIC) is not limited to the care provided by clinical counsellors and psychologists. Data reveals that, "a resilience-oriented approach to TIC can also be provided by child advocates that and can move from trauma information to neuroscience-based action with practical skills to build greater capacity for self-regulation and self-care in both child advocates and clients" (Leitch et al., 2017).

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The practical skills of TIC are reflected by the British Columbia Government so that teachers can help support the needs of a broader range of students. Everyday Anxiety Strategies for Educators (EASE) was created by The Ministry of Children and Family Development (MCFD) in collaboration with Anxiety Canada and British Columbia's Educators to generate a sustainable and comprehensive plan for mental health support in schools (Education, 2019). The program was launched in 2018 as a pilot; however, in 2020, it now includes over 3,500 students, 150 educators, 43 schools, and 11 school districts (Education et al., 2019). EASE is not a direct program implemented into a classroom but rather a collection of evidence-based anxiety management and resilience-building classroom tactics for students that educators learn through a workshop. The activities taught use CBT to address the thoughts, emotions, and reactions associated with anxiety to improve with overall life satisfaction and functioning (Province of British Columbia, 2020). Research indicates that the main goals of EASE are to help students recognize healthy and unhealthy thinking, build confidence when facing a challenge, and learn relaxation techniques to control negative emotions and build strength. British Columbian educators have access to these cognitive behavior seminars through professional development workshops offered by EASE (Province of British Columbia et al., 2020).

Although EASE was not designed to specifically target students who have endured ACEs to build a capacity for resilience, anxiety in some cases can be attributed to ACEs; therefore, the CBT approach of EASE can help those with ACEs as well. What is interesting here, is that the protective factor of a child advocate alone such as a teacher who supports those that have endured ACEs through practical neuroscientific supports (that are found in EASE) can help one who has endured ACEs build a greater capacity for resilience. This indicates that building a resilience capacity among those that have endured ACEs can be facilitated by teachers.

Trauma Informed Practice: Body-Mind based Therapy

Research indicates that narrative focus when coupled with CBT helps those that have dissociative disorders, PTSD and PTSD subtypes. However, symptomatology of these disorders is consistent with numbness to feelings and can onset visceral effect to one's body so that psychological pain from a traumatic experience can become trapped in the body which can result in physiological pains (Grabbe 2018, p. 78). Research indicates that there is a rationale for body-based therapy as a trauma informed practice to help build resilience among those that have endured ACEs. Findings indicate that a Trauma Resilience Model (TRM) resulting from ACEs supports somatic therapies, specifically, "TRM teaches the biology of trauma responses and the practice of emotion regulation through biologically based skills. Neuroscience theory supports somatic awareness models. TRM addresses trauma processing in a gentle and invitational manner and is a novel departure from existing therapies" (Grabbe et al., 2018). Understanding body-based therapies, specifically somatic therapy as a trauma informed practice indicates that building a resilience capacity because of ACEs can be beneficial for those suffering from dissociative disorders, PTSD and PTSD subtypes as their symptomatology is consistent with the supports found in Somatic Therapy (Grabbe et al., 2018). These research findings also highlight the complexities of trauma that one may have experienced because of ACEs and indicates that other therapeutic modalities may also serve as a beneficial trauma informed practice.

Research suggests that Accelerated Experiential Dynamic Psychotherapy (AEDP) may also help those who are suffering from dissociative disorders, PTSD, and PTSD subtypes because of ACEs by building a greater resilience capacity. What appears to be evident in AEDP is the specific work done on 'part differentiation' through the experiential navigation of traumatic events (Markin 2018, p. 213-220). Helping the client build greater resilience capacity through ACEs is done through the healing of very specific wounds, typically at an early age, that has interrupted healthy development through the imposition of traumatic narrative or events that

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continue to arrest the client's development of becoming him or herself and as a result has created insecure attachments (Markin et al., 2018). AEDP uses the 'part of the *self*' to help the client bring awareness to the painful event without overwhelming the client; however, this awareness is where the healing begins (Markin et al., 2018). Yet, what is consistent with research reviewed, is that for the client to begin to create positive cognitive affect, the client must have a deep feeling of connectedness and safety to the therapist or the supportive adult (Grabbe et al., 2018; Markin et al., 2018).

Based on the research I have conducted there appears to be a strong correlation between building a capacity of resilience among those who have endured ACEs and a trauma informed practice. Also, there appears to be specific needs of those who have psychopathological onset of dissociative disorders, PTSD and PTSD subtypes because of ACEs. Narrative focus through CBT, somatic therapy as well as experiential navigation in AEDP to the deep wounded part that has created insecure attachment (s) as a means of trauma informed practice is essential for building resilience capacity among those who suffer from PTSD and PTSD subtypes because of ACEs. However, what is also a continuing theme is the impact that protective factors have on building resilience capacity among those that have endured ACEs. It appears that protective factors and trauma informed practice work together to help build resilience capacity among those that have endured ACEs as indicated in the EASE program.

Building Emotional Safety in Relationships

Dr. Carl Rogers the father of Person-Centered Therapy indicated that connected and safe relationships are,

characterized by a sort of transparency in which my feelings are evident; by an acceptance of this person as a separate person with value in his own right; and by a deep empathetic understanding which enables me to see his private world through his eyes. When these conditions are achieved, I become a companion to my client, accompanying him in the frightening

search for himself, which he now feels free to undertake (Rogers, 1967, p. 34.).

Research supports Rogers in that connection between client and therapist must be transparent otherwise the navigation of the self becomes unsafe for the client. If the client feels the relationship is unsafe the defensive nature which has protected the client for potentially years of systematic abuse because of ACEs is likely to take effect (Schomarker 2015, p. 491-498). Research indicates that clients who suffer from insecure attachments fear being judged, unheard and misunderstood when discussing their concerns with psychotherapists. Therefore, it appears that healthy navigation with your client must incorporate a safe and vulnerable environment free of implicit or explicit judgements to build greater resilience capacity (Schomarker et al., 2015; Pinto 2019, p. 1-12).

Knight indicates that when the brain feels safe it is receptive to new information; however, if the brain feels unsafe the reptilian portion of our brain becomes over-stimulated and becomes primitive in its receptiveness as the focus is on survival. If trauma has occurred at a young age self preservation may become the primary basis of our responsiveness when we feel threatened even as we progress into maturity (Knight 2017, p. 1047). Research also indicates that emotional connectedness with this client helps strengthen secure attachments. The defensive and insecure attached client can often become hostile; however, it is within our capacity as counsellors to remain emotionally connected with the client despite his or her hostilities that helps create safety and safety is a foundational property of secure attachment (Knight et al., 2017; Yusof 2016, p. 59).

Clinical Psychologist Dr. Erik Erikson indicates that humans develop through eight different stages, the first being Basic Trust Vs. Mistrust. If basic trust is not given to the human there will be psychopathological consequences to his or her development, insecure attachment (s) being a primary example. Therefore, because hope and trust are linked to Erikson's stages

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of healthy development, the therapist must ensure that hope and trust remain central to the client therapist relationship or risk losing the safety of your client (Knight et al., 2017).

It appears trauma informed practices when considering which counselling modality must implement elements of Person-Centered Therapy into their practice. Client receptiveness and feeling connected appears to only take place when the client feels safe; therefore, practicing CBT, Somatic Therapy, or AEDP without the safety of your client impacts their ability to become resilient.

Limitations of ACEs

Based on the research conducted there appears to be an overrepresentation of white women who have a history of physical or mental health concerns because of ACEs in the data. To get a better representation of how protective factors and trauma informed practice impact and influence resilience among those that have endured ACEs, population groups in studies conducted need to diversify cultural and gender groupings. Research indicates that,

(1) resilience is not as much an individual construct as it is a quality of the environment and its capacity to facilitate growth, (2) resilience looks both the same and different within and between populations, with the mechanisms that predict positive growth sensitive to individual, contextual, and cultural variation, (3) the impact that any single factor has on resilience differs by the amount of risk exposure, with the mechanisms that protect against the impact of trauma showing contextual and cultural specificity for particular individuals ” (Unger 2013, p. 262-263)

Although ACEs are represented on a global scale the implications of how protective factors interact with trauma informed practice as a means of building resilience capacity among those that have endured ACEs are relative to risk exposure and research indicates that this varies between cultural groups. Data between various cultural and gender protective factors would need to be cross examined with various cultural and gender trauma informed practices and should be compared against each other to show levels of significance when measuring resilience among those that have endured ACEs. Nevertheless, it appears that data indicates that protective factors, specifically the role of a supportive adult, has a positive impact on

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building resilience capacity among white women who have physical or mental health concerns because of ACEs. Also, it appears that trauma informed practices also help build a greater resilience capacity among white women who have physical or mental health concerns because of ACEs. Lastly, protective factors, specifically the role of a supportive adult, when utilizing appropriate trauma informed practices and coupled with a Person-Centered therapeutic lens, can help build resilience among white women who have physical or mental health concerns because of ACEs, specifically those that are suffering from dissociative disorders PTSD and PTSD subtypes. Data also indicates that if one has endured four or more ACEs and if sexual abuse is one of these ACEs there is a greater risk factor for that persons physical or mental health. However, due to the over representation of white women in the data reviewed further analysis would need to be conducted to verify their significance that four or more ACEs has on a person and the extent that sexual abuse has across varying gender and cultural data sets.

Chapter 3: Summary, Recommendations and Conclusion

Summary

As indicated throughout this paper the complications of ACEs have a profound impact on students and on their continued development into maturity. Student functioning due to ACEs coincides with peer victimization, suicide and suicide ideation, violence, and weapons usage, drop-out and worsening of depression and anxiety symptomology. As these students leave high school life continues to compound the negative impacts that ACEs have on the individual. If a student does not complete high school that person is at greater risk of residing in a low-socioeconomic neighbourhood. If that neighbourhood does not have the amenities to help support the emotional/social as well as the physical wellbeing of the individual who has endured ACEs, specifically more than four ACEs that individual is at a high risk of developing chronic health related concerns in later life. Also, like in high school the lingering impacts of depression and anxiety worsen over time and continue to impact the person who has endured ACEs.

Research indicates that Non-Suicidal Self Injury (NSSI) and suicidality continue past high school among those impacted by ACEs and if the trauma goes unresolved one is at risk of PTSD, complex PTSD and a dissociative type of PTSD which is commonly found among the homeless population. Nevertheless, what was also consistent throughout literature was the positive impact that protective factors, specifically individuals who utilize trauma informed care and practice to build resilience among those that have endured ACEs. It appears that even if one has endured a horrific childhood riddled with complex adversities this person has the potential to build a resilience capacity that will lift him or her out of a life of intergenerational trauma impacted by ACEs. Research indicates that an environment which embodies safety and connectedness to the specific needs of the individual and is facilitated through the lens of trauma informed care and practice can impact resilience among those that have endured ACEs (Frewen et al., 2019; Cloitre et al., 2019; Metzler, et al., 2017).

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Understanding the complications of ACEs and the impact and influences they have on those affected may help us as educators be empathetic to these students' varying and diverse needs. Understanding how protective factors and trauma informed care and practice impact those that have endured ACEs may help give us insight into how we may begin to address childhood trauma among our student population. However, how we implement practices which aim to address the varying needs of ACEs in our schools also needs to be considered when looking at students functioning as empathy and insight alone is not enough to impact a student's resilience. In this chapter I will discuss recommendations that I have that highlight how we as educators can affect the trajectory of our students who have been impacted by ACEs by creating trauma informed programs that target the specific needs of those impacted by ACEs to help them build a greater resilience capacity. Specific reference will be given to the disposition of those that aim to facilitate programs of safety and connectedness for affected students as well as key factors of consideration when creating and establishing these programs.

Recommendations

My experiences as a Case Manager of at-risk youth have helped me arrive at many different conclusions on what constitute best practice with both program creation and individual connection. One of the most pressing and consistent experiences with my students is the projections they place on me because of their traumatic past. Many of my students have complicated and diverse insecure attachments stemming from their childhoods and as a result will often displace their anger and frustrations with circumstances onto me. As I hold space for my students' dysregulation and projections the bonds of safety begin to form through the establishment of trust. This trust often forms into a reliance on me due to their emotional immaturity, but a shift nevertheless occurs as I open spaces for navigation without judgement, honesty and kindness, compassion and attunement of the heart, and the beginnings of authentic healing. It is my opinion that creating an environment that permits safety for my students coincides with my own cognitive differentiation and maturity. If the case manager is

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unable to detach from projections or aims to create solutions to problems the students are going through from the lens that “If I work hard enough or smart enough, I can *fix* the student,” the case manager will burn out or create extrinsic change as effective practice should not center on fixing but rather healing. From my experience if the case manager focuses on fixing or becomes too rigid and focuses on solutions one or two things will happen, one, the case manager will burn out as *fixing* students’ problem are endless and the desire to fix likely has more to do with the case manager than the student, or two, creates an artificial space that does well to create extrinsic change but does not evoke intrinsic evaluative change. In short, the differentiated self in conjunction with a mentality that seeks to *heal* through experiential trauma navigation and connectedness through attunement to the heart of the student are vital to the disposition of one who seeks to create a program that helps the diverse needs of those that struggle with the effects of ACEs in schools.

Countertransference

The experiences of healing others that have been victim to horrendous traumatic events can be an emotionally draining but equally rewarding journey. An attuned connection to another's heart as they experience what it feels like to be themselves for the first time can elicit excitement and powerful response. My caution with this experience also comes with recommendation as it concerns the disposition of counsellor and/or program facilitator for those that have endured ACEs. As we enter that intimate space in therapy where the client begins to challenge him or herself and confronts the trauma that exists within that experience, such a navigation can be challenging for the client but can also be challenging for the clinician. This dynamic experience has the potential to impact certain levels of countertransference if the clinician has not permitted him or herself to examine parts of themselves that become responsive in session. Research indicates that,

given the inherent vulnerability that comes with disclosing one’s personal struggles, it makes sense that a therapist would remain silent about how their woundedness may be impacting the

countertransference and treatment of their client(s). It is important that we, as a community of mental health professionals, try to encourage openness and support, rather than silence and avoidance amongst our own, which contribute to relapse, continued dysfunction, and the failure to recover from various traumas and mental health issues. (Cuseglio 2021, p. 42).

In my opinion, healers we need to be mindful of what is impacting us as essentially this affects not only our personal wellness but also those that we aim to support. Therefore, the disposition of one who works with at-risk and extremely vulnerable youth who have endured trauma because of ACEs needs to evaluate oneself prior to program facilitation. Essentially, unresolved, or fused experiences can elicit countertransference which can have a negative impact on student functioning especially those that have endured ACEs. Therefore, I feel that as a matter of process counsellors and/or program facilitators of ACE programs in schools would do well to seek therapy as a means of self-care but also as a means of keeping the experience with the at-risk student client centered.

Program Creation

I have worked at WJ Mouat Secondary now for five years as the Intensive Behavior/Mental Health Case Manager. In those five years I have noticed extensive change in the baseline behavior of my students. When I started, I experienced far more externalizing behaviors and my advocacy at that time, though student-centered was far more focused on student functioning in the way of positive reinforcement and encouragement. This method had some success and my motivations appeared to establish trust and a permission to advocate for students needs; however, this connection lacked depth to student experience and students' behaviors would often continue to escalate and worsen over time. Despite several care team meetings and interventions with outside agencies, the retention of my students during my first three years was significant, specifically with the students who presented more externalized behaviors. The greatest change that I noticed with retention and student functioning came when I allowed myself to hold space for my student's dysregulation and began to support the student

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in his or her experience and allowed the student to *be*, which then gave more space for therapeutic interventions and/or a relational dialog that allowed me into some of their painful experiences. When I was able to meet the students in their place of pain authentic trust began to form and slowly the retention of my students and their functioning, specifically graduation increase and reduction of externalizing behavior resulting in drop-out, removal and suicidality, have begun to emerge.

From my perspective creating an environment that evokes emotive change to one's baseline behavior has less to do with the program and more to do with the process. The dynamic nature in which students present their needs is anything but rigid and therefore, I feel that to create a program that helps student functioning because of ACEs one needs to be mindful of what that need looks like for each student and how I can gain access to that vulnerable place inside each student's heart that aches for connectedness and belonging. However, what is consistent with research is that core to each program are three major themes: strengthen interpersonal relationships and social and emotional skills, support students' physical and mental health needs and reduce practices that may cause traumatic stress or retraumatize students. Adaptive functioning through developing stronger capacity for interpersonal and emotive skills can help students build resilience even if they have endured extensive ACEs. Trauma informed care which also supports one's physical health through getting access to medical clinics for basic and or complex needs stemming from ACEs helps the student feel safer and supported. Students that have endured ACEs are also at-risk of being traumatized by school-based decisions. Teachers, administrators, school counsellors, and educational support staff must be mindful of disciplinary action or punitive measures imposed on students because of their behaviors. According to research punitive measures can result in lack of access to resources that support the student's safety; therefore, I propose that harm reduction measures are considered first before punitive measures are imposed on a student as this action may

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compound the effects of ACEs and may retraumatize our most at-risk students (Murphy 2019, p. 10; Mann et al., 2015, p. 117; Bethell et al., 2014).

When considering the make up of a connection-based program for at-risk students you must consider all facets of the school, specifically the influence that your administrative team has with your program as without their support the sustainability of such a program will be greatly diminished. An ongoing dialog must be present between the school counsellor and/or program facilitator and school administration. I meet with my school administration once a month to discuss success and constructive feedback concerning my program and this relationship though strained at times is honest and helps me support my students in the capacity that coincides with the direction of the school and my students needs. As a program facilitator you must become an expert in relational dialog with not only your students but also the supporting cast of your school. A connection-based program for at-risk students cannot function on a school level without the support of your administration; therefore, program facilitators should be advised on how to integrate communication for students' success with administrators on an ongoing basis.

To create an inclusive program and not an 'island' that gently blends student functioning to a more supportive experience, conversations with teachers as well as support staff also needs to be ongoing. Students are essentially enrolled in classes so it is equally essential that the program facilitator have ongoing discussions with teaching staff as bridging the connection between connection-based program and classroom will be essential for student functioning. I have noticed that when conversations with teachers and educational support staff are open and ongoing, I tend to have more success in my program, students tend to function with more resilience in the classroom and teachers and educational support staff become more curious to the program I am creating and begin to show interest in how they could support or participate.

Dialectical Behaviour Therapy Group

Dialectical Behavior Therapy (DBT) is a branch of Cognitive Behavior Therapy (CBT) that focuses on mindfulness and the more immediate processing of one's feelings. CBT focus is concentrated on the interruption of automatic negative thoughts and has often been used as a modality for individual and group counselling. However, given the nature and extent of trauma my students have endured in their lives the disruption of negative thoughts may not be enough to impact my student's self regulation as a lasting method of intervention. "mindfulness-based treatments were developed specifically to overcome the shortcomings of Cognitive Behavioral Therapy (CBT) in meeting the needs of particular clinical populations. Marsha Linehan developed Dialectical Behavior Therapy (DBT) for women with borderline personality disorder and suicidality" (Jennings 2014, p. 2).

A part of the DBT sessions centers around Reality and Radical Acceptance. Helping my students identify situations and/or experiences that are out of their control to change has proven to have a positive impact on students who are suffering from PTSD (which many of my students struggle with). "Trauma-related emotions and radical acceptance showed significant changes from the start to the end of DBT-PTSD...shame, guilt, disgust, distress, and fear decreased significantly from the start to the end of the therapy whereas radical acceptance increased" (Görg 2017, p. 9).

DBT is a psychodynamic type of therapy that can have an impact on an audience broader than those that suffer from borderline personality disorder and suicidality. The mindfulness concentration that DBT offers has also shown to be highly effective in treating those that suffer from clinical depression and anxiety. Findings from a study that evaluated DBT's effectiveness on depressed and anxious patients in partial hospitals indicated that, "mindfulness acquisition accounted for significant proportions of the variance in symptom reduction for depression and anxiety" (Kirk 2019, p. 1169).

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Based on the similarities of needs that my students have and the corresponding data that indicates that DBT is highly effective for addressing those needs I feel that the creation of a DBT group would benefit my students at W.J Mouat Secondary. My primary objective is to decrease students' suicidality and intrusive process by strengthening my students' capacity of resilience. The following is a breakdown of seven sessions I have created that seem to work well for my students. Due to the nature of group therapy and my own experience, you should allow for flexibility within your group work and if your students are continuing to process from previous sessions continue to explore with them until a transition emerges which allows you to move into your next session. I have found that allowing time for extensive processing and evaluation produces a richer therapeutic experience.

Session 1: Building Safe Relationships

Objective/Purpose: To create a safe and inclusive classroom that invites deep reflection and vulnerability students need to feel safe and supported. Building relationships and connectedness will be key for helping sustain vulnerable and deeper processing of the self.

- 1) **Ice Breaker:** 2 truths and a lie.
- 2) **Introduction of DBT, Limits of Confidentiality (will be done in each session), creating a safe classroom (the rules)**
- 3) **Getting to know each other exercise:**
 - Favorite food and/or movie.
 - Interesting fact about themselves.
 - What student needs to feel safe and supported.
- 4) **Summary of Session and student feedback:** feedback 2 stars and a wish.

Session 2: Implicit to Explicit

Objective/Purpose: Help students to reframe language to access the feeling orientation of their process. Helping students move from implicit to explicit language increases self-

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regulation allows for deeper self-exploration and can increase objectivity. Reframing language this way will help the group connect deeper and will invite more vulnerability and connectedness which could also allow for deep reflective experience.

- 1) **Ice Breaker:** Dream Vacation.
- 2) **Tell me a time when you felt unheard.**
- 3) **Implicit to explicit:**
 - What does it feel like to be noticed by a friend?
 - How to navigate deeper process by noticing our implicit language
 - Mindfulness. Transforming our language from implicit to Explicit.
- 4) **Summary of Session and student feedback:** feedback 2 stars and a wish.

Session 3: Middle Path/Wisemind

Objective/Purpose: Help students navigate logical centers in their brain when feeling overwhelmed and put structures in place for them to prevent states of emotional dysregulation.

- 1) **Ice Breaker:** Superpower. What Superpower you would want to have and why.
- 2) **Tell me about a time when you felt overwhelmed.**
- 3) **Self Regulation Exercise:**
 - Discuss emotional dysregulation and cognitive process
 - Students create a 1-week schedule: include 1 ritual when awake, 1 exercise, 1 outdoor activity, 1 school-based work and making at least 1 meal throughout.
 - Students are to be notified that the schedule is not meant to be a pass or fail exercise only as a mindful exercise to help them notice if it helped improve emotional dysregulation.
- 4) **Summary of Session and student feedback:** feedback 2 stars and a wish.

Session 4: Reality & Radical Acceptance

Objective/Purpose: Help students notice that avoiding reality does not change reality but only hurt them. Help students accept that some things are not in their control to decrease anxieties around conflict management.

- 1) **Ice Breaker:** Something or someone you are grateful for (noticing gratefulness)
- 2) **Reality Acceptance:** 5 ways of conflict management
- 3) **Radical Acceptance:**
 - Have students place themselves in the place of their past, present, or ongoing conflict and tell me what they notice about themselves as they are managing the conflict.
 - Share personal story of conflict and acceptance
 - **Self- inquiry question:** What would you need to tell yourself to accept that some things are out of your control to change?
- 4) **Summary of Session and student feedback:** feedback 2 stars and a wish.

Session 5: Distress Tolerance

Objective/Purpose: Students will build skills on how to cope with distress and pain.
Emotional crisis management skill building.

- 1) **Ice Breaker:** Zombie apocalypse, 3 people you would bring and why.
- 2) **Distress & Pain:** Unavoidable (give example). If not dealt with you may act impulsively and when you act impulsively you could hurt yourself or others.
- 3) **Distress Tolerance Skills (ACCEPTS):** Activities, Contributing, Comparisons, Emotions, Push-Away, Thoughts, Sensations. Give examples for each and then have the students identify understanding of skill by sharing their own interpretation of the ACCEPTS model.
- 4) **Summary of Session and student feedback:** feedback 2 stars and a wish.

Session 6: Emotional Regulation

Objective/Purpose: Help students notice and understand the emotions they experience to reduce emotional vulnerability and stop unwanted emotions from starting in the first place.

- 1) **Ice Breaker:** Favorite dessert and/or holiday
- 2) **Emotional to Behaviour Responsiveness:** Discuss how emotional responsiveness impacts behavior: Life event---thoughts---feeling orientation---Behavior
- 3) **Emotional Regulation:**
 - Faulty thinking discussion
 - Using previously discussed skills such as mindfulness, distress tolerance, radical acceptance once you have noticed your faulty thinking to emotionally regulate (give example) then have students share their idea voluntarily.
- 4) **Summary of Session and student feedback:** feedback 2 stars and a wish.

Session 7: Student lead recap of DBT Skills and Knowledge Acquired

Objective/Purpose: Help students cement their skills and knowledge of DBT to empower and support them in their learning and processing.

- 1) **Ice Breaker:** If I had no money restrictions what I would buy and why.
- 2) **Recap of Sessions:** Student lead Recap of skills learned (voluntary share out). Hope here is to ping-pong student's knowledge acquisition between each other to further understanding. Facilitator will act as a guide only and to hold space for students in their vulnerability.
- 3) **Summary of Session and student feedback:** feedback 2 stars and a wish.

The high-risk nature of my students and their psychopathology requires a deep connection between counsellor and student. Creating a safe room free from all judgements but open to students' individual process requires a sustained effort in relationship and rapport building. Once trust has been established this is the time to start developing skills that connect to students' needs. DBT skill development, as indicated through research, helps to support

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students who struggle with borderline personality tendencies (tendencies in this case as students are not of age to be diagnosed with a personality disorder) history of suicidality, history of unresolved trauma, depression, and anxiety. Emotional regulation, middle path/wisemind, transformative language from implicit to explicit, reality and radical acceptance, and distress tolerance serve as tools to support mindfulness which is key to interrupting the vegetative state of the trauma victim and gives students the skills to identify and cope with intrusive process. The hope here is to decrease the risk of suicidality and increase the student's capacity for resilience.

Concluding Thoughts

We as healers have such a wonderful opportunity to connect with our vulnerable students in the schools we serve. The research surrounding ACEs and their impacts surrounding student functioning gives me great hope that the work we aim to do can have a profoundly positive impact on students' developmental processes. Our students come to us with deep woundedness and defensiveness but what is amazing to see is that even if that wound or defensive part runs deep, perhaps to an early childhood experience (s) the student still has a longing to connect to be validated and to be heard. The bravery of these students is astounding and consider it such an honour and privilege to navigate their experiences. It is such a joy to be allowed to that space when a student begins to open about their lived experiences both internally and externally. I have witnessed moments of students' resilience that continue to remind me that change is possible, and that having hope is not foolish or naive. Cultivating hope through connected based programs for students who have endured ACEs has been a reminder that when one continues to evaluate him or herself and then seeks to support others through authentic care the life of a child can transform.

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