AWARENESS AND PREVALENCE OF CHILDREN OF PARENTS DIAGNOSED WITH MENTAL ILLNESS.

Andréa Hanson

A Capstone Project submitted in partial fulfillment of the Requirements for the Master of Science Degree in Counselor Education at Winona State University

Fall 2010
Abstract

Although the mechanisms through which parental mental illness influences children's mental health and development are not always clearly understood, the presence of the association is well documented. However, the use of such evidence to generate policy and planning strategies aimed at reducing the burden carried by these children has been limited. Also, as it is estimated that only half of the burden of mental disorders can be reduced through currently available treatment modalities, this author will discuss the prevalence and helpful strategies for mental health professionals to work with these children.
## Contents

Introduction .........................................................................................................................1

Review of Literature ............................................................................................................4

  Parents with Mental Illness .............................................................................................4

  Effects of Parental Mental Illness on Children ...............................................................5

  Parents with Mental Illness and the Child Protection System .........................................7

  Intervention Strategies ....................................................................................................9

  What Do These Young People Need? ............................................................................10

  A Practical Tool for Children .........................................................................................14

Discussion ..........................................................................................................................16

References ...........................................................................................................................18

Appendix A ........................................................................................................................21
Introduction

Children of parents with mental illness (MI) are shown to have higher mortality rates, as well as an increased risk of developing a wide range of mental and addictive disorders (Weitoft G.R., Hjern A., Haglund B., Rosen M., 2003). Estimates suggest that 26% of adults 18 and over experience a diagnosable mental health disorder each year (Kessler, Chiu, Demler, & Walters, 2005), and that between 21% and 23% of children may live in families where at least one parent has a mental illness (Maybery, Ruepert, & Goodyear, 2006). Prevention programs and policies that have been developed to target these children are effective and it is known that many of these youngsters can do reasonably well with appropriate support, but without a clear understanding of the size of this population and its demographics, efforts aimed at improving their situation or limiting their exposure are seriously restricted.

There is a significant body of literature demonstrating that exposure to parental psychopathology puts children at risk of untoward outcomes. For example, children of parents with either depression, schizophrenia, or substance abuse or dependence, are at higher risk of developing the same respective condition as the parent (Beardslee W., Versage E., Gladstone T., 1998). Non-substance related psychopathologies are also more common among children of substance abusers (Clark D.B., Cornelius J., Wood D.S., Vanyukov, 2004). Similarly, children of parents with anxiety, substance use, and eating-disorders are at higher risk for psychopathology (Ramchandani P., Stein A., 2003). Parental depression is also associated with impaired development, behavior, physical health and higher health service use (Olfson M., Marcus S.C., Druss B., Alan Pincus H., Weissman M.M., 2003). Injuries are also more frequent among children of mothers with mental health problems. Poor development outcomes are four to six
times more likely among children of families affected by parental mental illness (Nicholson, Cooper, Freed, & Isaacs, 2008).

Many factors may explain the risk, including genetic inheritance, parenting quality, patterns of stimulation, relationship factors and other adverse experiences (Weissman M.M., Wickramaratne P., 2005). Compounding the situation further are single parent families where the guardian suffers from a MI or substance abuse, or families where both parents have a history of psychiatric disorders (Essex M.J., Kraemer H.C., Armstrong J.M., Boyce W.T., Goldsmith H.H., Klein M.H., Woodward H., Kupfer D.J., 2006). In these scenarios, the children are at an even greater risk of MI, substance abuse, death due to suicide, or drug overdose, as compared to children from two-parent families where only one parent experiences MI (Weitoft G.R., Hjern A., Haglund B., Rosen M., 2003).

Despite significant documentation of these detrimental associations, and interventions aimed at their prevention, few studies have focused on quantifying the children at risk. In a US community-based sample of first-admission patients with diagnoses of Schizophrenia/Schizoaffective Disorder, Bipolar Disorder with Psychotic Features, and Major Depressive Disorder with Psychosis, it was estimated that almost one third of first-admission psychiatric patients were parents (Craig T., Bromet E.J., 2004). In Australia, between 29% and 35% of female mental health service users are parents of children under 18, and 70% of children living with MI parents were under 6 years of age, suggesting that a large proportion of patients receiving mental health services are in fact parents (Weissman M.M., Wickramaratne P., 2005).

It should be noted, that of the few studies looking at the population of at-risk children, the vast majority have focused only on data from parents in treatment settings. It is highly important
to identify the children and to be able to reach them at a young age in order to prevent further problems related to the MI to take its effect.

The implementation of child mental health prevention programs requires that policy makers and practitioners become attentive to the large divergence between what is known and what is currently practiced. It has been suggested that in order to strengthen the link between research and practice in children's mental health, clearer strategic planning around prevention needs to be developed. As strategic planning requires characterization of the target population, adult patients under psychiatric intake should at least be asked whether they have children. Once it is identified that they are indeed parents, practitioners can identify programming in which these children can participate. Furthermore, it should be noted that even if this strategy were adopted, children of parents who do not seek treatment, and who therefore may be at greater risk, would fall through the cracks.
Review of Literature

Parents with mental illness.

In reality, women with mental illness are equally as likely to have children as women without mental illness (Ackerson, 2003; Nicholson and Biebel, 2002; Oyserman & Mowbray, 1994; Nicholson & Branch, 1994 and Oyserman et al, 2002). Many women choose to be parents and do not see their mental illnesses as blocking that ability. Mentally ill women who parent function better than women who do not parent but receive the same level of mental health care. However, very little research has addressed the parenting needs and development of parenting competencies for mentally ill parents. They are also at greater risk for losing custody of their children (Ackerson, 2003). Many social service agencies are more likely to remove a child from the home of a mentally ill parent while they seek treatment, as opposed to providing a well rounded prevention and family treatment program. Mental illness does not only impact the individual, but also affects family members, particularly children. Epidemiological studies have shown that up to 23% of all families have, or have had, at least one parent with a mental illness (Mayberry et al., 2009). Mental illness impacts parenting: for example Oyserman et al, (2005) found that parents who have mental illness offer less sensitive and competent parenting than other parents. These parents spend the majority of their time dealing with their illness as opposed to providing day to day care of their children. With training and parenting coaching this could be prevented.

When in treatment, mentally ill mothers are expected to fit into the male focused treatment paradigms. The system does not treat them as parents and ignores this aspect of their lives and personhood. A national survey by Nicholson and Branch (1994) found that only two
states included parenting needs in their assessments of adults with mental illness. Though this may have improved some over the last ten years, no current research is available to check for progress in this area. Nicholson and Branch (1994) also identified a huge gap in programming for mentally ill mothers. They are not given education on development or reproductive issues. Some treatment programs go so far as to discourage mentally ill women from having children due the misconception they cannot possibly parent adequately.

**Effects of parental mental illness on children.**

Despite the lack of research and treatment options for mothers with mental illness, several past studies have looked at how parental mental illness might lead to child pathology. Some studies suggest mental illness can and does have a profound effect on children. Generally, children of parents with mental illness may have more behavior problems and lessened cognitive, social and attention performance. They also have a greater risk for mental health problems. As suggested by Reupert and Meyberry (2007), families affected by mental illness may be particularly at risk as a result of associated poverty, social isolation, and marital conflict. Symptoms associated with mental illness among parents can result in implications for self esteem among young children. Research has clarified that the impact of mental illness on parenting skills is associated with the severity of psychiatric symptoms and the amount of community support rather than a specific diagnostic category (Mowbray, Oyerson, Bybee, & MacFarlane, 2002). Abusive parents tend to have greater psychopathology, and researchers have found a link between mood disorders and child maltreatment. In a study of child abuse cases, 52.4% listed mental illness of one or both parents as a risk factor (Mayberry et al., 2009). All of these findings indicate the presence of psychopathology provides a better predictor of problems than a simple diagnosis.
The parenting problems of mentally ill parents also differ by both the diagnosis and severity and chronicity of the illness. Depressed mothers have a higher rate of filicide and neonaticide. They also tend “to be more negative, less encouraging and more punitive in their parenting.” (Oyserman, Bybee, Mowbray & MacFarlane, 2002). Anxiety disorders, antisocial behavior, personality disorder and dissociative symptomology are more common among parents who abuse their children (Mayberry et al., 2009). Children of bipolar parents tend to have greater incidences of affective disturbance than parents without or with other mental illnesses. In all cases, the negative effects vary by the severity and chronicity of the illness, with increased relapses and severity of symptoms correlated with greater problems for the children (Oyserman, Bybee, Mowbray & MacFarlane, 2002).

However, more recent studies claim the effects of parental mental illness on children are less definitive and mitigated by several other factors. Oyserman, Bybee, Mowbray and MacFarlane (2002) found many women with mental illness are able to parent their children effectively. However, in this study, they did identify mental illness as a significant risk factor for children. There is an increased risk for sexual and physical abuse for children with mentally ill parents. However, it remains unclear whether this risk is due to parents committing such abuse or due to the increased vulnerability of a child whose parents are not as attentive to his or her needs. Several factors mediate this risk including the presence of a caregiver without mental illness, the severity of the illness and/or presence of a support network. In fact, the majority of children of parents with mental illness in this study (52.5%) did not have any issues with abuse or neglect (Mayberry et al., 2009).

The risk of parenting for mentally ill parents may be attributable to other factors such as poverty, low educational attainment and lack of social supports. No causal links have been
established, though all of these factors are linked to maternal mental illness in general (Horowitz and Garber, 2006). One cannot make an automatic assumption that mental illness leads to poor parenting or children at risk. Previous research suggests a particular diagnosis or the presence of psychopathology may predict outcomes for the health and well-being of children. The interaction between parenting and a particular diagnosis proves complex. One cannot make a cause and effect hypothesis of how one does or not affect the other. Mental illness and parenting must be seen from a multi-factorial perspective analyzing both additional risk and protective factors that add or detract from a mentally ill parent’s quality of parenting (Horowitz and Garber, 2006). If most children of a parent with mental illness do not suffer from abuse or pathology, then a diagnosis or psychopathology alone cannot be seen as leading to problems for children. Research needs to expand its scope to focus more on what those additional protective and risk factors are and how to best increase those protective factors and decrease the risk to best meet the needs of these parents.

Parents with mental illness and the child protection system.

Unfortunately, the child protection system does not operate from the perspective described above. In many states, a diagnosis of parental mental illness in a child protection matter puts the case on a faster track for the termination of parental rights (Ackerson, 2003). Incompetent parenting attributed to mental illness proves one of the most common grounds for termination of parental rights (Ackerson, 2003). Those involved in the child protection system tend to have biases assuming the lack of parenting competency and potential for change with parents who have a mental illness despite ample research suggesting otherwise. Child protection workers tend to be under trained in the area of mental health and thus seek guidance elsewhere (Jacobsen, Miller & Kirkwood, 1997; Ackerson, 2003). They send parents to mental health
professionals who have little or no training in the area of child protection (Budd, Poindexter, Felix & Naik-Polan, 2001). The lack of coordination and understanding between mental health professionals and child protection personnel can have dire consequences for parents with mental illness. They may not be assessed appropriately for the risk factors that got them into the system. They may lose their children due to treatment plans not meeting their actual needs or a treatment system not set-up to address their parenting issues (Budd, Poindexter, Felix & Naik-Polan, 2001). Children of parents with mental illnesses are at risk on several levels. Some may experience the negative consequences described above due to the effects of their parent’s mental illness. Others may end up in out-of-placement due to maltreatment or neglect issues with their caregiver’s mental illness as a contributing factor. The lack of effective assessments, treatment and coordination of services may block the children’s return to their homes. The primary goal is safety of the child. In cases where the factors leading to the child protection, the system often refers parents to the mental health system for assessments of their parenting competency. However, the assessments done in the mental health system rarely address actual parenting ability (Ackerson, 2003). Instead, they focus on personality, intelligence and academic functioning (Budd, Poindexter, Felix & Naik-Polan, 2001). Research does not indicate that any of these factors actually affect quality of parenting for a mentally ill parent. Children are then removed from the home of the mentally ill parent. A more proactive solution would be to implement intervention for these children to be able to thrive in the home environment with the mentally ill parent. Unfortunately the focus is on specific parenting needs and they are compared with optimal parental functioning rather than a competent or minimally acceptable level of skill (Ackerson, 2003). Few parents operate at an optimal level most of the time, and a more reasonable measure would assess for minimum parent functioning. Existing assessments have
been developed according to white, middle class standards and do not allow for cultural or community differences in parenting standards and practices. Current assessments ignore the research suggesting the importance of contextual factors in parenting (Ackerson, 2003). Most importantly, none of these assessments are designed to address the specific issues that led to these parents getting into the child protection system (Ackerson, 2003).

**Intervention Strategies**

Programs designed for parents with a mental illness who have young children, hold considerable promise for improving children's life-course trajectories and for reducing health and development problems and associated costs to government and society. To date, this promise has not been achieved. Fulfilling the potential of parenting interventions will require substantial improvements in current practice for developing and testing such programs. Intervention development will be improved if clinicians and investigators ground parenting interventions in theory and epidemiology; and carefully pilot them to ascertain program feasibility, participant engagement, and behavioral change prior to testing them in randomized trials. Studies of parenting interventions will be improved if they adhere to the highest standards for randomization; if they examine objectively measured outcomes with clear public health relevance; and if they minimize selection factors known to compromise the analysis of data. Policy and practice recommendations for parenting interventions will be improved if they are based upon replicated randomized controlled trials, if the interventions are tested with different populations living in different contexts and if they are examined in dissemination studies before public investments are made in such programs. Procedures need to be developed to ensure that the essential elements of evidence-based parenting programs can be implemented reliably in a variety of practice settings so that they will produce their intended effects. To date, few programs
have met these high programmatic standards, with the result that many large-scale policy initiatives for at-risk parents have failed. Evidence is accumulating, however, that some programs delivered by professionals, especially nurse home visiting programs for pregnant women and parents of young children, produce replicable effects on children's health and mental development, and that these programs can be reliably reproduced with different populations living in a variety of community settings.

**What do these young people need?**

The current arrangement of most mental healthcare separates treatment of adults and children. Youth and adult providers often do not even know each other. The facilities may be geographically distant from one another. Funding sources and chains are often distinct. Collaboration of treatment for a family is rare. Sadly, this arrangement creates a gap in care and perpetuates the problem of minimal attention to the children of parents with mental health related concerns (Sherman, 2007).

Social workers and counselors, with skills in navigating complex systems, coordinating care among a wide range of providers, and empowering the underserved, are in a unique position to address this problem. Workers specializing in treating adults (such as in adult inpatient psychiatric units, Veterans Administration hospitals, day treatment programs) are challenged to open the dialogue with all their clients about this topic (Sherman, 2007). Asking about the challenges faced in parenting, the impact of the illness on their children, and what community support is available for the children can be extremely helpful.

In addition, workers primarily treating children are encouraged to assess this facet of the child’s experience. Remembering that one in five families has a member living with an MI, many children whom social workers and counselors serve have parents dealing with these issues
(Sherman, 2007). Assessing the impact of the parent’s illness on the youth and asking about other adults who can help when the parent is unable can be useful.

Children of parents with an MI need information, support, and hope. Counselors can see, hear, and support these young people in many important ways. According to Sherman (2007), the following are 10 concrete things that these youths need:

1. Reassurance that they’re not alone.

The experience of an MI in the family can be lonely and confusing. Regardless of the illness, all young people need to be reminded that they are not alone. Counselors can help to minimize this sense of isolation by establishing support groups for teens and families dealing with an MI. The opportunity to talk to other people who face similar situations can be comforting and healing.

2. Honest acknowledgement of the parent’s difficulties.

Some families avoid talking about the illness with the hope that this approach will be less stressful for the child. However, ignoring the proverbial “elephant in the room” creates even more problems. Even if the family and adults are trying to protect the children, young people may feel quite resentful, even years later. Therefore, it’s important to talk openly about various struggles that families face instead of perpetuating the secrecy and shame often surrounding mental illness.

3. Information about the illness.

People, children especially, fear what they do not understand. Kids need answers to questions like: “What is going on? Why is this happening to me? How can I make my parent better? Will I be like my parent some day?” Connecting with community resources, such as the National
Alliance on Mental Illness or the Depression and Bipolar Support Alliance, can increase awareness of support available for these families.

Counselors may host a family day or children’s program in which psycho-education is provided to family members. Counselors can talk about famous people who have mental illness. May, which is National Mental Health Month and October which includes Mental Health Awareness Week are especially good times to highlight these topics. Talking openly about these issues helps reduce the stigma and encourages young people to confide in helping caring adults.

4. To be told that they are not to blame.

Young people often blame themselves when problems arise in a family. It’s reassuring for children to be told they didn’t do anything wrong. Sending this message clearly and consistently can relieve considerable guilt and shame among teens.

5. To know that the parent loves them.

Reminding young people that their parent cares about them can be comforting. Sometimes, parents behave in rejecting ways that can be confusing and hurtful to children, or parents are so consumed with their own problems they’re unavailable for their kids. Explaining why parents act in confusing ways can help kids avoid taking the behavior personally. Further, encouraging children to consider that their parents are probably “doing the best they can” under the circumstances can be useful.

6. To be able to be kids.

Due to the family’s preoccupation with the parent, some youth are given excessive responsibilities such as childcare for younger siblings, household chores, and even managing the
parent’s behavior and medications. It’s important for kids to be able to get away from the heavy burdens at home and just have fun. A mentoring program can be helpful in this area.

7. Support in knowing how to deal with stigma and their friends.

Sadly, stigma continues to surround people living with mental illness. Often, people forget that this stigma extends to the person’s family as well, so the young people in the family often feel embarrassed and ashamed. For example, family and friends usually bring casseroles, send cards, and visit when someone has a physical health problem such as undergoing surgery; however, emotional problems typically evoke different responses from the community. Family and friends may make hurtful comments or may avoid the family, which further compounds the pain and grief for the youth.

Counselors can empower children and teens by providing education and support in dealing with friends. For example, counselors can role-play with teens about how to respond to friends’ unkind comments. Counselors can help teenagers weigh the pros and cons of talking about family problems with trustworthy friends.

8. Safe people to talk to.

These young people need support from healthy adults and teens in their extended family, community, school, and church. Research has clearly found that young people growing up in challenging family situations have better outcomes if they have one positive adult in their lives to support them along the way.

A counselor can be this important person. Counselors can be emotionally present and supportive to these youths and their families, providing a confidential, accepting environment. You can
listen to and validate teens’ emotional pain without judging them or rushing in to give advice. Making time to be available and providing a supportive, listening ear can be invaluable.

Although young people cannot fix their parents, they often want to be helpful. Counselors can brainstorm with teens about small, specific ways they can support their parent, such as by playing cards together, sending a kind e-mail, or cleaning his/her room without being asked.

It’s important for kids to know that situations probably won’t always feel as tough, and many effective treatments are available for their parent. Recovery from serious mental illness is possible.

   Despite the challenges involved in dealing with mental illness, facing difficulties can bring families closer together. Both parents and children may discover strengths, resilience, and courage in themselves and each other that never would have surfaced otherwise. Families can grow by communicating openly and supporting each other so that they can navigate future difficulties more effectively. It is critical for counselors to deliver age appropriate information regarding mental illness to children. Understanding changes in the behaviors of their parents may help children avoid blaming themselves or feeling rejected when their fathers or mothers symptoms are exacerbated. Psycho-educational programs can be very beneficial to this young population by educating the children about mental illness, improving self esteem, increasing coping skills, and creating additional supports.

**A practical tool for children.**

The use of a workbook can be very beneficial to gather and share information with children of parents with mental illness. Family Services of the North Shore developed a
workbook that can be used with children whose parents are diagnosed with a mental illness. They have worked with many families where a parent or family member had a mental illness. Their workbook was specifically created for children who have a family member with mental illness. The goal of developing the workbook was to lessen the stigma of mental illness and help children gain insight and understanding of their parent’s disorder. The workbook is broken down into three sections. Section one contains a general discussion about the concept of mental illness for children who may never have discussed this topic. Section two focuses on the personal experiences of the child who has a family member with a mental illness. This section allows the child to name the illness, to identify who has it, and to discuss the symptoms of the particular illness. Children have the opportunity to explore the range of feelings they may have. This section encourages them to ask questions and to look at treatments that are currently available. Section three introduces the idea of coping skills and self care to children. This section includes practical suggestions and various exercises for children to do. There are extra copies that can be found at the back of the workbook, the idea being that children might like a separate copy of their favorite one. This section also helps children to identify the specific supports available to them in their community. An extra copy of the page which includes the names and phone numbers of important people in their community can be found at the back of the workbook as well (Family Services of the North Shore, 2010). (See Appendix A) for sample worksheets.
Discussion

Unfortunately, families, professionals, and society often pay most attention to the mentally ill parent, and ignore the children in the family. Providing more attention and support to the children of a mentally ill parent is an important consideration when treating the parent. Research on child outcomes has uncovered multiple sources of risk and resilience for children who have parents with mental illness. The majority of studies have focused on white, middle class samples of children of depressed mothers. It is therefore difficult to know whether these same models might be applied more generally across race, class and parental psychiatric diagnoses. In addition, the influence of ethnic and cultural differences is not understood. Within these limitations, studies have revealed that both biological and environmental factors can be sources of risk and resilience. However, most investigations of resilience have focused on environmental variables. Specifically, studies have revealed that heredity, severity and chronicity of illness, parenting behavior, marital discord, and family relationships are important mediators of the relationship of parental mental illness and child outcomes. Spousal or partner characteristics, environmental stress and support, and child characteristics such as temperament, cognitive styles and interpersonal skills are important moderators. Studies have focused heavily upon sources of risk, and may have missed potentially powerful sources of resilience upon which interventions might be based. Data does not reflect children's subjective experience of parental mental illness, or reports of what children think might be useful. In spite of these limitations, interventions founded upon what is known about sources of risk and resilience has been somewhat beneficial, though few and far between. In particular, efforts to enhance children's understanding of mental illness and parents' understanding of children's needs have shown promising results. Increased research attention must be paid to strengths and sources of resilience
among both parents and children; and to how sources of both risk and resilience relate to ethnic and cultural differences. Children must be asked about their experiences of living with parents with mental illness, and their needs. Effort should be made to bridge the gap between research and practice. Current knowledge about sources of risk and resilience should be translated into practical interventions that enhance sources of resilience and mitigate sources of risk. These interventions should then be evaluated for effectiveness. As service providers of parents with mental illness it is our duty to provide as much care and consideration to the offspring of such individuals. Identifying and providing good collaborative care for families can be helpful for these children in the future.
References


http://parentalmentalillness.org


Appendix A

IMAGINE

Here is an exercise that may be helpful to you when you are upset.

Sit or lie down in a quiet place. Close your eyes.

Picture yourself in your favorite place. If you can’t think of a favorite place you can make one up.

Take a big breath and when you are ready, breathe out.

Keep breathing slowly in and out.

Now keeping your eyes closed and breathing in and out, picture yourself doing your favorite thing in your favorite place.

Keeping your eyes closed, look around your favorite place.

What do you see? How does your body feel?

Any special smells?

Try to stay in your special place for a few minutes.

When you are done, take a big breath and as you breathe out, open your eyes and look around.

When you are ready you can get up and go on with your day.
ANGRY FEELINGS

It’s okay to feel angry. Everyone does sometimes. But it is not okay to hurt yourself or others.

Here is an exercise you can do when you are feeling angry.

Think about what is making you angry.

I am angry because

__________________________________________________________

(describe what is making you angry)

Take a deep breath. Hold it for a few seconds.

As you breathe out, let the angry feelings out.

Remember it is okay to be angry and you can use this exercise anywhere.
MUSCLE RELAXATION

When we have a lot of worries, our body parts may get tight. They may start to ache. This muscle relaxation exercise may help you to feel loose and get rid of these aches. Follow these steps:

Sit or lie down in a quiet place, with your hands by your side. Close your eyes.

Breathe in slowly and tighten all your muscles in your face, forehead, eyes, and your mouth.

As you breathe out, let all the muscles in your face, forehead, eyes, and your mouth go soft and loose.

Breathe in slowly and raise your shoulders up to your ears. Make them hard and tight.

As you breathe out, let your shoulders go soft and loose.

Breathe in slowly and clench your fists hard and tight. Feel your arms get hard and tight.

As you breathe out, open your hands and let your arms go soft and loose.

Breathe in slowly and tighten all the muscles in your stomach by pulling your belly in towards your back.

As you breathe out, let your belly go soft and loose.

Breathe in slowly and point your toes toward the ceiling.

As you breathe out, let your feet go loose and soft.
HOW TO GET RID OF WORRIES

When we have a lot of thoughts that worry us, sometimes it is hard to concentrate. Here are some ideas that may help you get rid of some of the worries.

1. Think about something that worries you.

Picture a stop sign in your mind.

Say “STOP” in your head.

Then think about your favorite activity or sport and picture yourself playing and having fun.

If you cannot stop thinking about your worries, talk to _____________________________________________

(a person you trust)

2. Think about something that worries you.

Place loose elastic on your wrist.

Snap the elastic and say “STOP” in your head.

Then think about your favorite activity or sport and picture yourself playing and having fun.

If you cannot stop thinking about your worries, talk to _____________________________________________

(a person you trust)