Child Protection Network

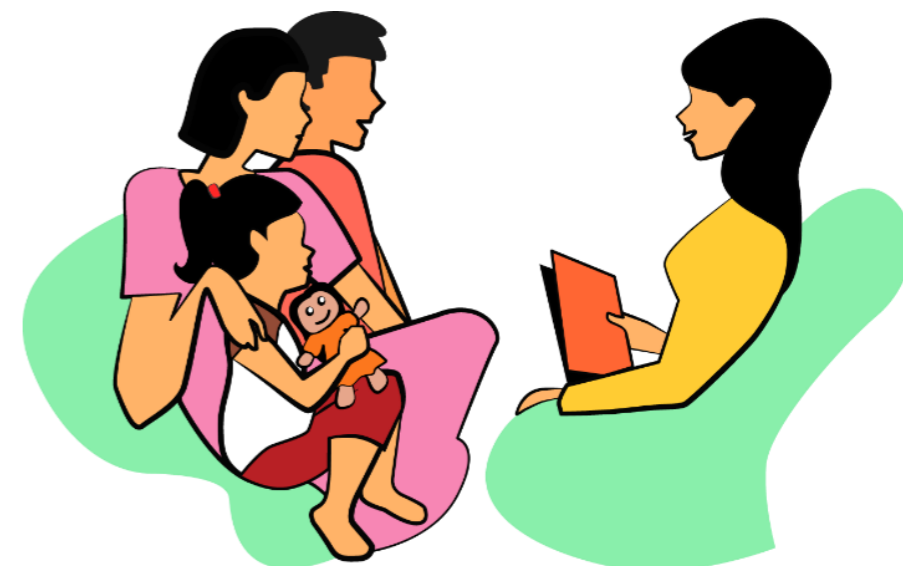CONSUELO FOUNDATION

unicef

PRESENT

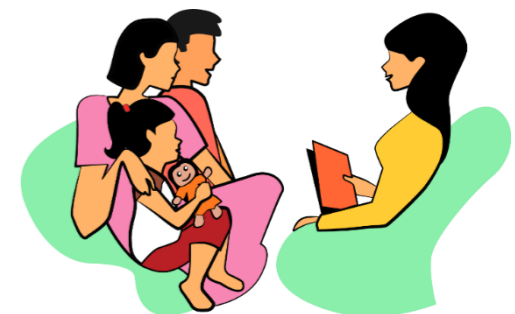# AKO PARA SA BATA

THE INTERNATIONAL CONFERENCE IN MANILA

THEME:

STRESSED?
Coping, Recovery, and Healing

DECEMBER 1-2, 2016
SMX CONVENTION CENTER MANILA

90% OF A CHILD'S BRAIN DEVELOPMENT HAPPENS BEFORE AGE 5

FRONTAL LOBE

HANDLES ALL THOUGHT AND VOLUNTARY BEHAVIOR MEMORY, GOAL FORMATION, ABSTRACT THINKING, PLANNING, AND IMPULSE CONTROL

PARIETAL LOBE

ASSOCIATED WITH BODILY SENSATIONS LIKE HEAT, COLD, PRESSURE, AND PAIN CONTROLS TASTE, TOUCH, THE ABILITY TO RECOGNIZE OBJECTS, HAND-EYE COORDINATION

OCCIPITAL LOBE

CONTROLS VISION AND VISUAL RECOGNITION

TEMPORAL LOBE

CONTROLS HEARING, SMELL, LANGUAGE SKILLS, AND SOCIAL UNDERSTANDING

CEREBELLUM

RESPONSIBLE FOR BALANCE AND MUSCLE COORDINATION.

SOURCES:

HTTP://WWW.URBANCHILDINSTITUTE.ORG/WHY-0-3/BABY-AND-BRAIN

HTTP://WWW.BABYCENTER.COM/INSIDE-A-CHILDS-MIND-A-VISUAL-GUIDE

HTTP://WWW.CREMEDELACREME.COM/PRESCHOOL_TIPS/YOUR_CHILDS_BRAIN_DEVELOPMENT.HTM

HTTP://BRAININSIGHTS.MYSHOPIFY.COM/BLOGS/NEWS/5291502-IT-HAPPENS-IN-THE-BRAIN-AND-IT-BEGINS-EARLY

HTTP://BRAINMIND.COM/BRAINLECTURE7.HTML

Experience-dependent Brain Growth and Development

Human Brain Development
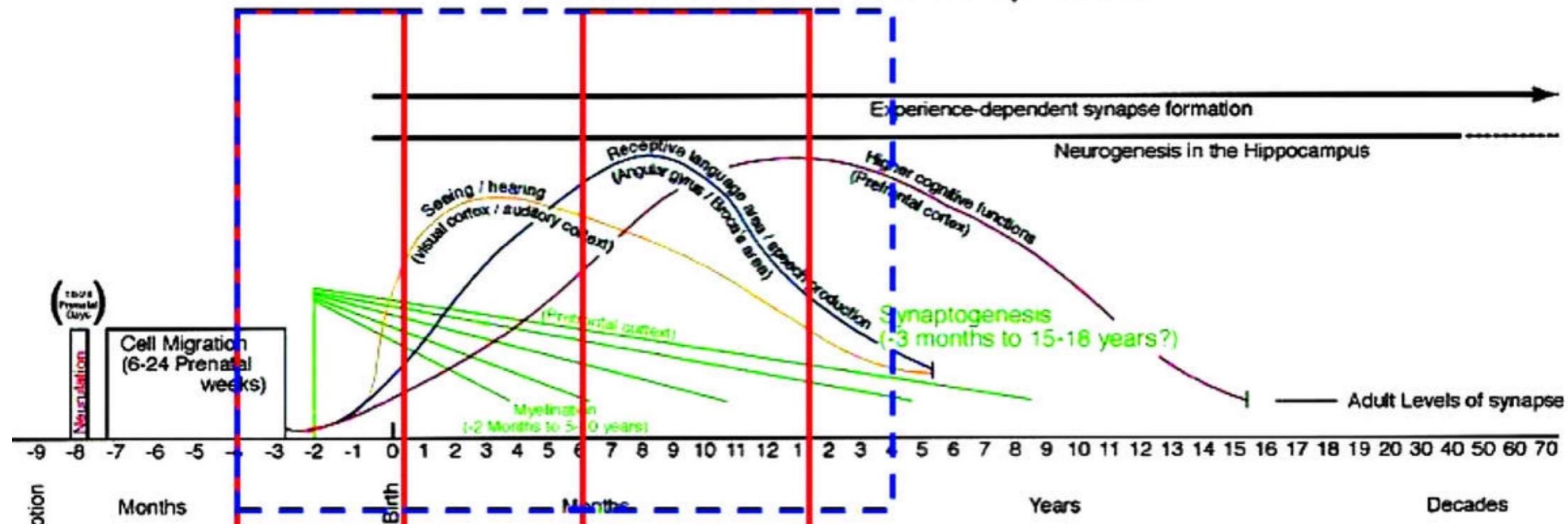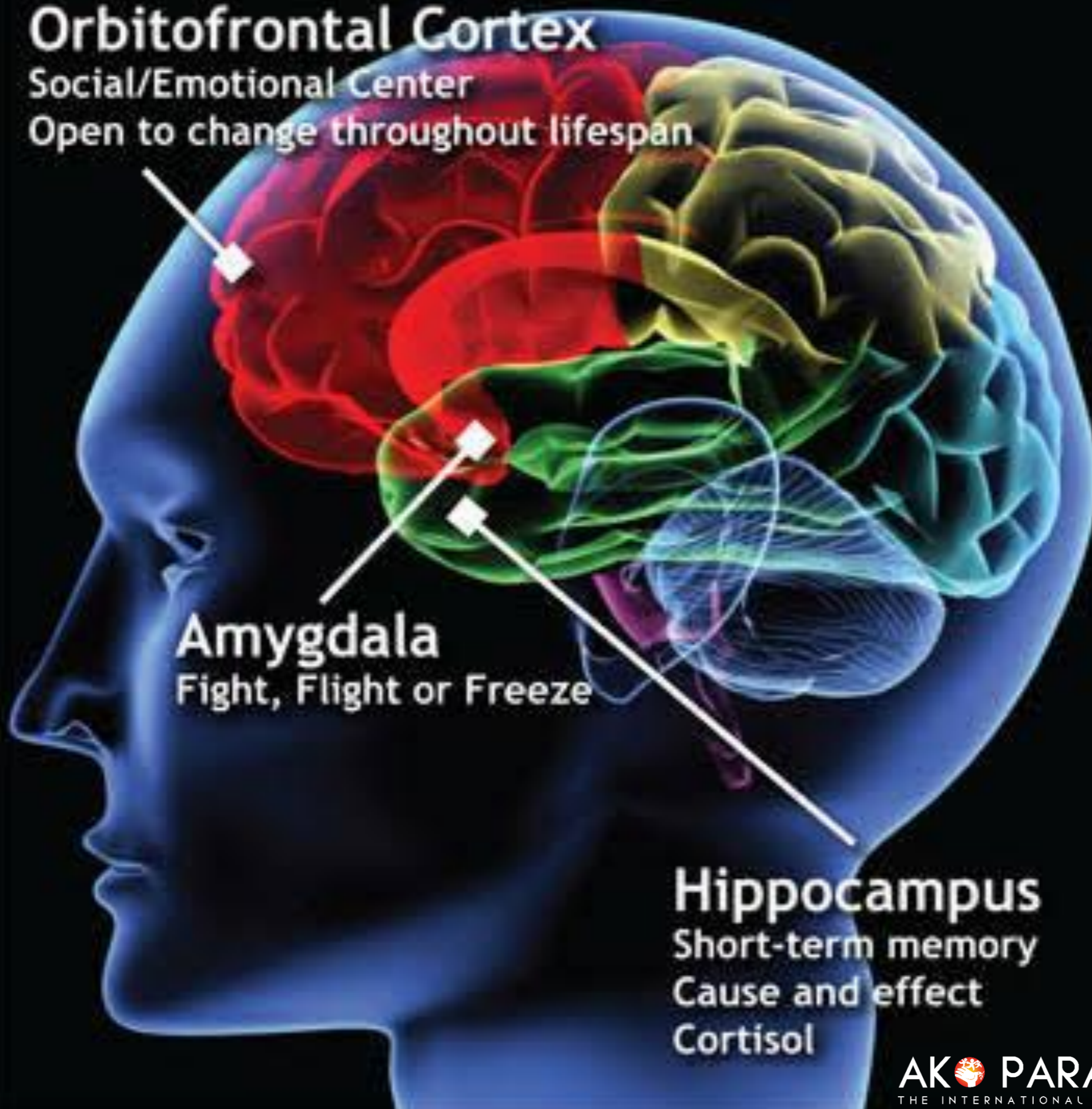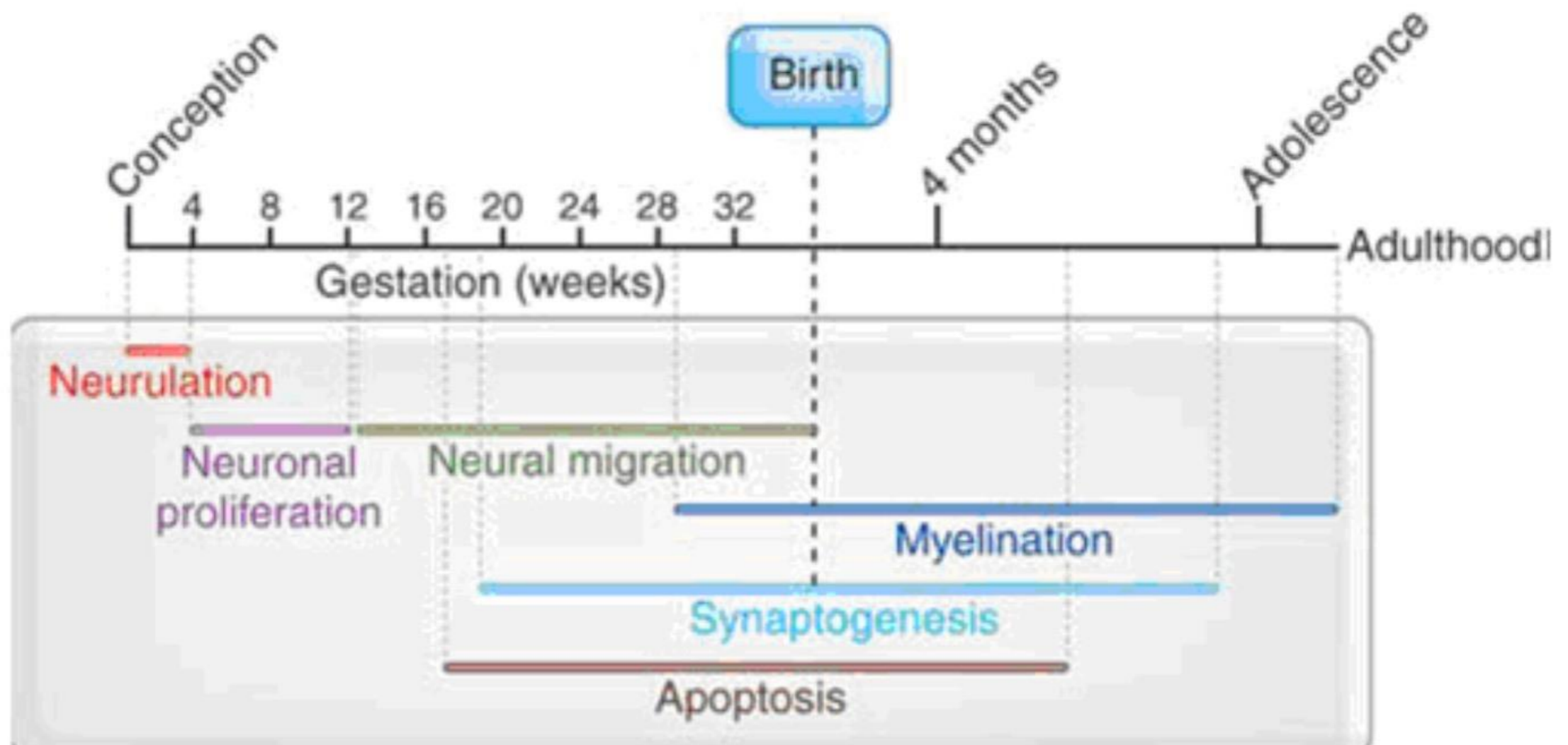
1.1 Synaptogenesis in Neural Development

Synaptogenesis has its peak activity at 18 weeks of gestation and continue to maintain high levels of activity into childhood. Although the activity tapers off with age, activity-dependent synaptic plasticity persists throughout life [3

Synaptic Density
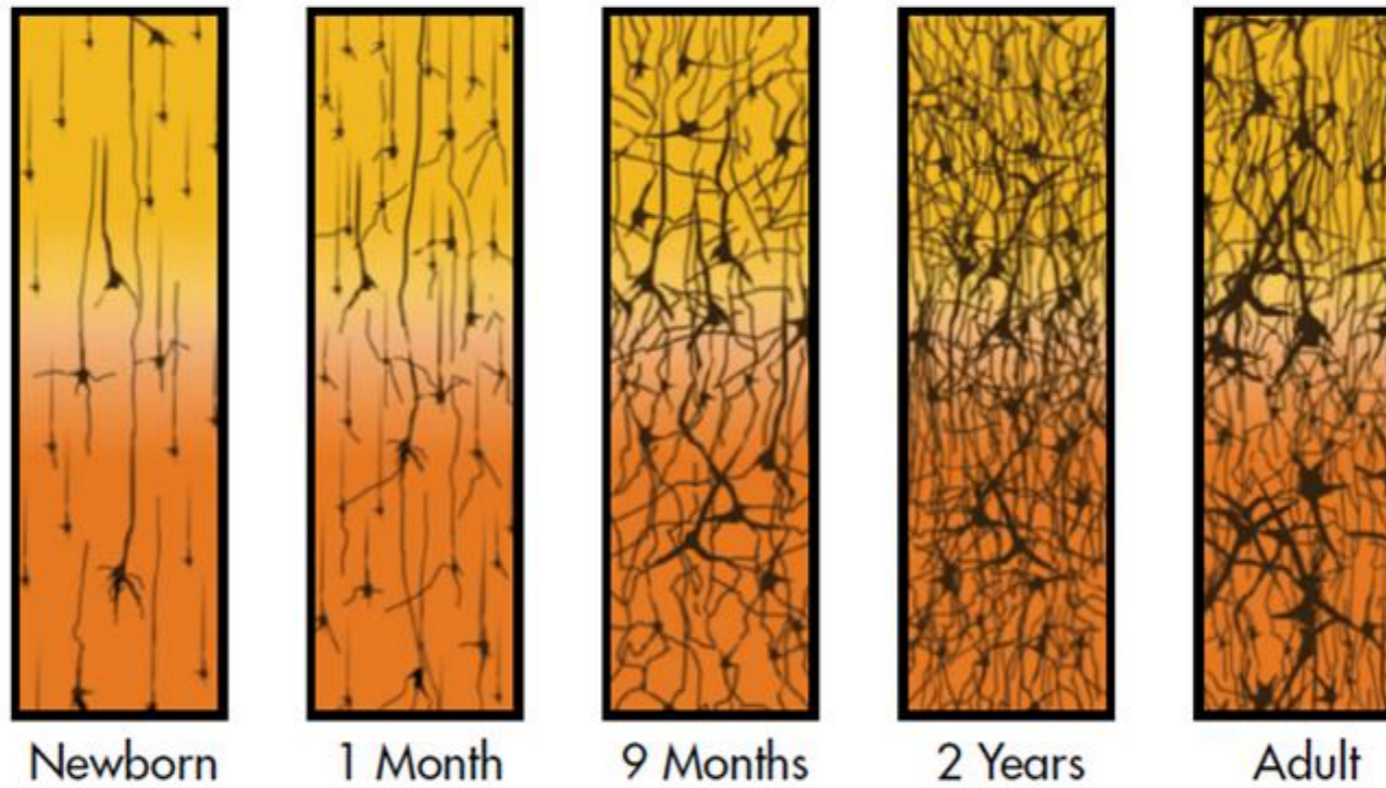
FIGURE 3:
Synapse Density Over Time

Source: Corel, JL. The postnatal development of the human cerebral cortex. Cambridge, MA: Harvard University Press; 1975.

Newborn | 1 Month | 9 Months | 2 Years | Adult

36 weeks gestation | Newborn | 3 months | 6 months | 2 years | 4 years | 6 years

Synapse formation

Synapse pruning

Brain Development

B

D_2 CONTROL STRIATA (m & f)
2.2% LOSS PER DECADE [p<0.002]

upper limit for adults

D_2 DENSITY, pmol/g

age, yrs
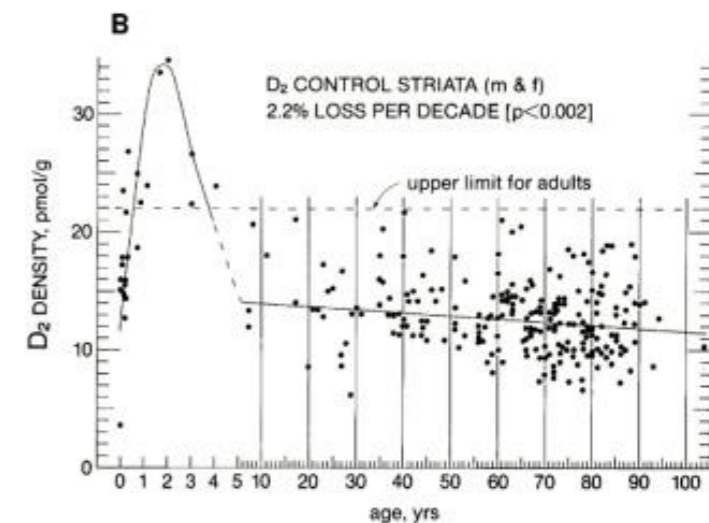
Reproduced from Seeman et al.: Human Brain Dopamine Receptors in Children and Aging Adults. Synapse 1987; 1:399–404. Copyright © 1987, Wiley-Liss, Inc. a division of John Wiley and Sons, Inc. Reprinted by permission of John Wiley and Sons, Inc.

Learning and Unlearning: Connecting the Essentials

At Birth   6 Years Old   14 Years Old

TRAUMA

▸ An emotional wound, resulting from a shocking event or multiple and repeated life threatening and/or extremely frightening experiences that may cause lasting negative effects on a person, disrupting the path of healthy physical, emotional, spiritual and intellectual development. - NCTSN

▸ KEY elements. (SAMHSA 2012)

  ▸ Event

  ▸ Experienced

  ▸ Effects

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Traumatic Stress and Critical Windows of Brain Development

Cortex

Limbic Brain

Mid Brain

Brain Stem

Normal Growth

cognitive functioning:
12 months - 48 months

emotional functioning:
6 months - 30 months

motor functioning:
first year

state regulation:
pre-birth - 8 months

(Adapted from: Perry, 2002)
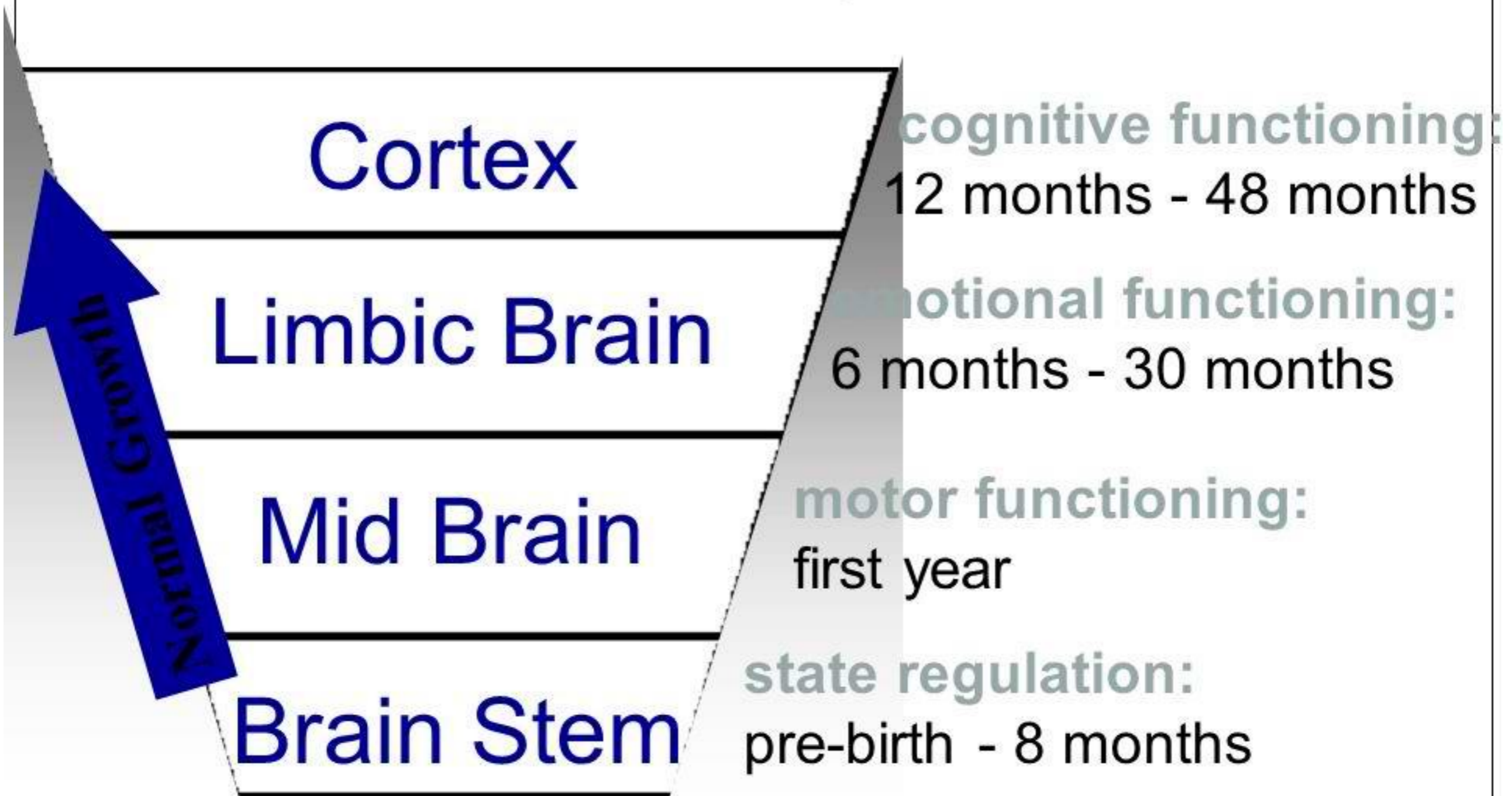
Northern Illinois University Center for Child Welfare & Education - 2013

Trauma & Brain Development

Reptilian Brain ●
Limbic System ●
Neocortex ●
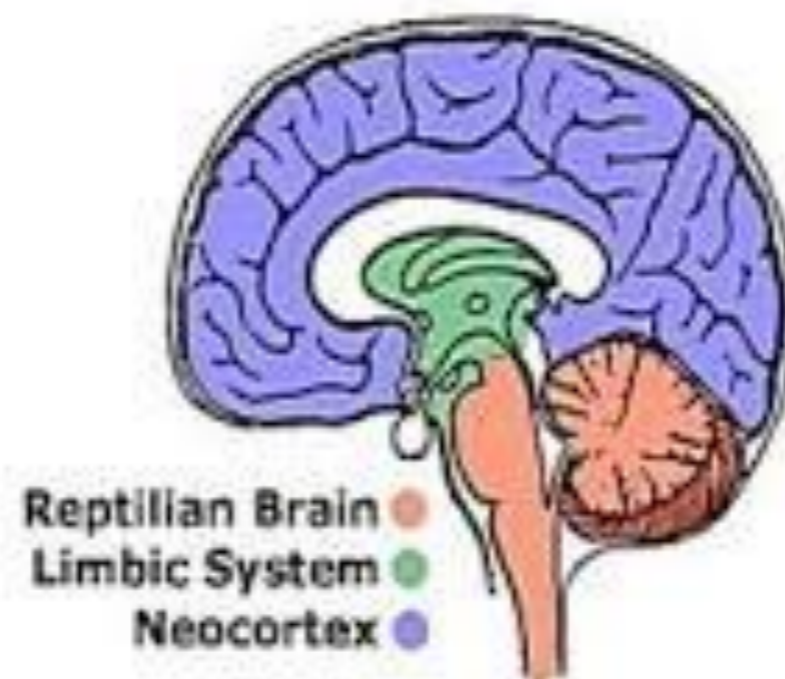
Typical Development

- Cognition
- Social/Emotional
- Regulation
- Survival

Developmental Trauma

- Cognition
- Social/Emotional
- Regulation
- Survival

Adapted from Holt & Jordan, Ohio Dept. of Education

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Childhood Trauma Exposure Disrupts the Automatic Regulation of Emotional Processing

Hilary A Marusak[1,2], Kayla R Martin[3], Amit Etkin[4,5] and Moriah E Thomason*[2,6]

[1]Department of Psychiatry and Behavioral Neurosciences, Wayne State University School of Medicine, Detroit, MI, USA; [2]Merrill Palmer Skillman Institute for Child and Family Development, Wayne State University, Detroit, MI, USA; [3]Wayne State University School of Medicine, Detroit, MI, USA; [4]Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, CA, USA; [5]Sierra-Pacific Mental Illness Research, Education, and Clinical Center (MIRECC) Veterans Affairs Palo Alto Health Care System, Palo Alto, CA, USA; [6]Department of Pediatrics, Wayne State University School of Medicine, Detroit, MI, USA

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a trauma > comparison emotional conflict
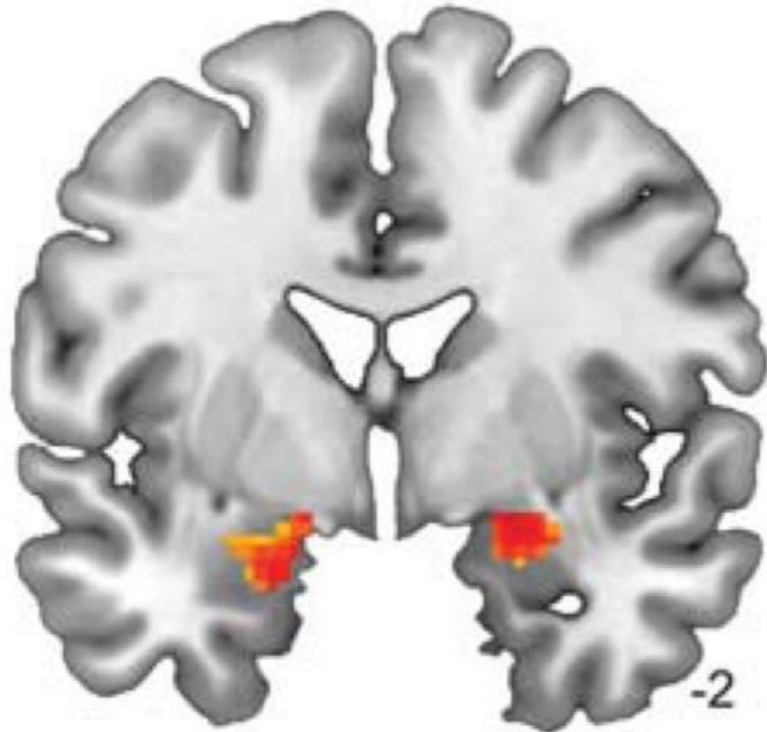
b anatomically-defined amygdala ROI
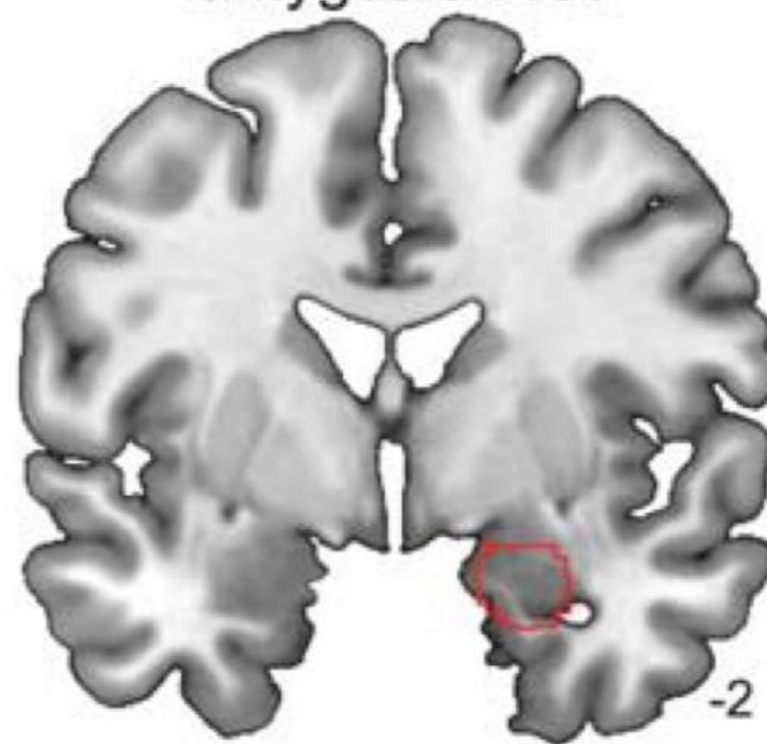
c right amygdala

d right amygdala

$r^2 = 0.185$
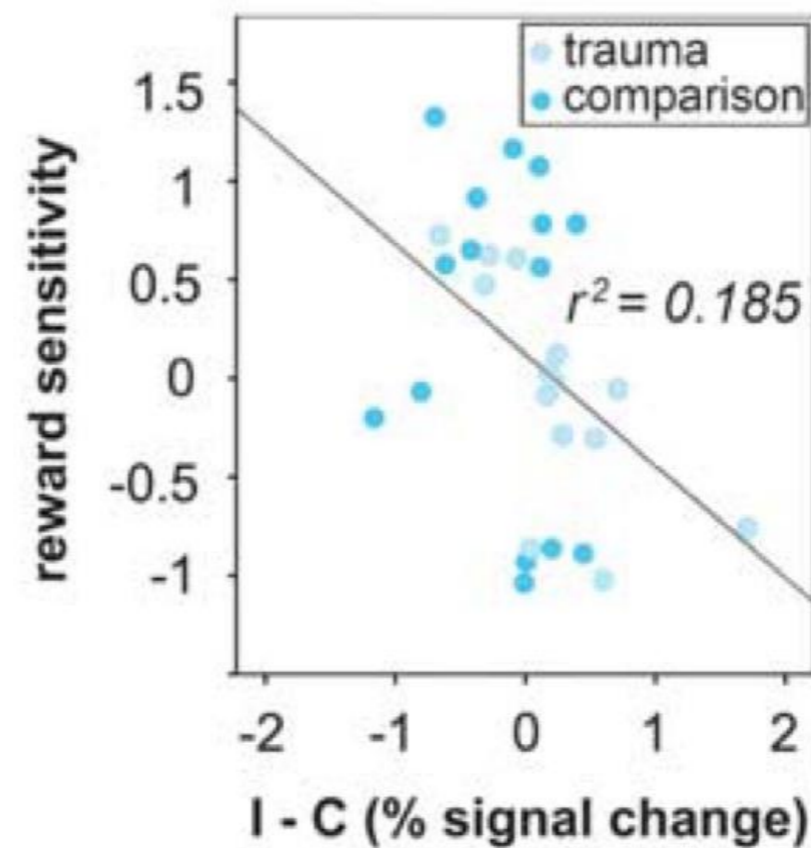
a trauma > comparison emotional conflict regulation
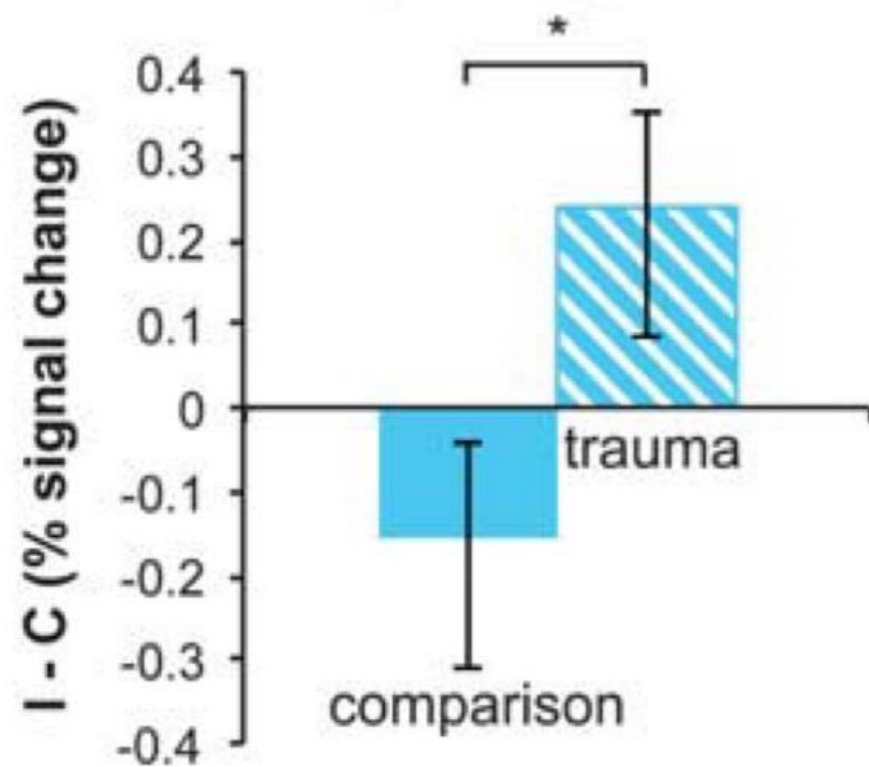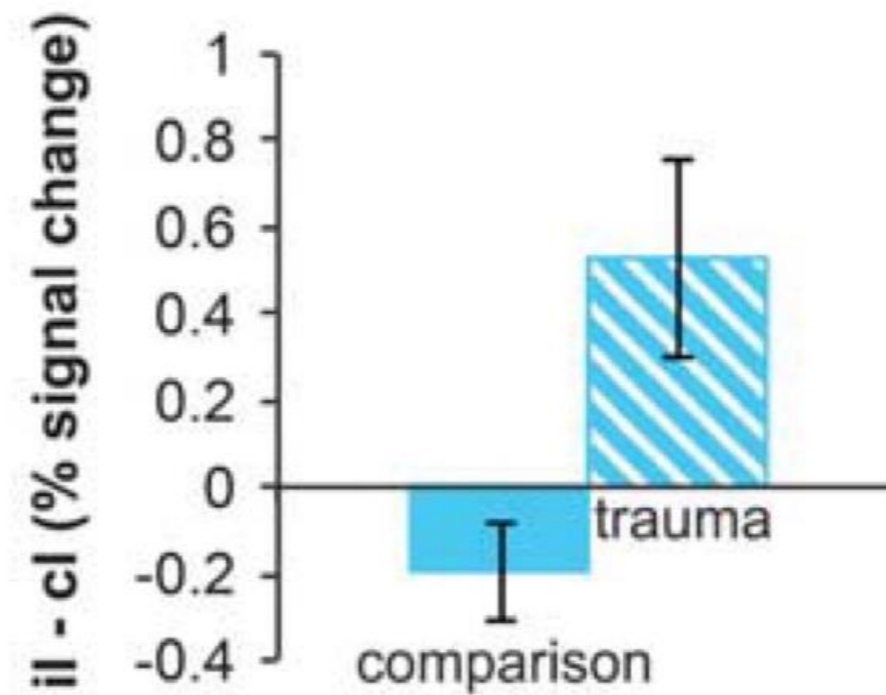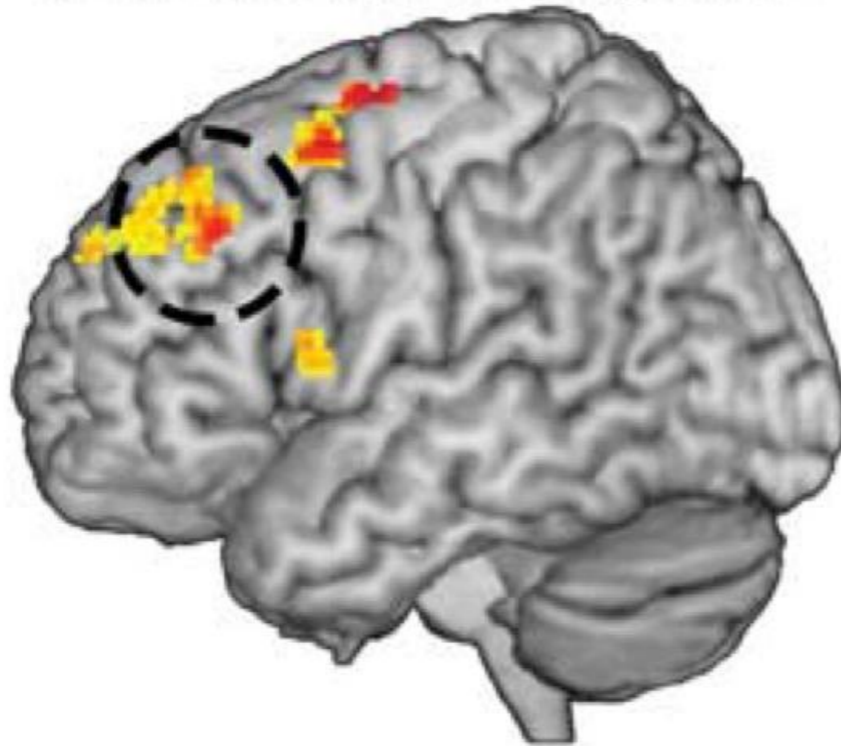
b trauma > comparison emotional conflict regulation

a

Accuracy | Reaction Time
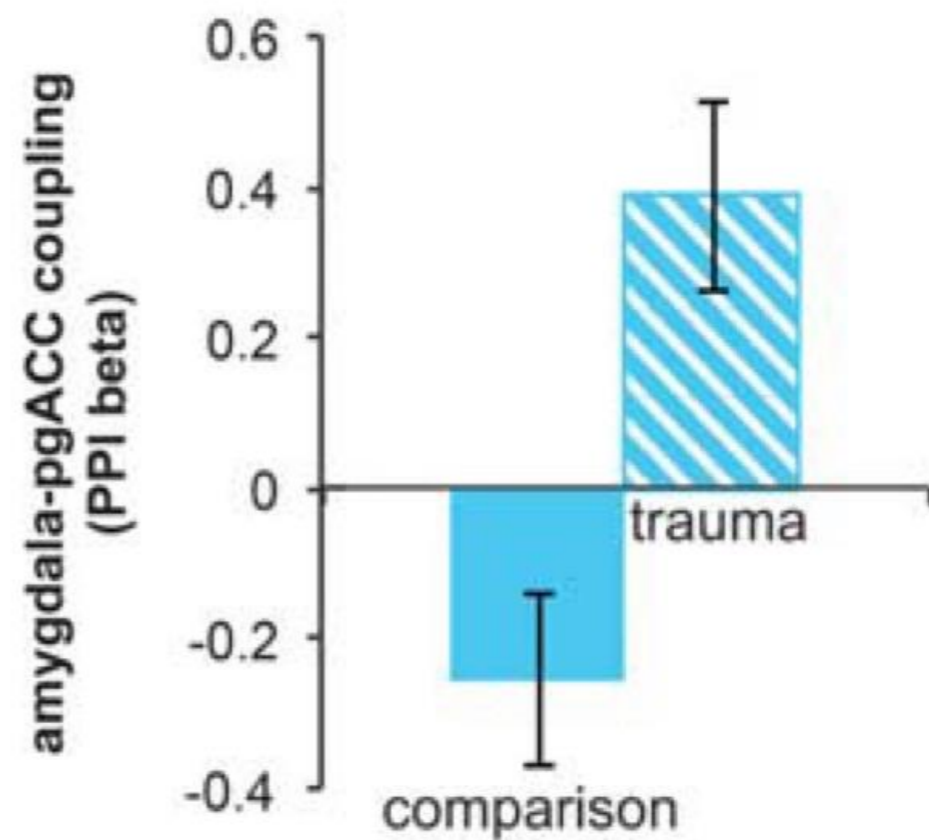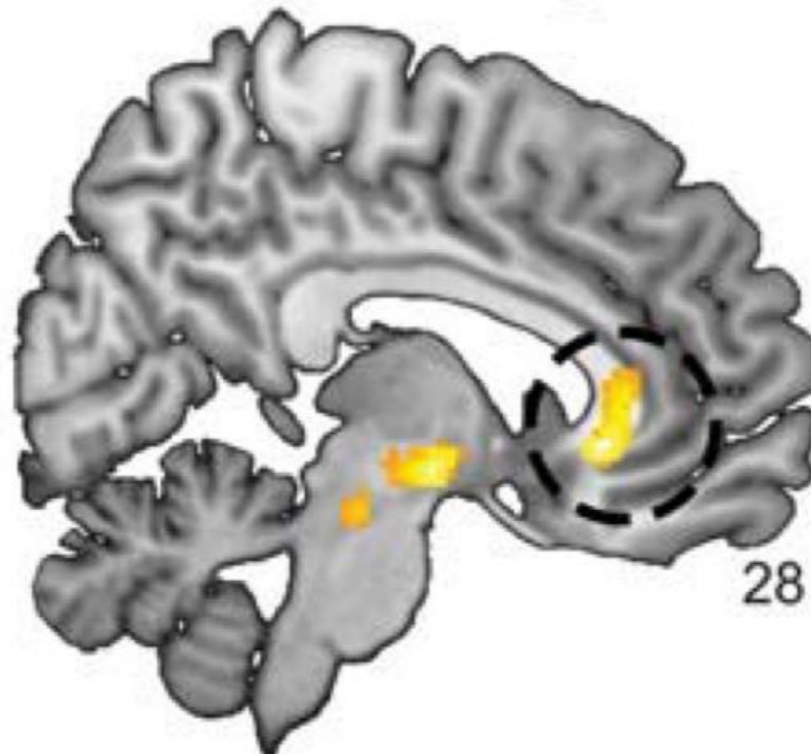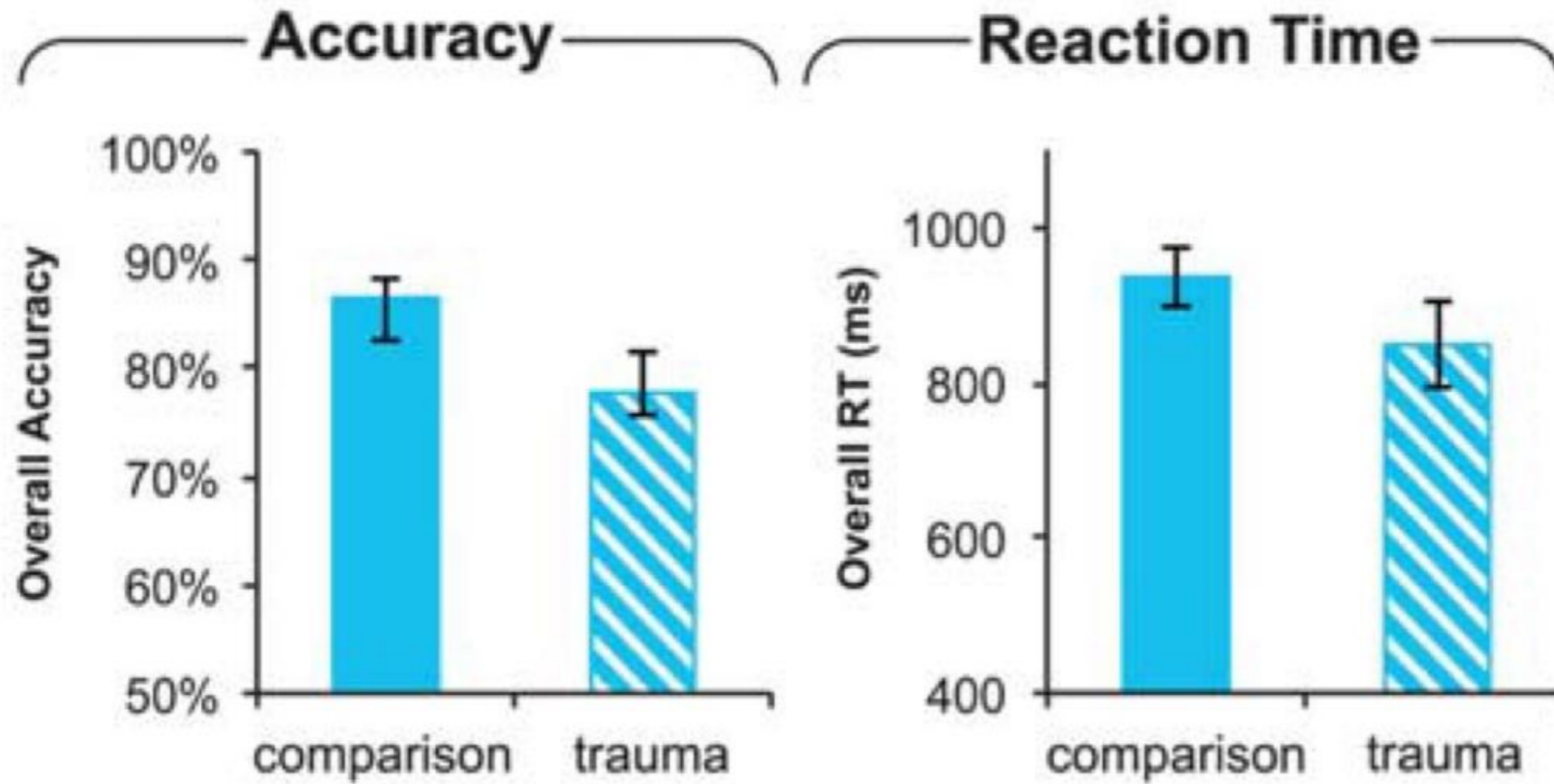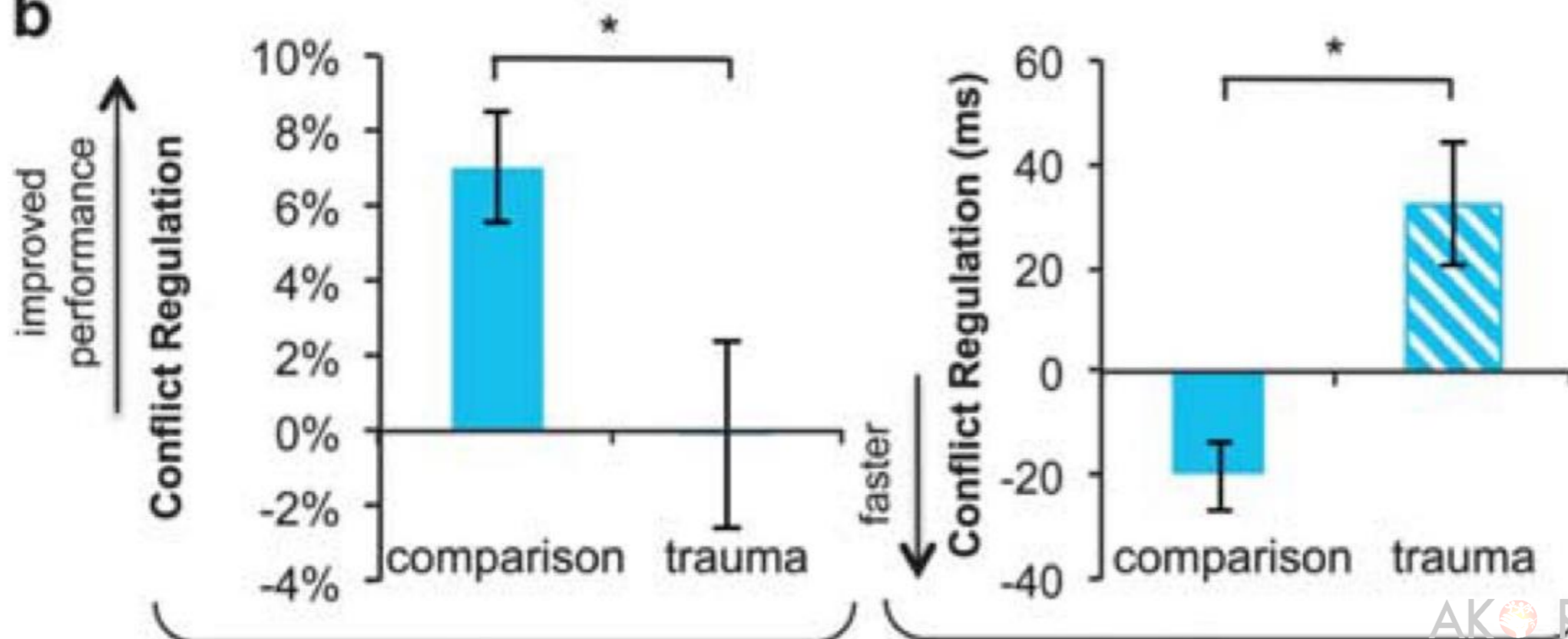
Healthy Brain

This PET scan of the brain of a normal child shows regions of high (red) and low (blue and black) activity. At birth, only primitive structures such as the brain stem (center) are fully functional; in regions like the temporal lobes (top), early childhood experiences wire the circuits.
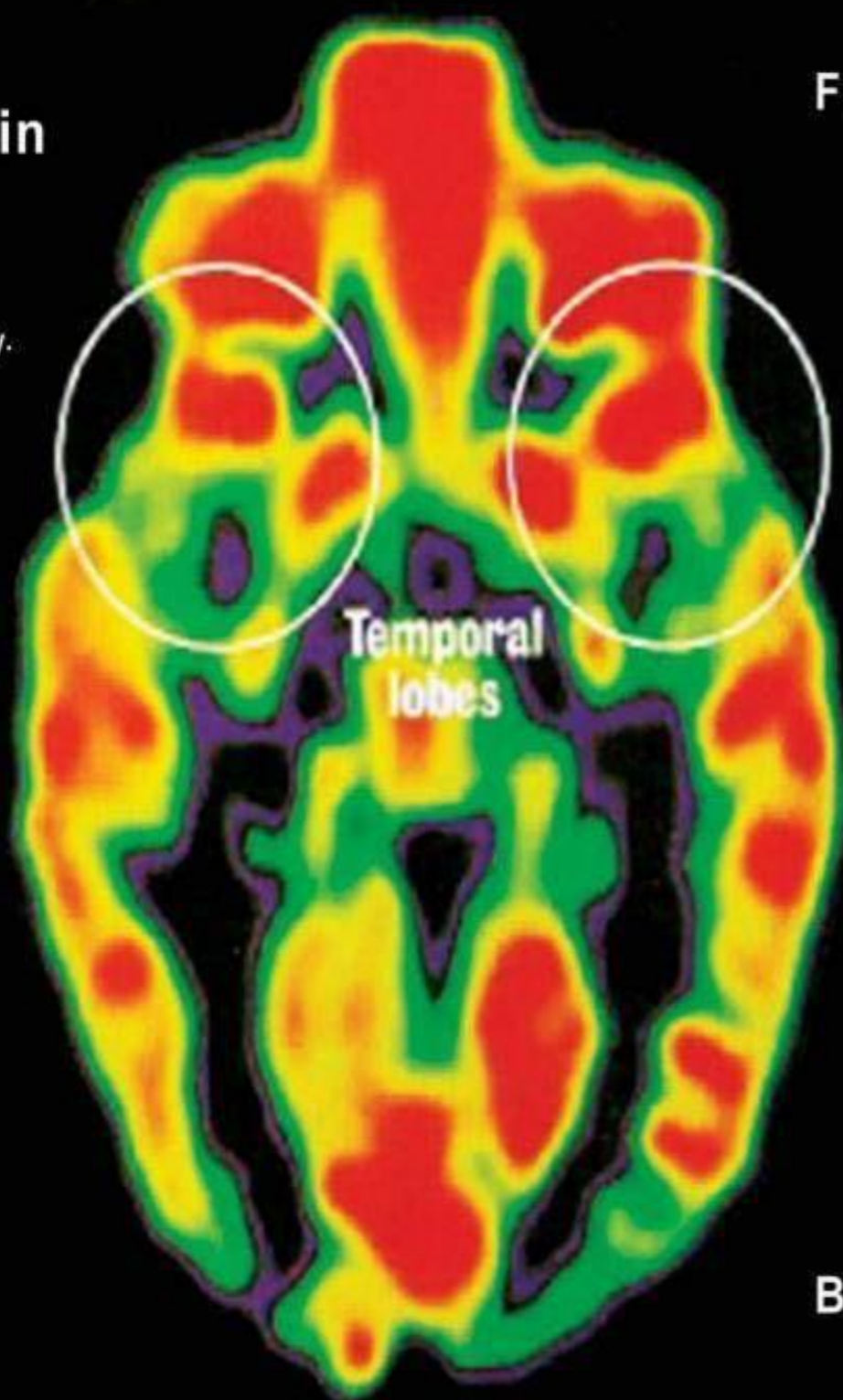
An Abused Brain

This PET scan of the brain of a Romanian Orphan, who was instutionlized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (top),which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.

Front

Temporal lobes

Temporal lobes
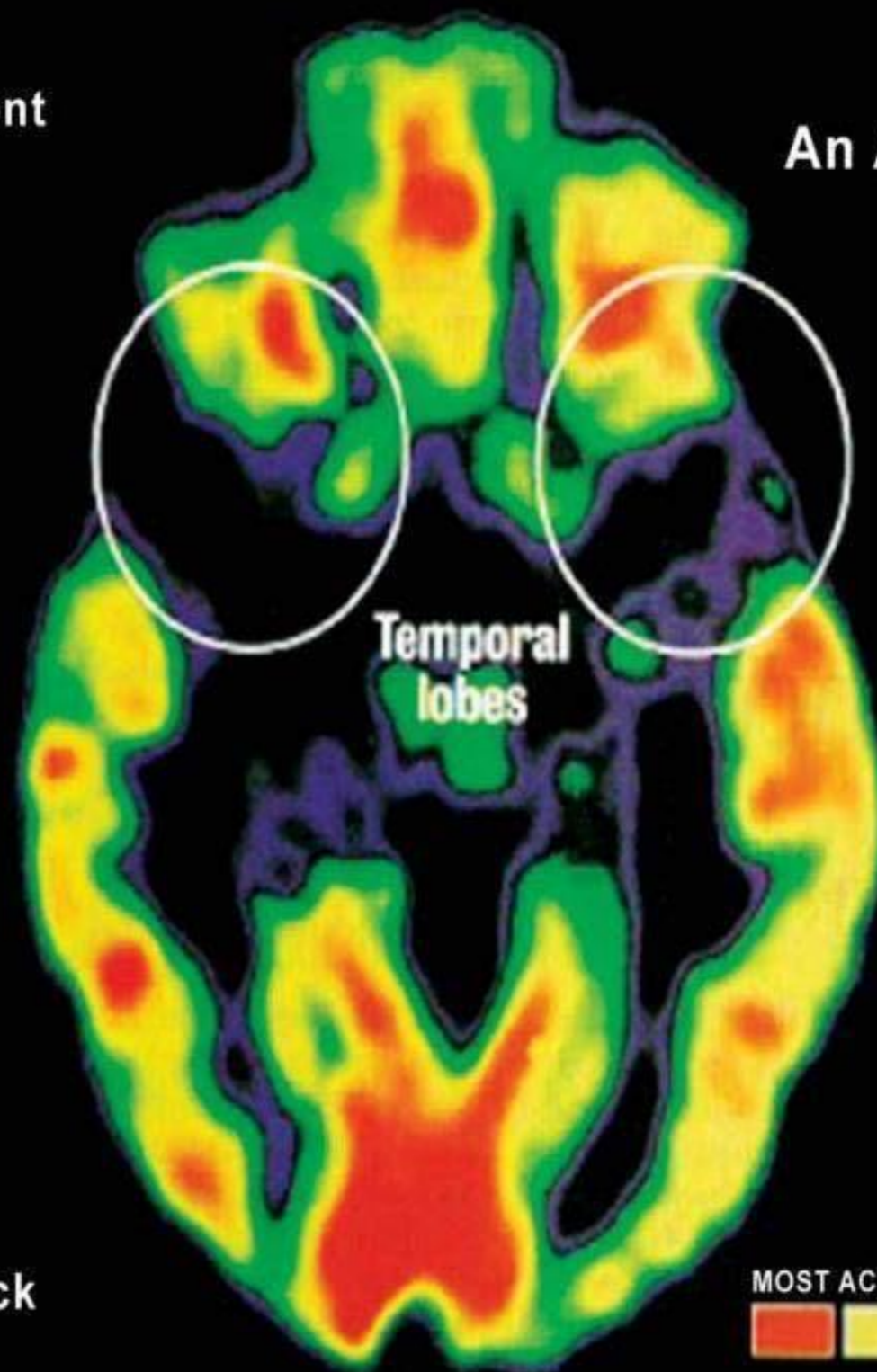
Back

MOST ACTIVE   LEAST ACTIVE

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Death

Conception

Early Death

Disease, Disability, and Social Problems

Adoption of Health-risk Behaviors

Social, Emotional, and Cognitive Impairment

Disrupted Neurodevelopment

Adverse Childhood Experiences
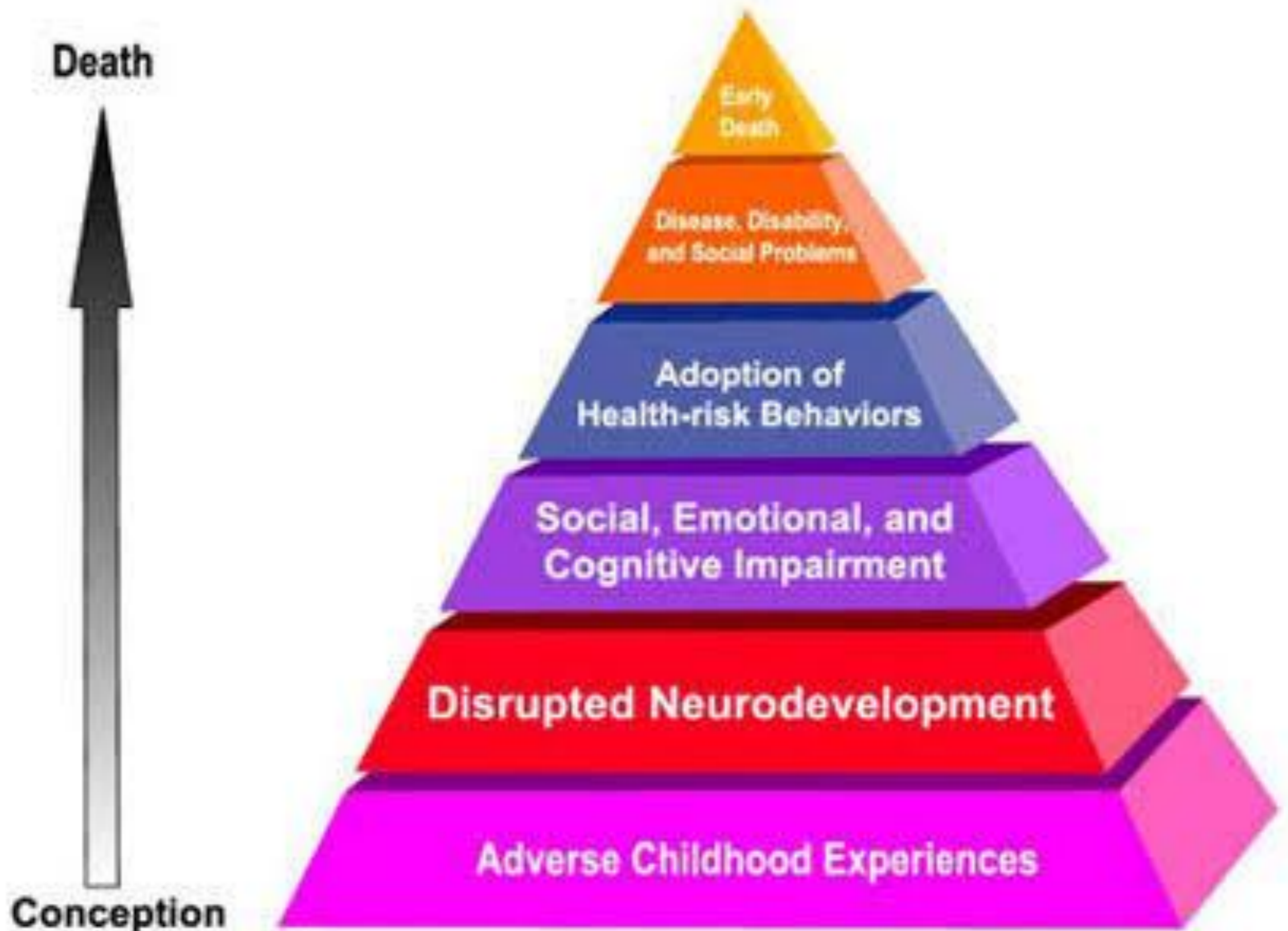
Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

We remember trauma less in words and more with our feelings and our bodies

[van der Kolk & Fisler, 1995]
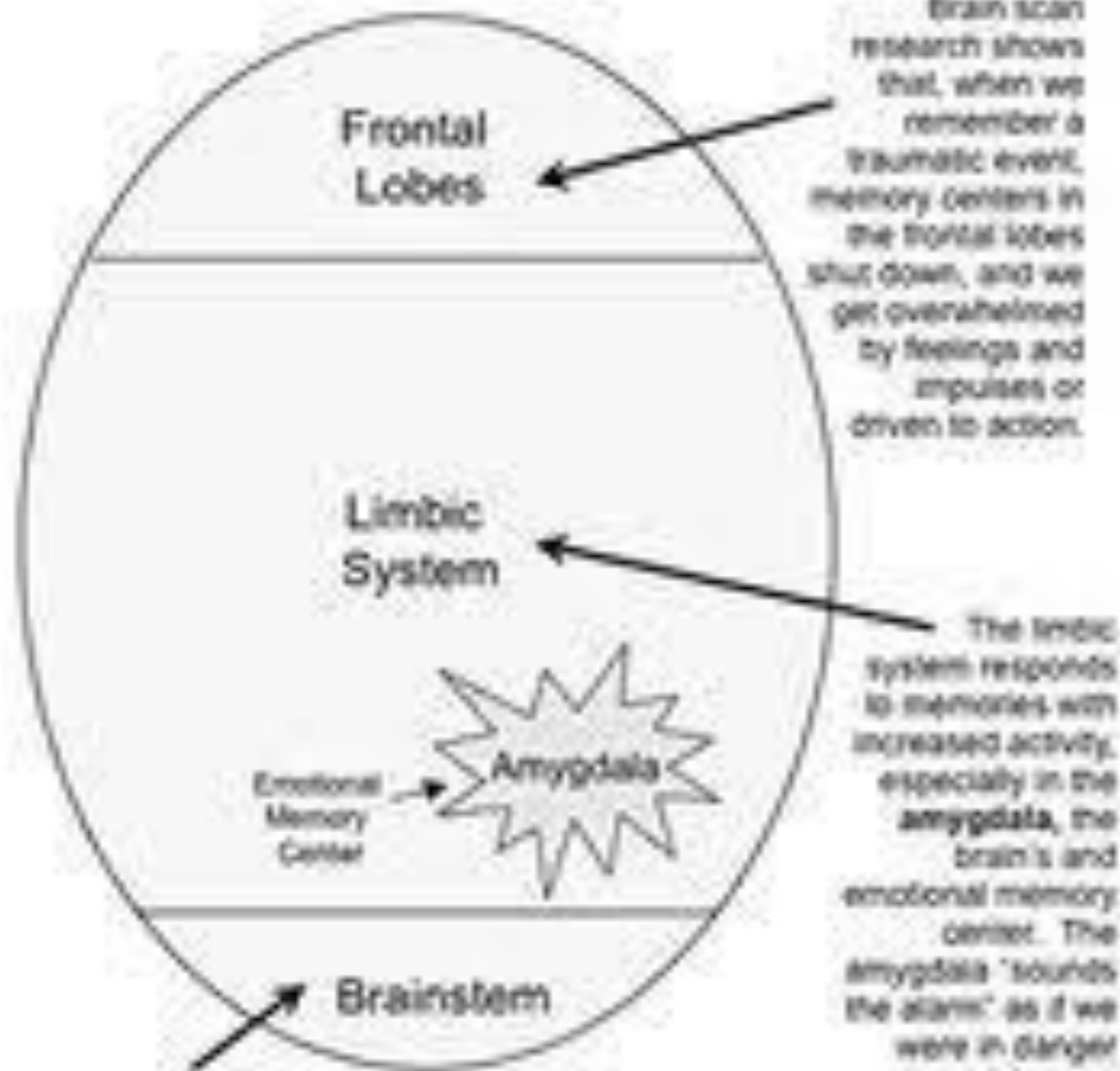
Frontal Lobes

Brain scan research shows that, when we remember a traumatic event, memory centers in the frontal lobes shut down, and we get overwhelmed by feelings and impulses or driven to action.

Limbic System

The limbic system responds to memories with increased activity, especially in the **amygdala**, the brain's and emotional memory center. The amygdala "sounds the alarm" as if we were in danger right now.

Emotional Memory Center → **Amygdala**

Brainstem

The reptilian brain reacts instinctively to the amygdala's "alarm." Heart rate increases. We stop breathing or hyperventilate. Muscles tense. We either speed up or shut down.

Copyright 2007 Janina Fisher, Ph.D.
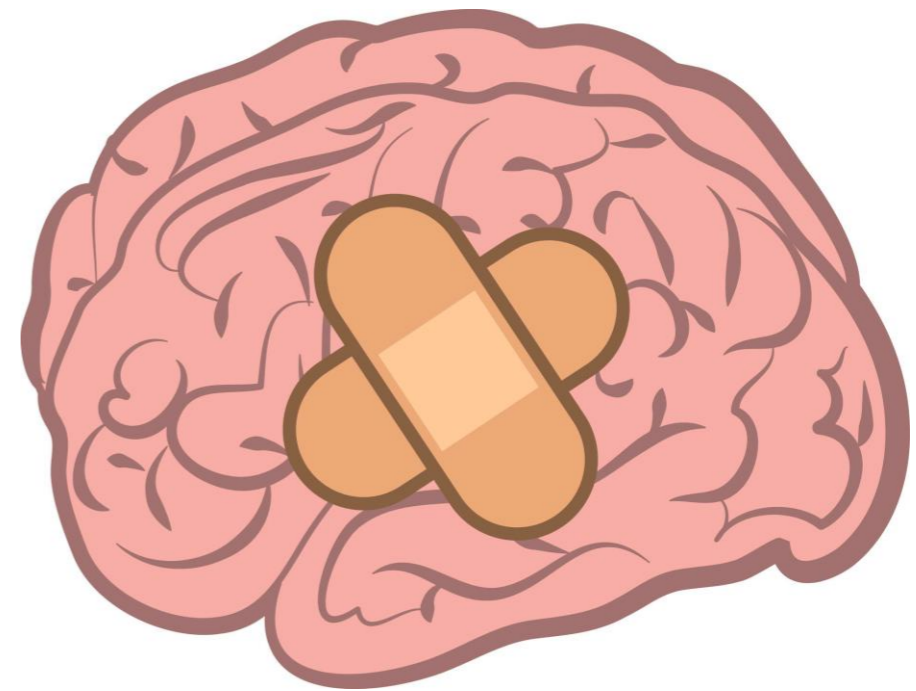
The Impact of CII's Trauma Therapy

80.7
PERCENT

of clients showed a significant reduction in trauma symptoms after completing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

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THE BRAIN IS PLASTIC. RE LEARNING IS POSSIBLE.

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One second to injure your brain..weeks, months & years to recover.

TBILifeCoach

SALAMAT PO!

GERARDO CARMELO B. SALAZAR, MD

gcbsalazar@ludhmc.com

Before

Before I struggled

After

After I am happy because I don't struggle that much.

1981

JAS-ANZ

QUALITY ASSURED COMPANY ISO 9001

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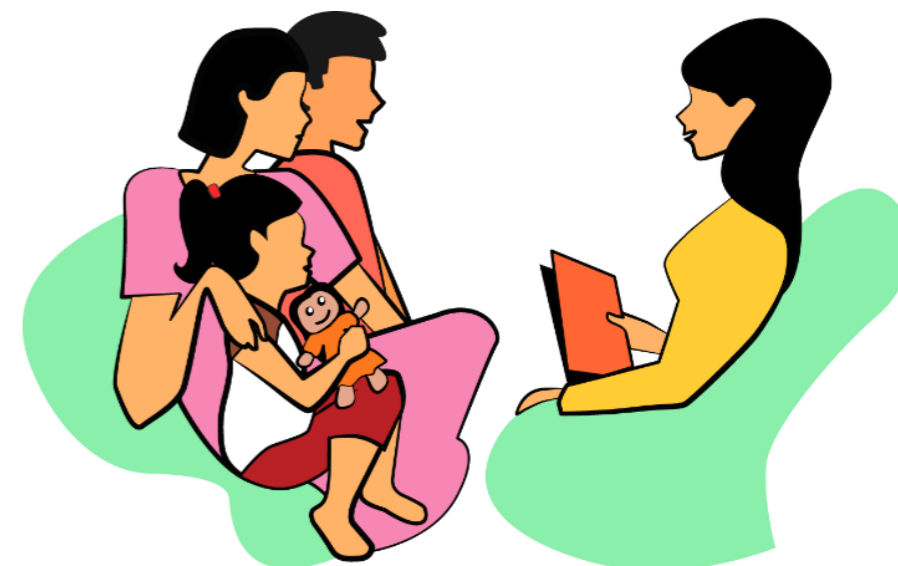
TRAUMA INFORMED CARE IN THE SCHOOLS

MARLEEN WONG, PH.D. LCSW

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THE INTERNATIONAL CONFERENCE IN MANILA

THEME:
STRESSED?
Coping, Recovery, and Healing

DECEMBER 1-2, 2016
SMX CONVENTION CENTER MANILA

- # The Invisible Wounds of Child Trauma: Trauma Informed Care in Schools

  - ## Marleen Wong, Ph.D. LCSW

Senior Associate Dean and Clinical Professor

University of Southern California School of Social Work

Principal Investigator, USC/LAUSD/RAND/UCLA

Trauma Services Adaptation Center

for Resilience Hope and Wellness in Schools and Communities

National Child Traumatic Stress Network

Marleen Wong PhD University of
Southern California

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Trauma Services Adaptation Center for Resiliency, Hope and Wellness in Schools

- **USC SCHOOL OF SOCIAL WORK**
- **LAUSD – School Mental Health**
- **RAND HEALTH – Los Angeles, DC, Pittsburgh**
- **UCLA NIMH Partnered Research Center for Quality Care**
- **UCLA TIES for Families**
- **UCLA Depts. of Psychiatry and Pediatrics/Geffen School of Medicine**

All Are Members of the National Child Traumatic Stress Network in the US

Marleen Wong PhD University of Southern California

A Brief History of PTSD

- Civil War – Soldier's Heart

- WWI – Shell Shock

- WWII – Wartime Neurosis

- Vietnam War – VA Study – PTSD

- Rights of Victims of Crime – Rape Centers

- Traumatized Students in Schools

USC School of Social Work

Events That Changed the Culture of Education

- Columbine 1999
- 1995 - Oklahoma City
- 2001 - 9/11 Terrorist Attacks NYC/DC
- 2005 – Hurricanes Katrina and Rita
- 2007 - Virginia Tech/University
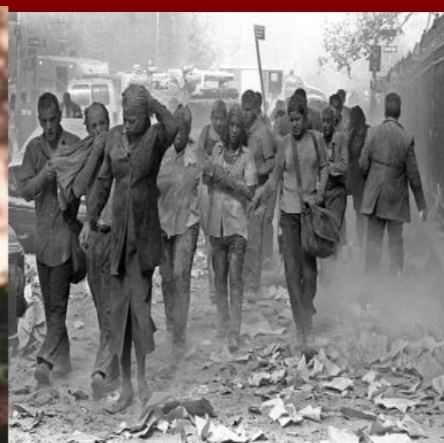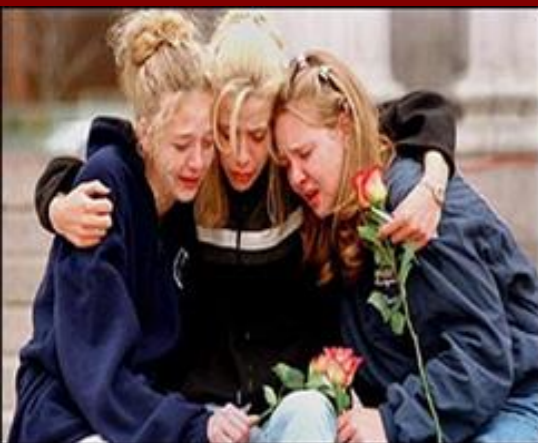
2012 – Newtown CT

What are the consequences of trauma?

*…*One night a year ago, I saw men shooting at each other, people running to hide. I was scared and I thought I was going to die.

After this happened, I started to have nightmares. I felt scared all the time. I couldn't concentrate in class like before. I had thoughts that something bad could happen to me. I started to get in a lot of fights at school and with my brothers…

– Martin, 6th grader

Through a Trauma Lens

…One night a year ago, I saw men shooting at each other, people running to hide. I was scared and I thought I was going to die.

After this happened, I started to have nightmares. I felt scared all the time. I couldn't concentrate in class like before. I had thoughts that something bad could happen to me. I started to get in a lot of fights at school and with my brothers…

– Martin, 6th grader

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Why a program for traumatized students?

While walking we saw people crying because they had no food and water. We saw bodies in the street. They had an old man dead in a chair. I was so scared I thought I was going to die. We were walking on the bridge, and the army men started to shoot in the air, and I just started to cry I was so scared. It started to rain and everyone started to cry, saying, "I hope another hurricane don't pass by."

Keoka, 10th grade

Why a program for traumatized students?

I know when my mother starts to drink. I have to hide after school. I go outside. I try to stay at my friend's house but then I have to go home. I sneak in or run to my room. Sometimes she fights with her boyfriend and she leaves me alone. Sometimes, she finds me and starts to yell and scream. She hits me with her hands and picks up stuff to throw at me. Even when she stops and says she's sorry, I'm scared all night and can't sleep. I get up and can't think right. I'm no good at school.

Stefan, *7th grader*

RAND/USC/UCLA Research

- 88 to 92% Violence Exposure
- 27% PTSD
- 16 % Childhood Depression
- 76 % of Parents wanted family referrals
- Zip Codes – High Crime, Poverty, Gang Conflicts, Drug Sales/Use/Abuse
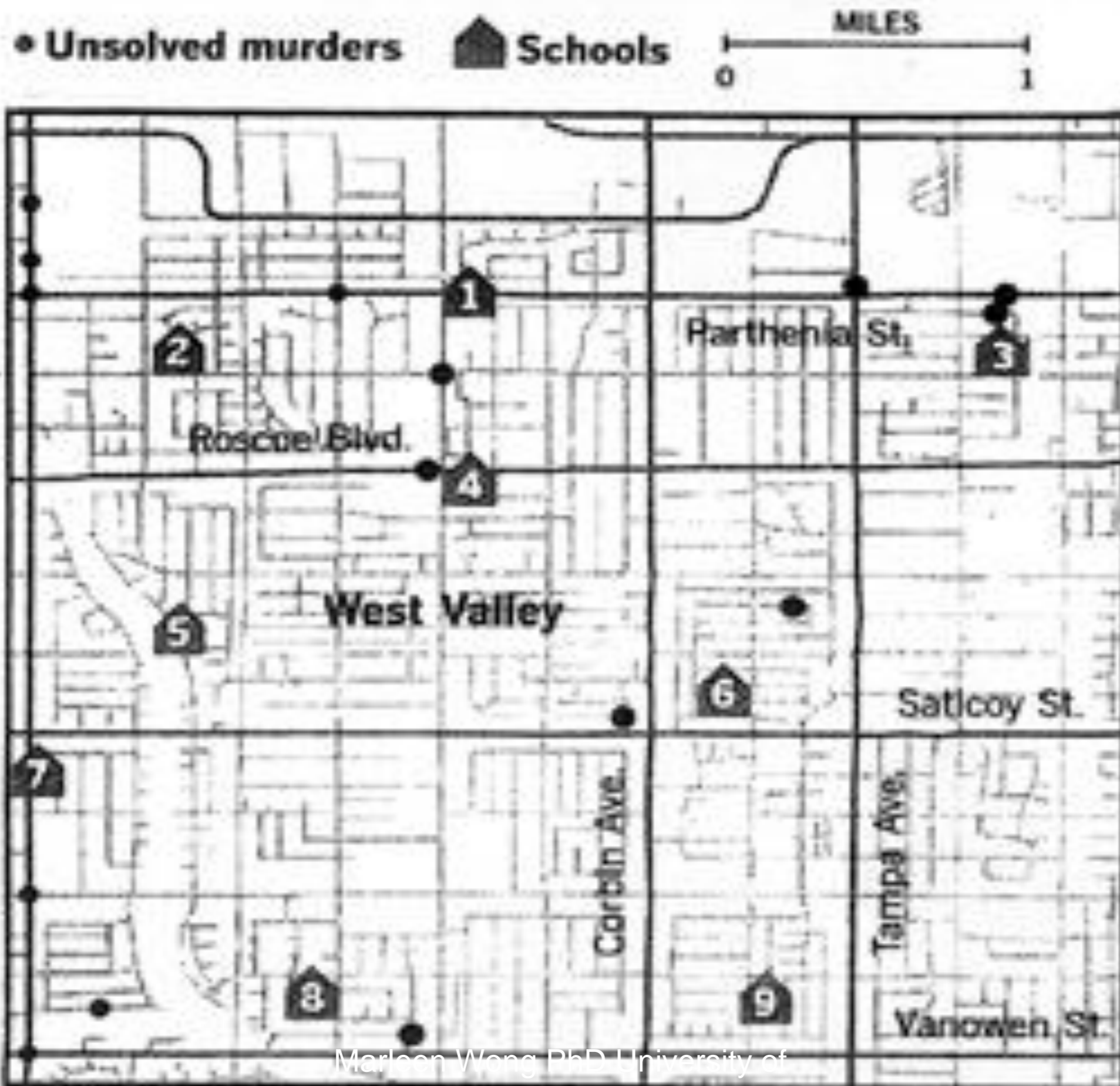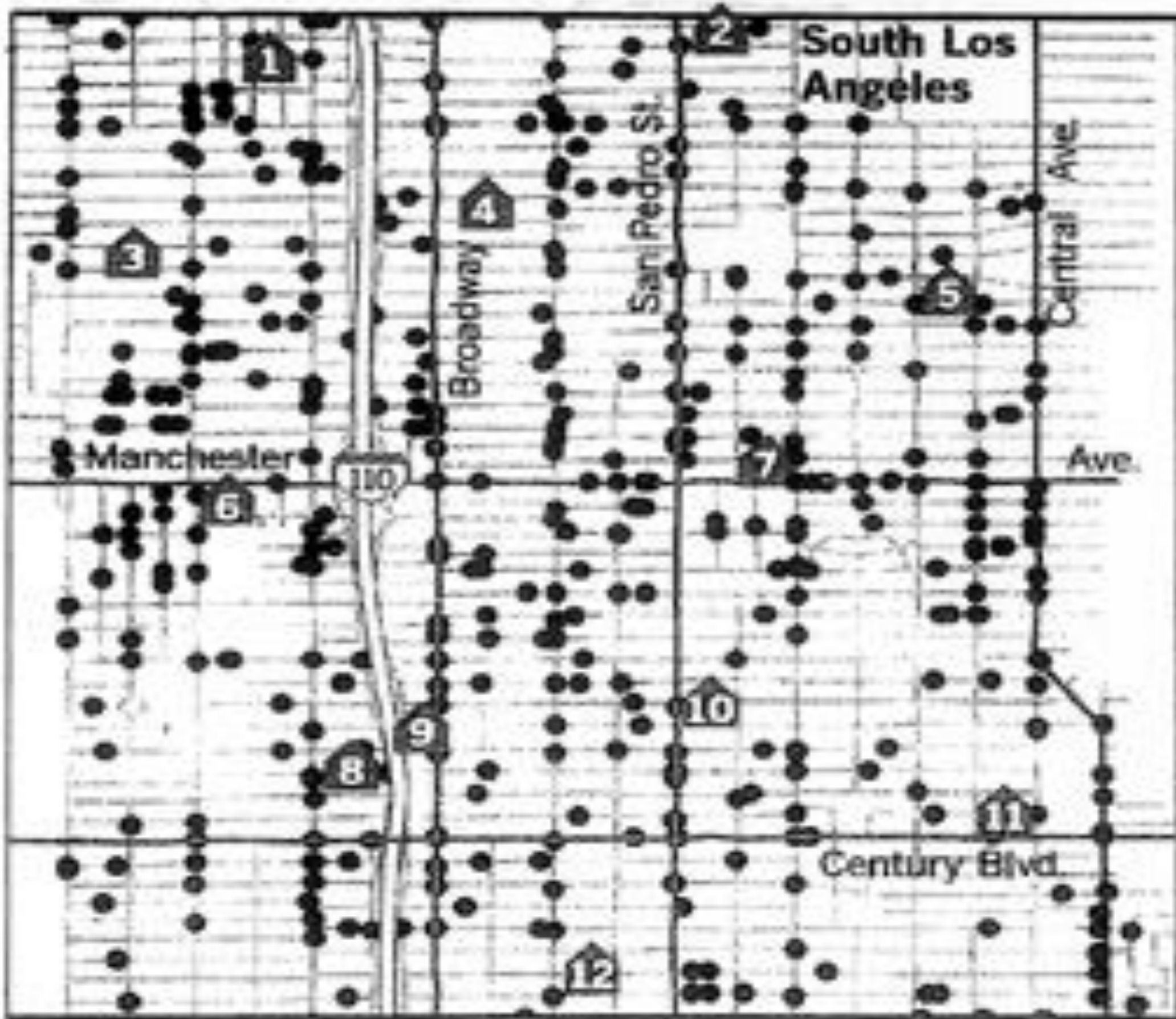
Legend: • Unsolved murders ⌂ Schools — MILES 0 to 1

Map labels: Parthenia St., Roscoe Blvd., West Valley, Saticoy St., Vanowen St., Corbin Ave., Tampa Ave.

School markers numbered 1 through 9.

Marleen Wong PhD University of Southern California

South Los Angeles

Marleen Wong, PhD University of Southern California

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What is Childhood Trauma

- Severe Emotional Response – Event(s)
- Frightening/Threatening/Overwhelming
- Unable to Cope
- One Discrete Event; Multiple Events; Cumulative Ongoing Events

National Child Traumatic Stress Network

- www.nctsn.org

Marleen Wong PhD University of Southern California

Types of Traumatic Stress

Acute trauma - a single traumatic event or sudden loss, physical or sexual assault

Chronic trauma - Multiple and varied events- domestic violence, a serious car accident, a victim of community violence

Complex trauma - Multiple interpersonal traumatic events from a very young age.

All have profound effects on nearly every aspect of a child's development and functioning.

USC School of Social Work
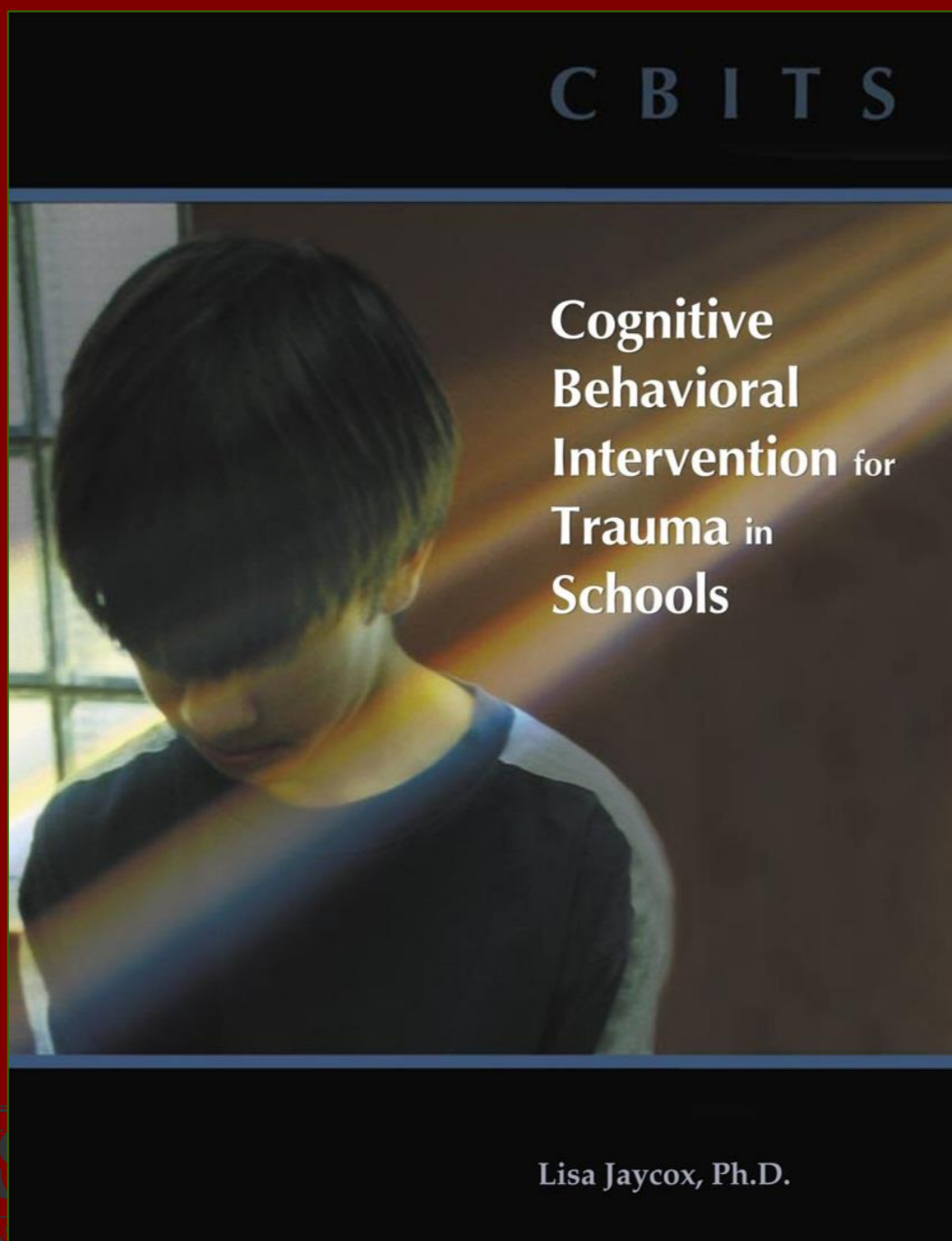
Support for Students Exposed to Trauma (SSET) – Modified for Use by Teachers

- **Modified version of CBITS**

- **Delivered by: Teachers, Graduate Interns and School Counselors**

- **Proven effective in research trials**

PROGRAM MANUAL

Support for Students Exposed to Trauma: The SSET Program

Group Leader Training Manual, Lesson Plans, and Lesson Materials and Worksheets

Lisa H. Jaycox • Audra K. Langley • Kristin L. Dean

RAND HEALTH

Core Concepts in Trauma Informed Schools

Early Detection and Intervention

Exposure to violence and trauma are detected early with early intervention

Understanding Effects on Student Learning

Students learn skills to cope more effectively with the distress that interferes with learning

Informed Teachers and Parents

Teachers and parents learn how they can support fearful and anxious students in the classroom and at home

USC
UNIVERSITY
OF SOUTHERN
CALIFORNIA

A K
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B TA

The White House Summit: Rethinking Discipline 2015

e School Pipeline to
REAL. Schools   have
d and   maintain it due to
current disciplinary   policies and practices

Marleen Wong PhD University of
Southern California

What is the School to Prison Pipeline?

- Policies and practices that push children out of classrooms and schools

- Policies and practices that are primarily punitive and law enforcement focused

- Practices that fail to fund social work and other services that are preventive in nature and developmental in scope (American Academy of Pediatrics, 2003)

School Contributions to the Prison Pipeline

Catherine Lhamon, Assistant Secretary for Civil Rights, US Dept. of Education

Filing CR Complaints of discrimination against school districts with harsh, punitive and reactive suspension/expulsion policies, targeting students of color. "We have the trust of the national community bringing to us their deepest hurts and asking for resolution…"

Marleen Wong PhD University of Southern California

Harsh Facts in the US

- Black students are suspended and expelled at a rate four times greater than white students, a trend that begins in preschool.

- Black students represent
  - 16% of student enrollment,
  - 31% of students subjected to a school-related arrest.

How Does Teaching Fail Traumatized Students?

Phillip Goff, UCLA:

ors fail to utilize brain science approaches to learning which may contribute to the achievement gap and discriminatory approaches to discipline in schools

Child Trauma Changes Brain Chemistry and Function

- Extreme Stress has a measurable effect

- The amygdala functions dominate

- The frontal cortex does not activate

- Flight or fight/Life or death situations are not fertile ground for learning or positive relationships

The Change in Brain Development

- Problems in Executive Functioning
- Little Emotional and Behavioral Self Regulation
- Inhibiting Language Development
- Low Academic Achievement
- Impaired Peer and Adult Relationships

(Perry 2000)

Marleen Wong PhD University of Southern California

The White House Summit: Rethinking Discipline 2016

- Trauma Informed Approaches – to Protect Girls – from Trauma and Depression

- Increased Commercial Sexual Exploitation of Girls

- In Gangs

- Abused Girls Leaving the Child Welfare System

Risk Factors For Childhood Trauma

- Poverty – Especially Urban Poverty
- Family Member Incarceration
- Domestic Violence
- Abuse and Neglect
- Family Chaos and Conflict
- Homelessness/Housing Insecurity
  - **(Kiser,2007)**

A Place to Begin –
Identifying At Risk Students

Chronically Absent Students

Expelled and Suspended Students

Students in Foster Care/Juvenile Justice

Special Education

Hostile, Angry, Acting Out Students

Depressed Withdrawn Students

Bullied Students

Organization or system that is trauma-informed:

- SAMHSA Definition

- 1. Realizes the widespread impact of trauma and creates potential paths for recovery;

- 2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others in the system

- 3. Integrates knowledge about trauma into policies, procedures, and practices

- 4. Seeks to actively resist re-traumatization."

Resilience Hope and Wellness

Risk Factors

Are Not Predictive Factors

Because of Protective Factors

A MOST RELEVANT and TIMELY TOPIC

Extrafamilial and intrafamilial stresses

Extrafamilial or Societal Factors That Impact on Filipino Families Nowadays:

- Horrendous traffic that debilitates and erodes our energies

- No time for family

Extrafamilial or Societal Factors That Impact on Filipino Families Nowadays:

- Violence in our midst graphically portrayed by the media almost everyday (very powerful subliminal effect)

- Violation of human dignity and respect as our core value

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Extrafamilial or Societal Factors That Impact on Filipino Families Nowadays

- Intrusion of technology into family life – texting, Facebook, Instagram, etc. – lessens actual person-to-person communication
- Internet addiction and cyberbullying – adolescent depression

Extrafamilial or Societal Factors That Impact on Filipino Families Nowadays

- Feminization of global labor migration (more mothers away) – "Nawala ang Ilaw ng Tahanan"
- Changes in family structures, etc. – single parent families, separated families, blended families

Intrafamilial Stresses

- Conflicts among parents and children (generational gap)
- Marital conflicts
- Sibling rivalry, favoritism, bullying
- Questioning core family values

The Family is a System

- Any stress experienced by one member is inevitably experienced by all the other members.

  "Ang sakit ng kalingkingan ay nararamdaman ng buong katawan."

Source: Carandang, MLA. (1987, 2001). *Filipino children under stress: Family dynamics and therapy* (5th printing). Manila, Philippines: Ateneo de Manila University Press.

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How do families react? How are they affected?

- Family stressed – 1st sign on children (the most vulnerable members of the family)

- Children acting out – barometer of the family mirror/absorb family stress – signal for help - *tagasalo*

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How do families react? How are they affected?

- Eg. 10 – drowning "red flag'

      7 – stealing (financial set-back)

      4 ½ - playhouse, "want to die"

      17 – leaves the house, escape from stress

How do families react? How are they affected?

- Stage of development and their different reactions:

  - Younger:

    - Fears, nightmares – negative world view

    - Aggression/fighting, tantrums, etc.

    - Inattentiveness (lack of focus)

    - Restlessness

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PARA SA
BATA

How do families react? How are they affected?

- Older – barkada – both good and bad

    - defiance of rules

    - aggressive behavior – bullying, cyberbullying

    - depression – withdrawal

    - school failure/truancy

    - drugs

- Parents – depression/anxiety

    - displace aggression on children (the easiest targets)

Resiliency Factors in our Families

Children are resilient. They find creative and healthy ways of coping with changes:

- Playing
  - Necessary to child's health development
  - They play our their fears or anger
  - Most natural way of expressing emotions

Resiliency Factors in our Families

- Making friends
  - Friends talk to, share with, have fun, connect with (peers) – through internet, technology

Resiliency Factors in our Families

- *achieving*
  - build sense of competence (psychological need)
  - I am good at something/self-worth
- *reaching out & communicating*
  - asking directly
- *using creative channels of expression*
  - dance, music, arts, sports, etc.
  - compositions, themes, stories
- also necessary for adults/parents

What families can do: harnessing resources

- Learn to communicate
  - ask & listen/reassurance
  - time to share: let them tell stories by listening not teaching lesson at that time

- take care of marital relationship – pillars/architects, make it your problem, talk, ask for help – so it does not become the child's problem

- Have family rituals – dinners out, prayers, etc. Regular, predictable family time.

What families can do: harnessing resources

- Tell stories - healing stories, inspirational life stories, share stories with lessons/values.

- Listen to the adolescents – listen to their music, get to know their friends, do not insult their friends.

- Learn conflict resolution – accept that conflict is necessary & learn ways to deal with it.

What families can do: harnessing resources

- time and stress management – talk about/release stresses – physical activities/ release

   - parents - have time with each other, enjoy without the kids

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BOTA

VERY IMPORTANT:

- *Parents must take care of themselves and their own lives* – so the young child must not make "salo"

- Reach out to others, extended family, community resources

Today, do one little thing to take better care of yourself

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Strengthen our families –

Solid -- THE BEST PLACE TO START -- in the task of building the inner strength and fiber of our nation.

Mother Teresa (upon receiving the Nobel Peace Prize)

"How can we have peace in the world? Go home and love your families."

How do we make the family a caring community in harmony?

MINDFULNESS
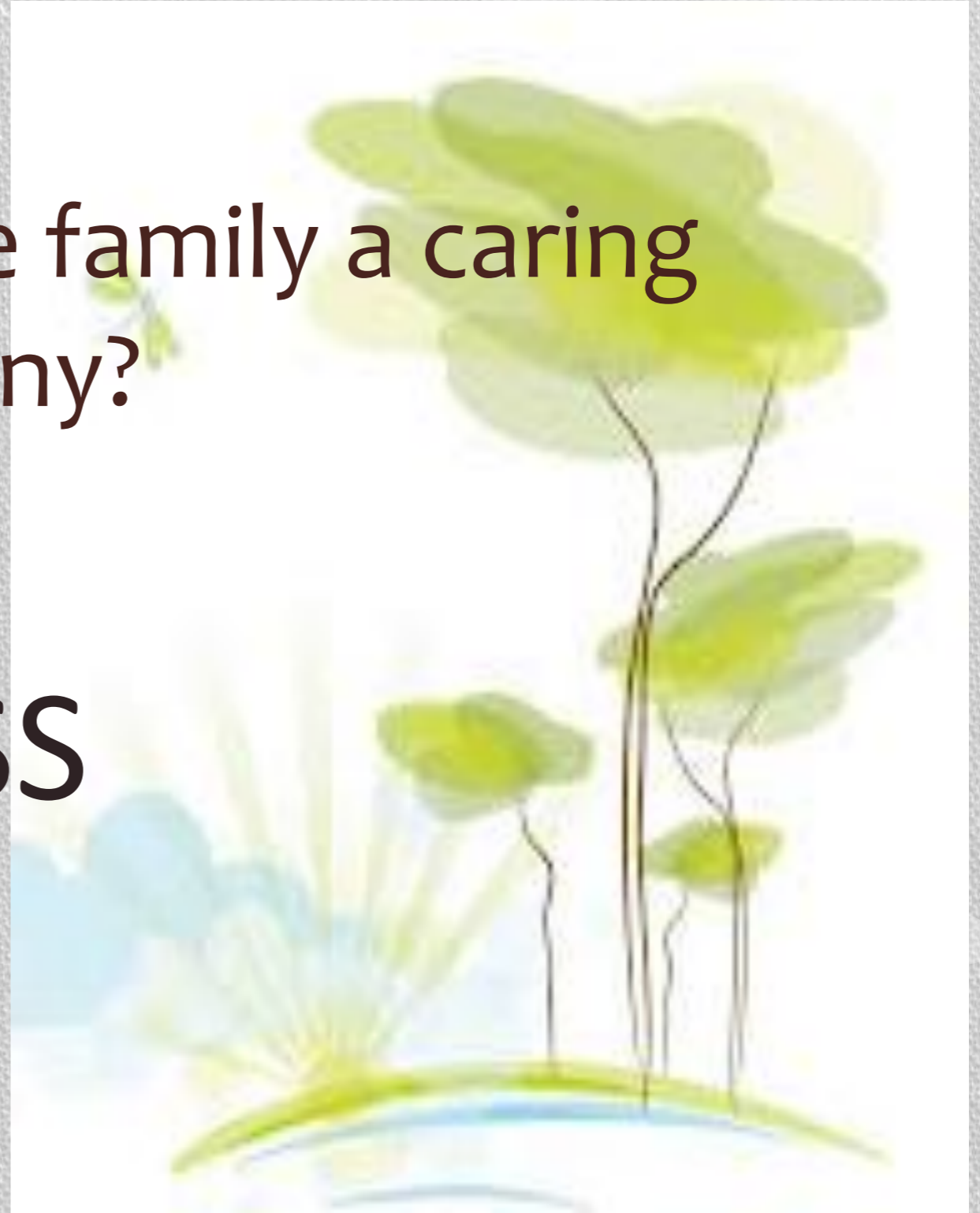
What is Mindfulness?

- ***Mindfulness*** is deliberately paying attention, being fully aware of what is going on both inside yourself – in your body, heart and mind, and outside yourself; in your environment without judgment and criticism. <u>Warmed by kindness, spiced by curiosity.</u>

  - Thich Nhat Hanh

- ***Mindfulness:*** We pay attention with respect and interest, not in order to manipulate, but to understand what is TRUE. And seeing what is TRUE, the heart is FREE.

  - Suzuki Roshi

- A way of life

MINDFULNESS

A way of life and practice.

Being TOTALLY PRESENT in the moment non-judgmentally , open and accepting.

Being aware of what is going on
inside you and around you NOW.

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Mindfulness Practice in the Family

A) Communication:

How do family members interact and talk to each other?

It means giving

TRUE PRESENCE
and
DEEP LISTENING.

PRACTICE KINDNESS AND COMPASSION

"If we can smile, we can be peaceful and happy, not only we but everyone will profit from it."

This is the most basic kind of peacework.

- Thich Nhat Hanh

The Family (School of Compassion)

- The family was a school of compassion and kindness. It's here that we learn to live with other people.

- Daily we have to move to one side in order to accommodate the needs of other family members. NEARLY EVERYDAY THERE IS SOMETHING TO FORGIVE.

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- Young:
- "The family was the place where a young child learned to live as a fully humane and mature person." – Confucius

- "The source of love is deep in us and we can help realize a lot happiness... One word, one action, one thought can reduce another person's suffering and bring that person JOY."
- Thich Nhat Hanh

Wayne Dyer: REMINDER

- "When you have the choice to be right or to be kind, always choose to be kind. Remember that you have that choice in all your daily interaction."

Wayne Dyer: REMINDER

- "This one key of being kind rather than right in any interaction that you will have will do more in transforming your life than any other course that you will take or any book that you read, or any talk that you can ever listen to. Be kind and give up your need to be right."

Summary for Parents: Basic Guide in Strengthening the Family

MINDFUL COMMUNICATION

DEEP LISTENING
TRUE PRESENCE

MINDFUL PARENTING

How to Discipline with Dignity:

Correct behavior but do not insult the person.

Discipline vs. Abuse

CORE VALUE - RESPECT

Be honest – (values)

Be kind -- be the good example
for your children

Have Family Rituals

Family meals
Praying together
Day for outing
Day for cleaning the house together, etc.

Enjoy your children

Let them PLAY
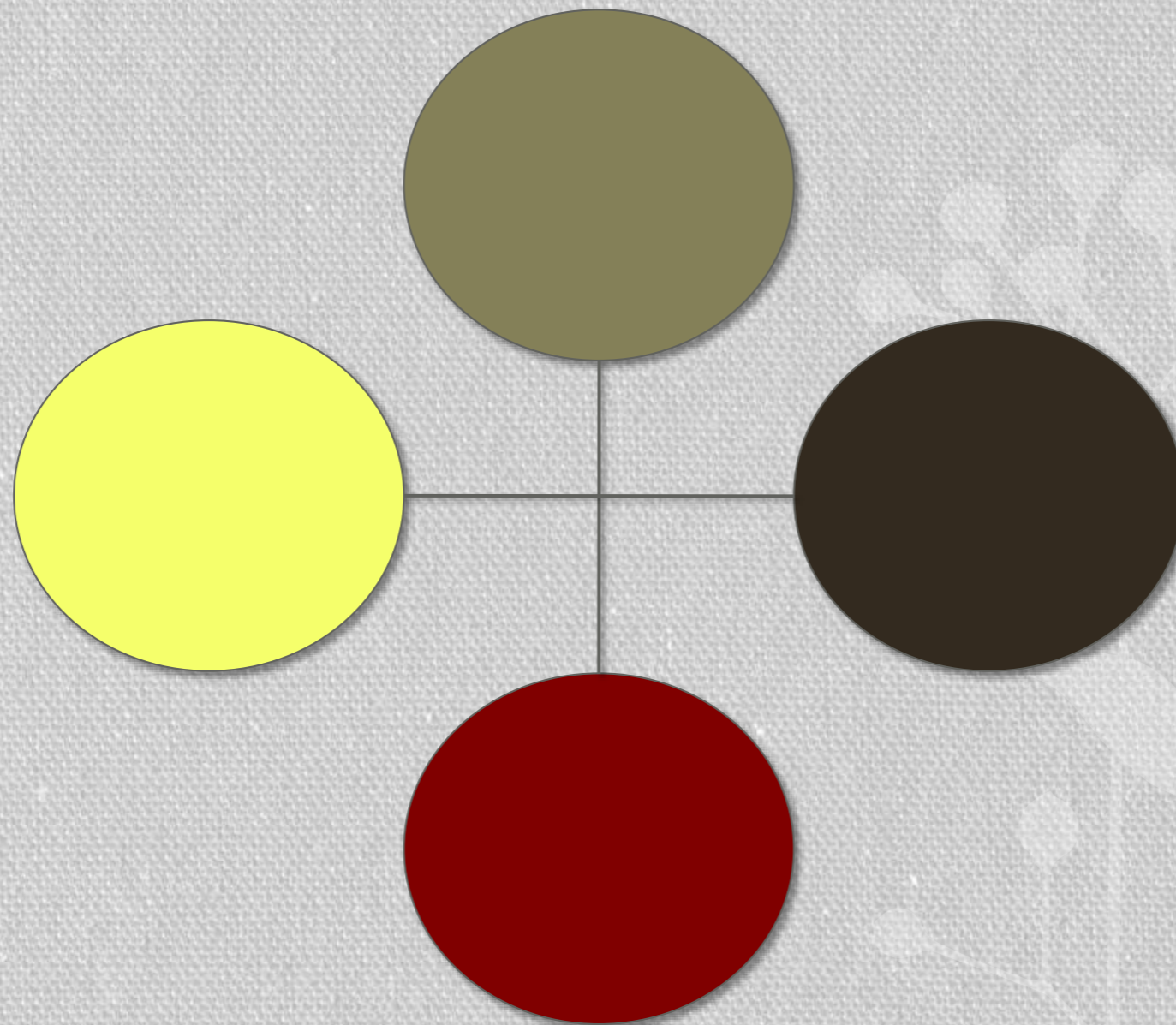
"It's in the shelter of each other that people live."

Irish Proverb

Child Protection Network

CONSUELO FOUNDATION

unicef

PRESENT

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THEME:

STRESSED?
Coping, Recovery, and Healing

DECEMBER 1-2, 2016
SMX CONVENTION CENTER MANILA
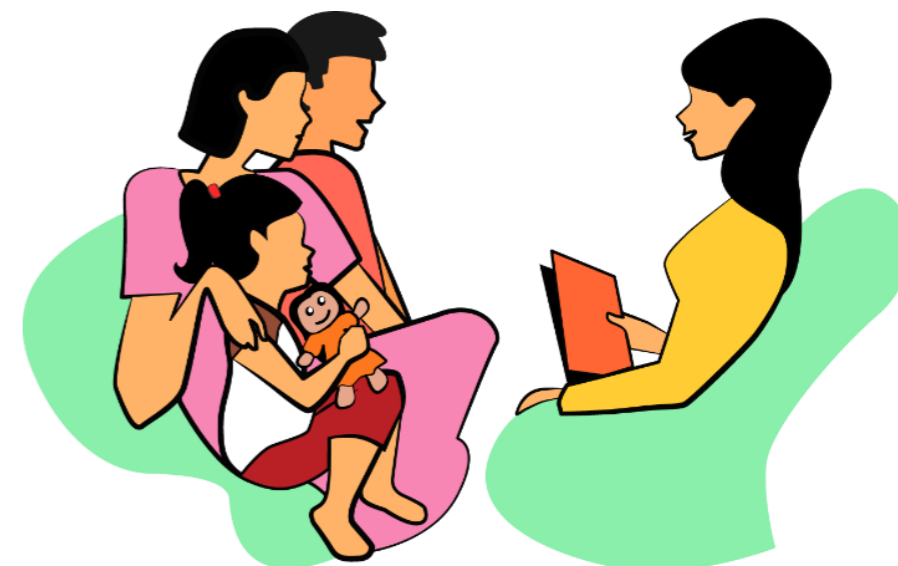
Spirituality and the Recovery from Trauma

Cornelio G. Banaag Jr. M.D.

Ako Para sa Bata

December 01, 2016

Spirituality

- Spirituality: complex concept experienced differently by different people, in different cultures of different gender and ages

- Traditionally expressed in religion, art, nature and the "built environment" (churches, temples, mosques, synagogues, pagodas, shrines) in search of the sacred

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Spirituality

- Definition has changed overtime

- Contemporary concept includes not only traditional religious indicators but also a host of themes commonly regarded as positive psychological states

- Common themes that describe spirituality
  - Purpose and meaning in life
  - Sense of connectedness: to self, others, nature, higher order
  - Call beyond self, concern and compassion for others
  - Quest for wholeness and harmony
  - Sense of transcendence: belief that there is more to life than the material
  - Activities that give meaning and value to life

Spirituality and Religion

- Spirituality: an attribute of the individual; personal/ private affective experience of the sacred; focuses on elements that provide meaning in life

- Religion: an organized social institution with prescribed beliefs, rituals, practices in relating to the sacred, with well defined boundaries

- Shared elements: common search for what is sacred or holy in life; transcendent relationship to a higher power (God/ Allah/ Buddha)

- In the best of all worlds, spirituality and religion are partners

- The most profound experience of the divine is given form and articulation through liturgy, rituals, symbols

Miller, Thoresen 2002

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Spirituality

- Intrinsic to human nature is the need to make sense of the world around us and our meaning and place within it.

- Spirituality: vehicle through which that meaning is sought

- For some, that vehicle is religion

Mental Health Foundation 2006

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Spirituality and Health Outcomes

- Growing body of literature exploring implications of spirituality in various mental and physical health outcome

- Mounting evidence that spirituality/ religiousness
  - May enhance subjective states of well-being (Ellison, 1991)
  - Lower levels of depression and psychological distress (Williams et al 1991)
  - Reduce mortality and morbidity (Levin 1996)

Miller, Thoresen 2002

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Spirituality and Health Outcomes

- UK review of literature

- Meta-analysis of 42 studies on association between mortality (of any cause) and spiritual activity demonstrates

- People with high religious involvement likely to live longer than non- religious counterparts

- Positive correlation to benefits for those with cardiovascular disorders, AIDS, cancer

Mental Health Foundation 2006

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Children, Spirituality and Religion

- Children do not make sharp distinction between spirituality and religion

- Children see the 2 concepts as highly related but with blurred boundaries in every day life

- Research/experience lead us to believe many children search for spiritual understanding at an early age
  - 3 yo boy watching newborn baby brother asks: if he were not born where would he be now?

- Children's feeling and thoughts about God appear to be a natural part of human development

- Children learn about God by watching people/acts of kindness and sharing

Children, Spirituality and Health

- Very young children have ideas of divine realities, faith, prayer

- Religious traditions provide structures for moral development, socialization of the child into different ideals of personhood and behavior, and link every day events of life to a sacred world

- Religion/spirituality: can influence child's ideas about illness, suffering, coping, healing.

- Issues with direct relevance to pediatricians, child and adolescent mental health professionals

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Children, Spirituality and Health

- A study in relationship between religion/spirituality and health in children

- Demonstrated religious practices are prevalent, perceived by children as helpful especially during adverse circumstances like being ill

Barnes et al 2000

Spirituality and Coping

- Child's spirituality and engagement in religious community provide structure for positive coping strategies

- Religious community provides child with a sense of security, of being assisted in coping

Barnes et al 2000

Spirituality and Parenting

- Spiritual/religious beliefs can shape family planning, pregnancy, childrearing, fatherhood, motherhood, meaning in child's illness

- May affect parent's response to child's disability or mental illness

Barnes et al 2000

Spirituality as Alternative Treatment

- Parents may engage in religious therapies as complements or alternatives to biomedical treatment

- Religious therapies can include prayers, anointing, laying on of hands, exorcism

- Reflects parents perception of limitations of biomedical/biopsychosocial model of treatment

- May function as barrier to appropriate biomedical treatment

Barnes et al 2000

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Spirituality and Coping

- Studies support the role of spirituality in children facing
  - Night time fears
  - Psychiatric problems
  - Hospitalization
  - Cancer
  - Terminal illness
  - Suffering adverse events/trauma

Barnes et al 2000

Contemporary Forms of Trauma

- Neglect
- Physical abuse
- Verbal abuse
- Sexual abuse
- Domestic violence

- Community violence
- School-based violence
- Natural disasters
- War
- Trafficking/slavery

Effects of Trauma

- Emotional dysregulation
- Cognitive impairments
- Internalizing/externalizing behaviors
- Relationship problems
- Physical/somatic complaints
- Spiritual "unrest"

Adult Survivors of Childhood Trauma

- Denouncing religion altogether
- Change in their faith affiliations
- Turn to more personal form of spiritual practice
- Often mention importance of spirituality in their survival and recovery
- Spirituality as resource for healing, finding meaning
- Trauma results in spiritual awakening

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Spirituality and Psychotherapy

- Until recently: great divide between religion/spirituality and psychotherapy

- Increasing recognition of limitations of the biopsychosocial perspective

- Mental health professional continue to feel uncertain about spiritual issues in psychotherapy

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Guidelines on Use of Spirituality with Children (Biopsychosociospiritual)

- Clinicians should routinely assess children's spiritual beliefs and practices

- Assess the child and family beliefs/values

- Assess the child and family daily practices

- Assess the child and family spiritual/religious involvement in their community

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Levels of Biopsychosociospiritual Interventions

- Individual counseling/psychotherapy

- Group psychotherapy

- Community based interventions integrated with mental health professionals and religious leaders

Suggested Activities

- Create a safe/sacred place to acknowledge/remember the trauma
- Saying or writing a prayer
- Reading spiritual text
- Journaling and story telling
- Use of creative arts
- Connection with nature

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Conclusions

- Spirituality is part of children's everyday life

- Children's spirituality needs to be nurtured

- Spirituality plays an important factor in the face of adversities and losses

- Trauma can have long lasting negative impact in the life of an abused child.

- Mental health practitioners should be willing and able to include spirituality in the psychotherapeutic care of child trauma survivors

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Further Information and Resources (Mental Health Foundation)

Further information can be found in the following publications.

- **Strategies for Living** [33]
  Mental Health Foundation, 2000. ISBN 1-903645-72-6
  http://www.mentalhealth.org.uk/publications

- **Knowing our own Minds** [32]
  Mental Health Foundation, 1997.ISBN 0-901944-39-4
  http://www.mentalhealth.org.uk/publications

- **Taken Seriously (The Somerset Spirituality Project)** [19]
  Mental Health Foundation, 2002.ISBN 1-903645-29-8
  http://www.mentalhealth.org.uk/publications

- **Spirituality and Mental Health Care: Rediscovering a Forgotten Dimension** [8]
  John Swinton.Jessica Kingsley, 2001.ISBN 1-85302-804-5
  http://www.jkp.com/catalogue/

Further Information and Resources (Mental Health Foundation)

- **Mind Guide to Spiritual Practices[153]**

  Sara Maitland.Mind, 2004. ISBN 1-903567-41-6

  http://www.mind.org.uk/information/booklets/

- **Promoting Mental Health: A Resource for Pastoral and Spiritual Care [94]**

  Church of England

  http://www.cofe.anglican.org/info/socialpublic/homeaffairs/mentalhealth/parishresource.pdf

- **Spirituality and Mental Illness [72]**

  Rethink, 2004

  http://www.rethink.org/documentation.rm?id=690

HOW CHILDREN SEEK HELP
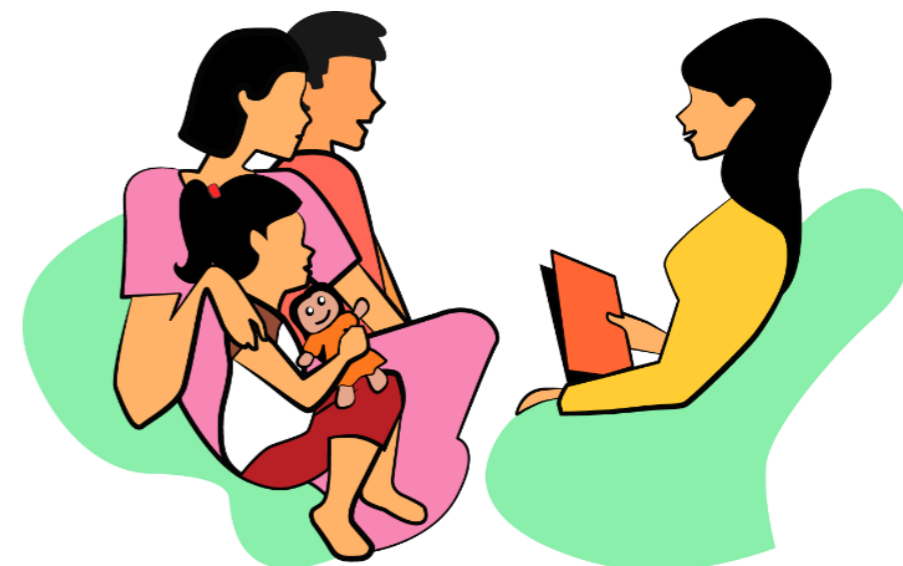
BERNADETTE J. MADRID, MD

AK PARA SA BTA
THE INTERNATIONAL CONFERENCE IN MANILA

THEME:
STRESSED?
Coping, Recovery, and Healing

DECEMBER 1-2, 2016
SMX CONVENTION CENTER MANILA

How Children Seek Help

Bernadette J. Madrid, MD
Executive Director
Child Protection Network Foundation, Inc.

OBJECTIVES OF THE PLENARY LECTURE

- Share the results of the National Baseline Study on Violence against Children (VACS) on the disclosure of abusive experiences of children and the response to their disclosure.

- Compare the VACS result with the profile of children seen at the Child Protection Unit.

- Identify the challenges that prevent children from seeking help and accessing child protection services.

- Make recommendations on the next steps.

Results of the National Baseline Study on Violence Against Children (2015)

- Council for the Welfare of Children, UNICEF
- National Steering Committee on VACS

National Baseline Study on Violence Against Children (2015)

- Prevalence is very high!

- 3 out of 5 were physically and psychologically abused, and bullied

- 1 in 5 children were sexually violated.

- More than half experienced at least 2 types of abuse.

Type of Violence	Lifetime Prevalence	Current Prevalence (Last 12 mos.)
Child Physical Abuse	66.3%	35.1%
Child Psychological Abuse	59.2%	33.0%
Child Sexual Abuse	17.1%	1.6%

National Baseline Study on Violence Against Children (2015)

In actual numbers:

Number of children in the Philippines in 2015 is **40,392,575**

Physically abused children = **26,780,277**

Psychologically abused children = **23,912,404**

Sexually abused children = **6,907,130**

Type of Violence	Lifetime Prevalence	Current Prevalence (Last 12 mos.)
Child Physical Abuse	66.3%	35.1%
Child Psychological Abuse	59.2%	33.0%
Child Sexual Abuse	17.1%	1.6%

How many of the abused children disclosed
what happened to them?

- Among those who were physically abused,
  only 10.1% disclosed to someone:
  51.6% were male
  48.4% were female

How many of the abused children disclosed
what happened to them?

- Among those who were emotionally abused,
  only 11.8% disclosed to someone:
    45.5% were male
    54.56% were female

How many of the abused children disclosed what happened to them?

- Among those who were sexually abused, **only 11.9% disclosed to someone:**
  56.3% were male
  43.7% were female

For the few children who disclosed, how long after the abuse did they disclose?

- It is the same pattern for the different types of abuse; approximately half disclosed within 3 days of the incident while the other half disclosed weeks, months and years after.

To whom, if ever, did the children disclose what happened to them?

- **Majority disclosed to their friends**
- **10-20% disclosed to their mother**
- **Very few to other relatives**
- **Almost none to the authorities**

The key role of teachers and guidance counselors:

The teacher and guidance counselor are the most common persons with the duty to report, that abused children disclose to or seek help from.

What were the common reactions of the first person to whom abuse was disclosed?

1. Listened to me, was sympathetic
2. Talked to the perpetrator
3. Did nothing
4. Did not believe me
5. Informed my parents or guardian

Was there a difference in the reaction to boys versus girls?

YES!

For sexual abuse, there was less sympathy for the boy and more either did nothing or did not believe the boy.

Attitudes Towards Reporting

78% of the respondents claimed that they would report a case of child abuse to the Authorities if the abused person is a relative or a close friend and

68.8% said that they will report even if the abused person is not personally close to them.

How many reported to the official acceptors of reports of child abuse i.e. barangay, police, DSWD?

- For physical abuse and psychological abuse: 1% -2 % of the 11% who disclosed

- For sexual abuse: 2% - 5% of the 12% who disclosed

Less than 1% reported to the official acceptors of reports.

Awareness of Services

- 29.2% of the children were aware of services that they can utilize for their needs.

- Among those who were aware of child protection services, 30.5% have utilized Child Protection Units; which is 8% of the total respondents.

Most common reasons for not seeking help from professionals & other community leaders:

1. I do not see what happened to me as a problem.
2. I am shy or afraid to consult them.
3. I can handle my own problem.
4. I have someone to confide my problems.

Profile of the Children Seen at the Child Protection Unit (2005-2015)

A total of 13,245 children consulted at the Child Protection Unit (CPU) from 2005-2015 with an average of 1,204 children per year. Figure 1 shows that those who consulted were mostly females (87%).
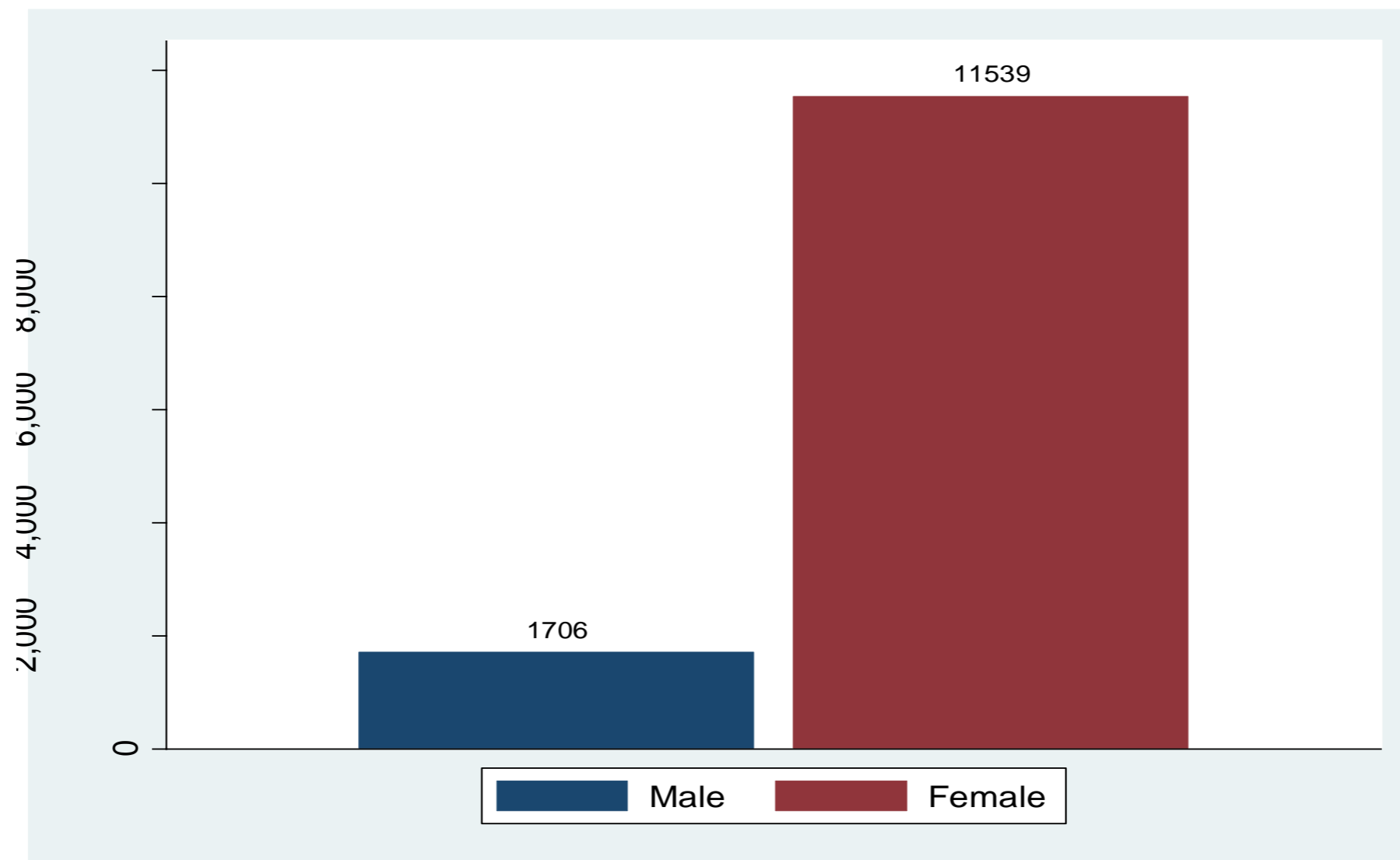
Of the 11,539 girls , 30 percent are between 13 to 15 years of age while another 17 percent are those between 16 and 17 years of age. On the other hand, majority of the boys are 9 years old and below (Figure 2).
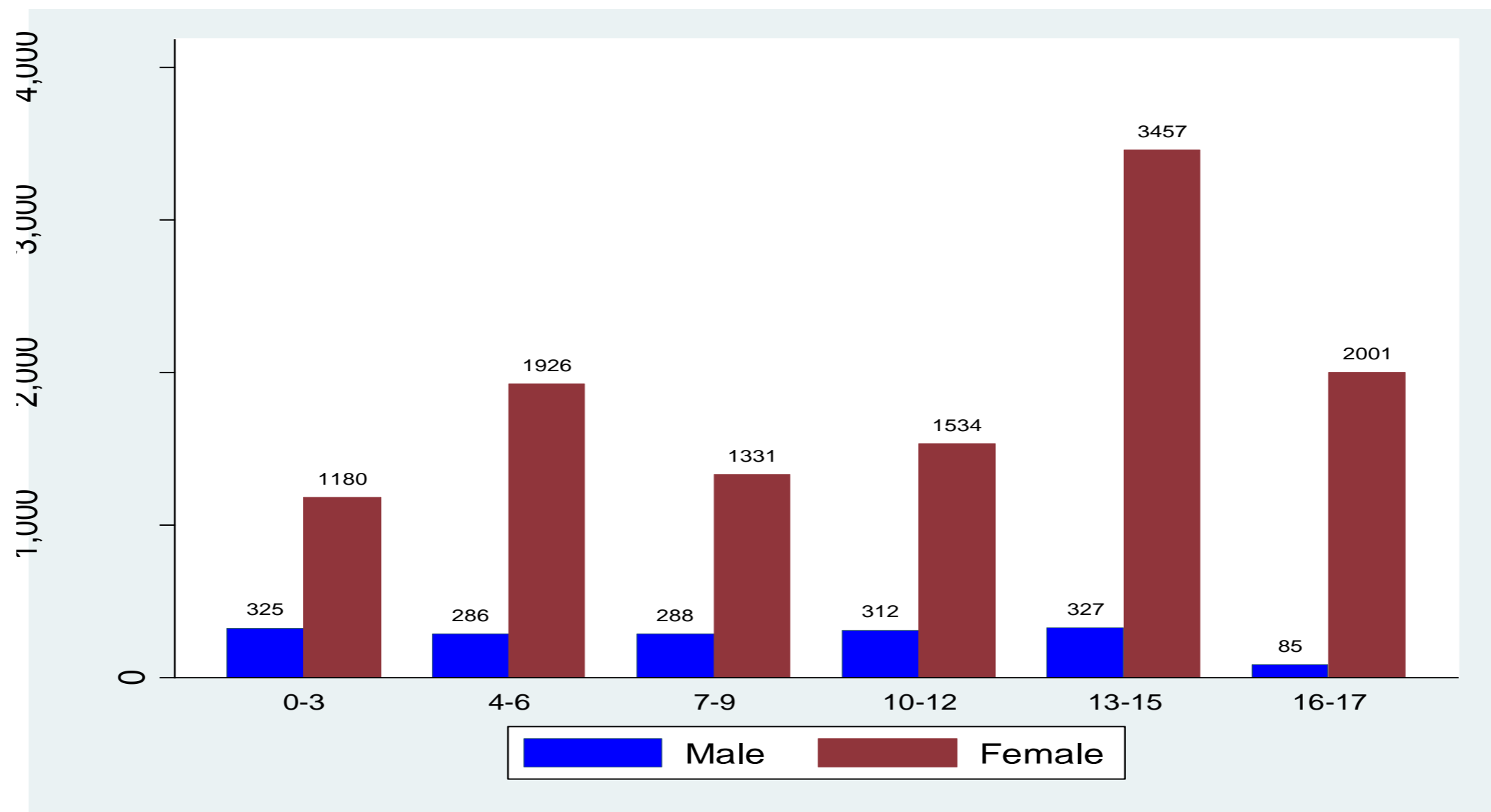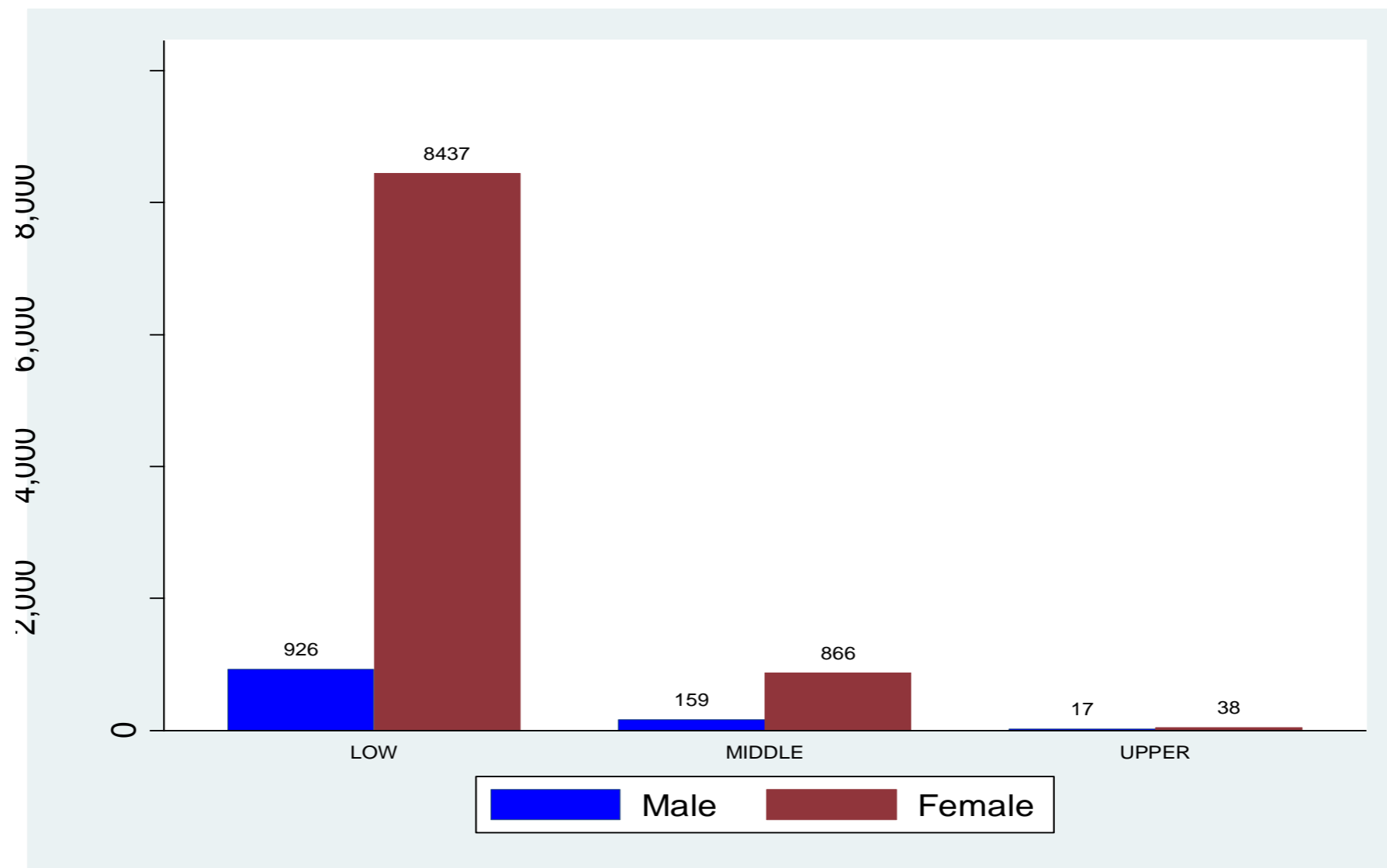
The boys who are brought to CPU are significantly younger than the girls for both physical and sexual abuse.

- The median age of the girls is 12 years old.
- The median age of the boys is 9 years old.

# 9 out of 10 girls and 8 out of 10 boys came from a poor household

Socio-economic status of CPU patients by sex (n = 13,245)

Based on the results of the National Baseline Study on Violence Against Children (2015) the prevalence of abuse in the low, middle and high-income classes is the same.

It seems, however, that **majority of the middle and high-income classes do not report abuse!**

Most reported type of abuse among the girls is sexual abuse with a total of 8,220 (71%) of the 11,539 female consultations. Whereas, half of the boys experienced sexual or physical abuse.
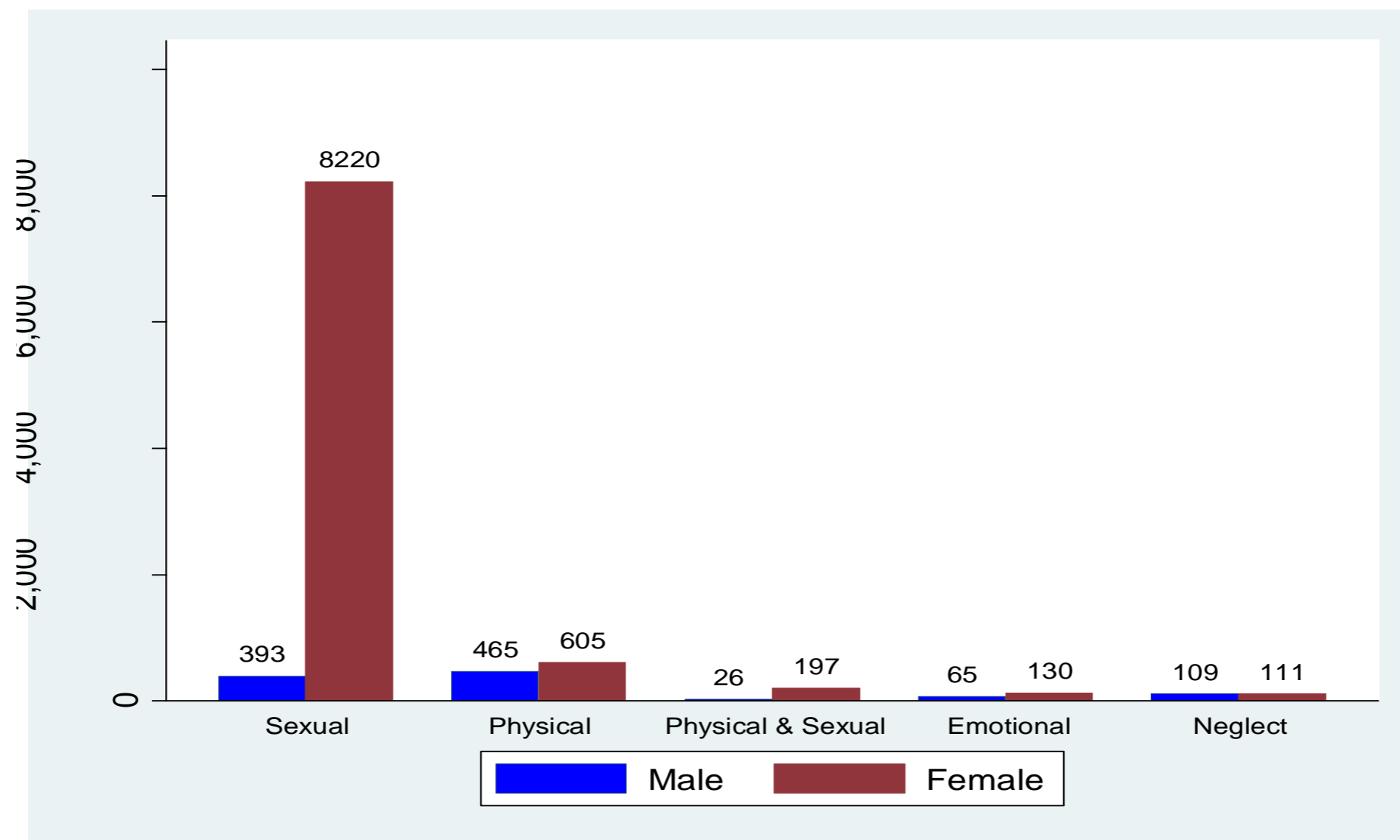
Distribution of CPU patients by type of abuse and sex (n = 13,245)

Many of the sexually abused boys and girls were abused several times before they were brought to CPU.
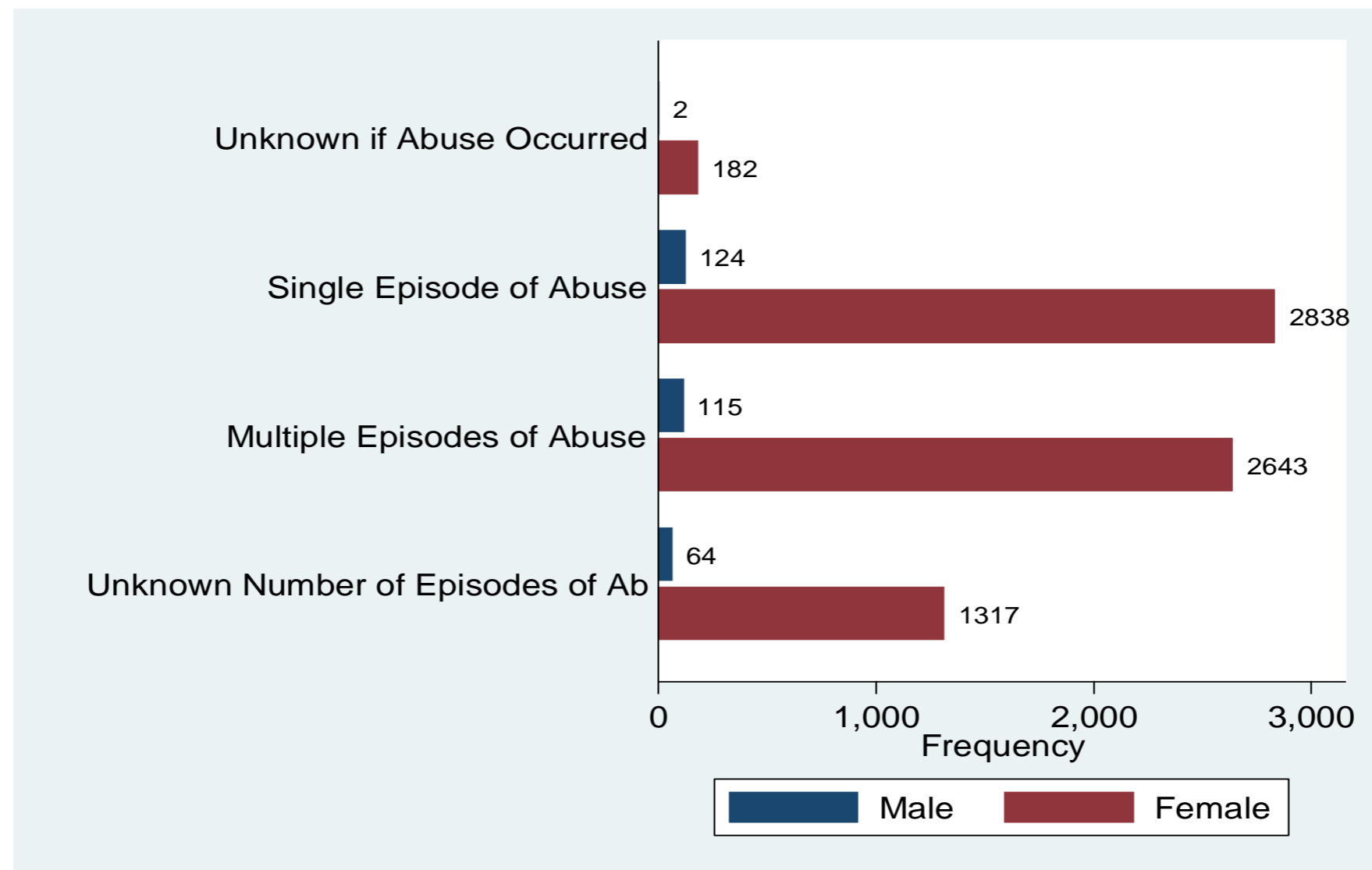
Occurrence of abuse by sex among sexually abused patients (n = 8,613)

A delay in seeking care puts children at risk for
continuing abuse or repeated abuse.

Female patients were commonly referred to the CPU by the PNP, whereas, most males came to CPU on their own accord
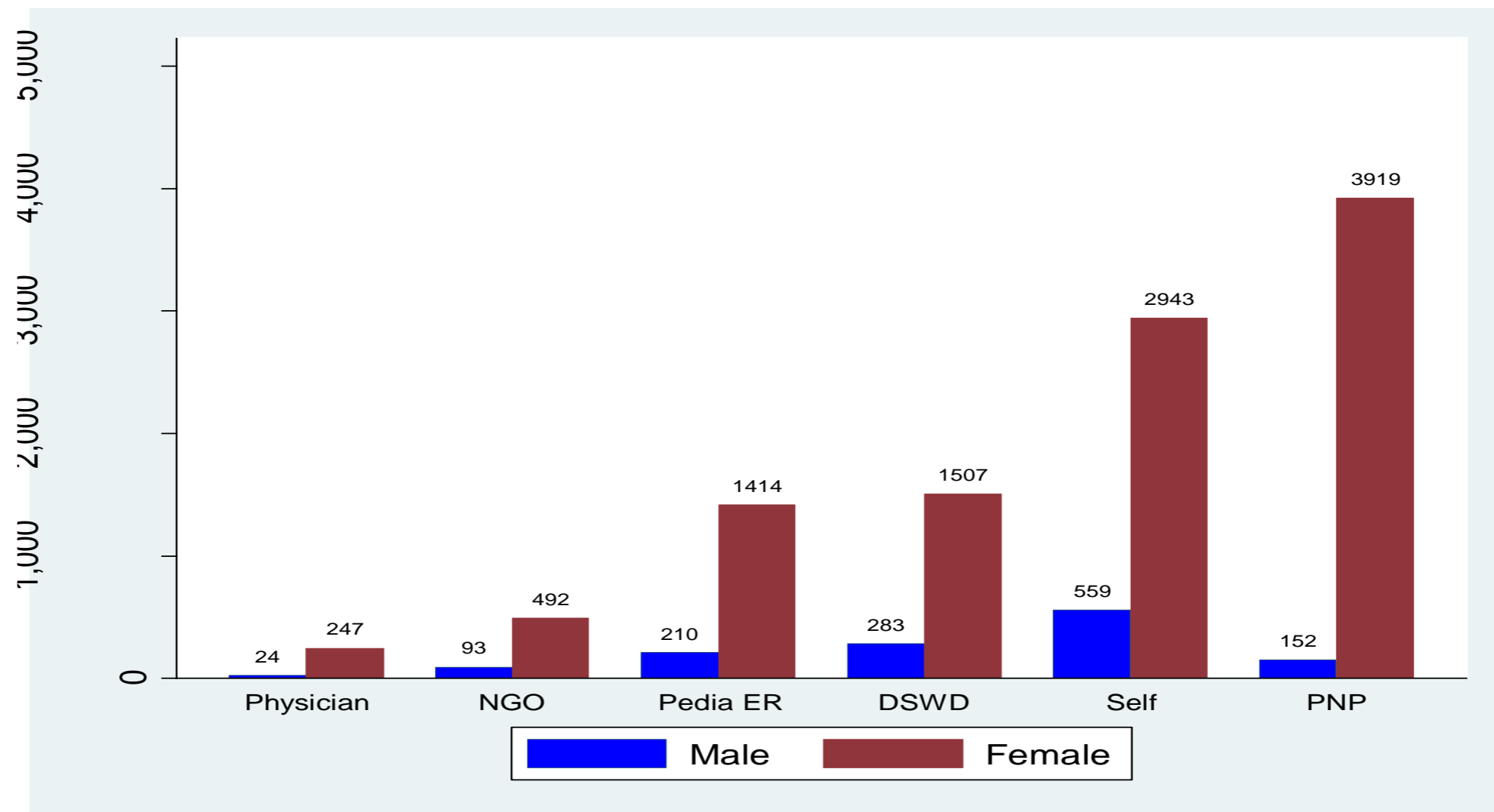
Source of referral by sex (n = 13,245)

Among the physically abused male and female patients, majority reported the abuse to the CPU directly. This is followed by referrals from DSWD for both males and females
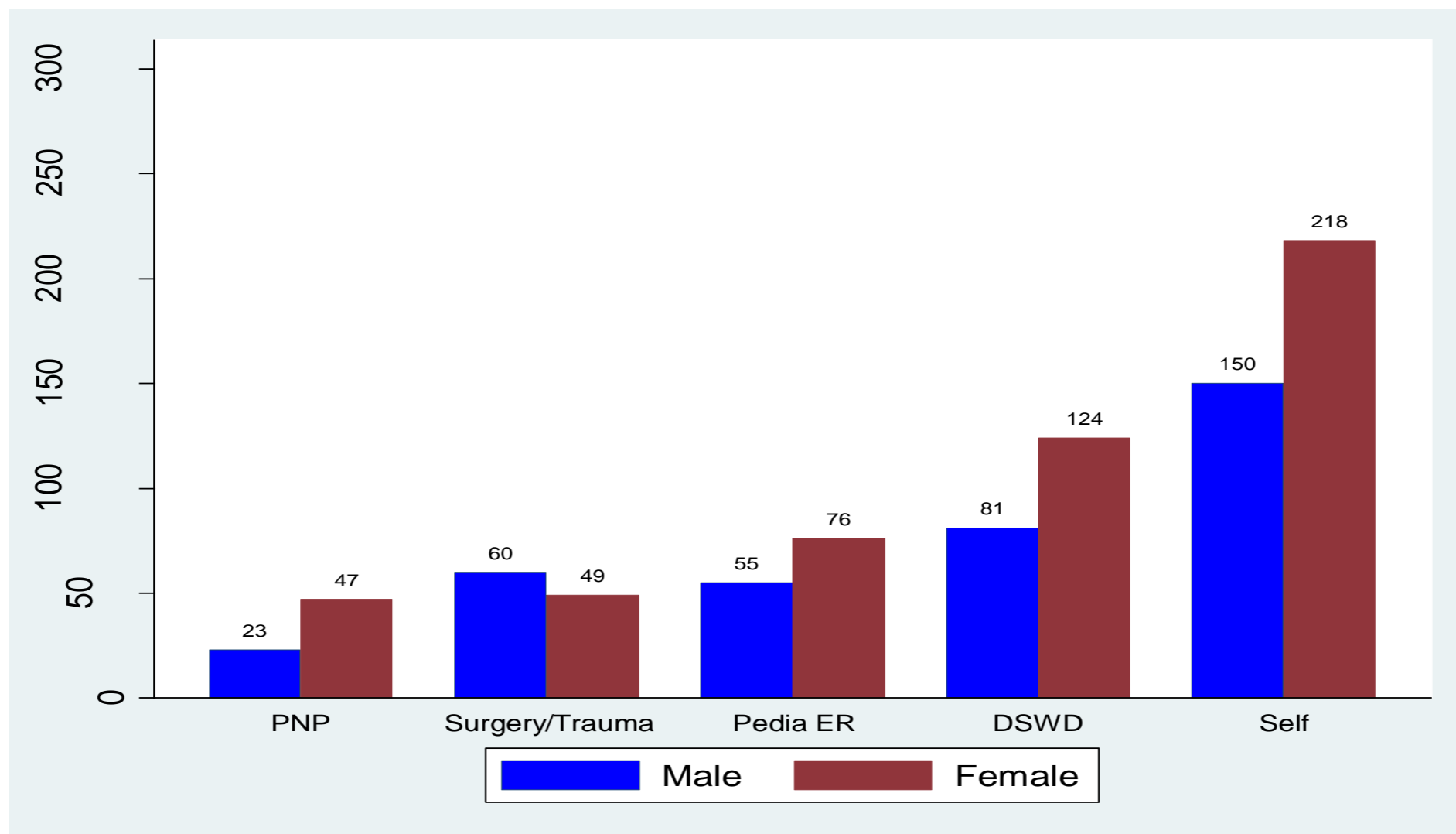
Source of referral among physically abused patients by sex (n = 1,070)

Among the emotionally abused patients, majority of both males and females reported the abuse by themselves. This is followed by patients referred by the DSWD for females and patients referred by the PNP for males.
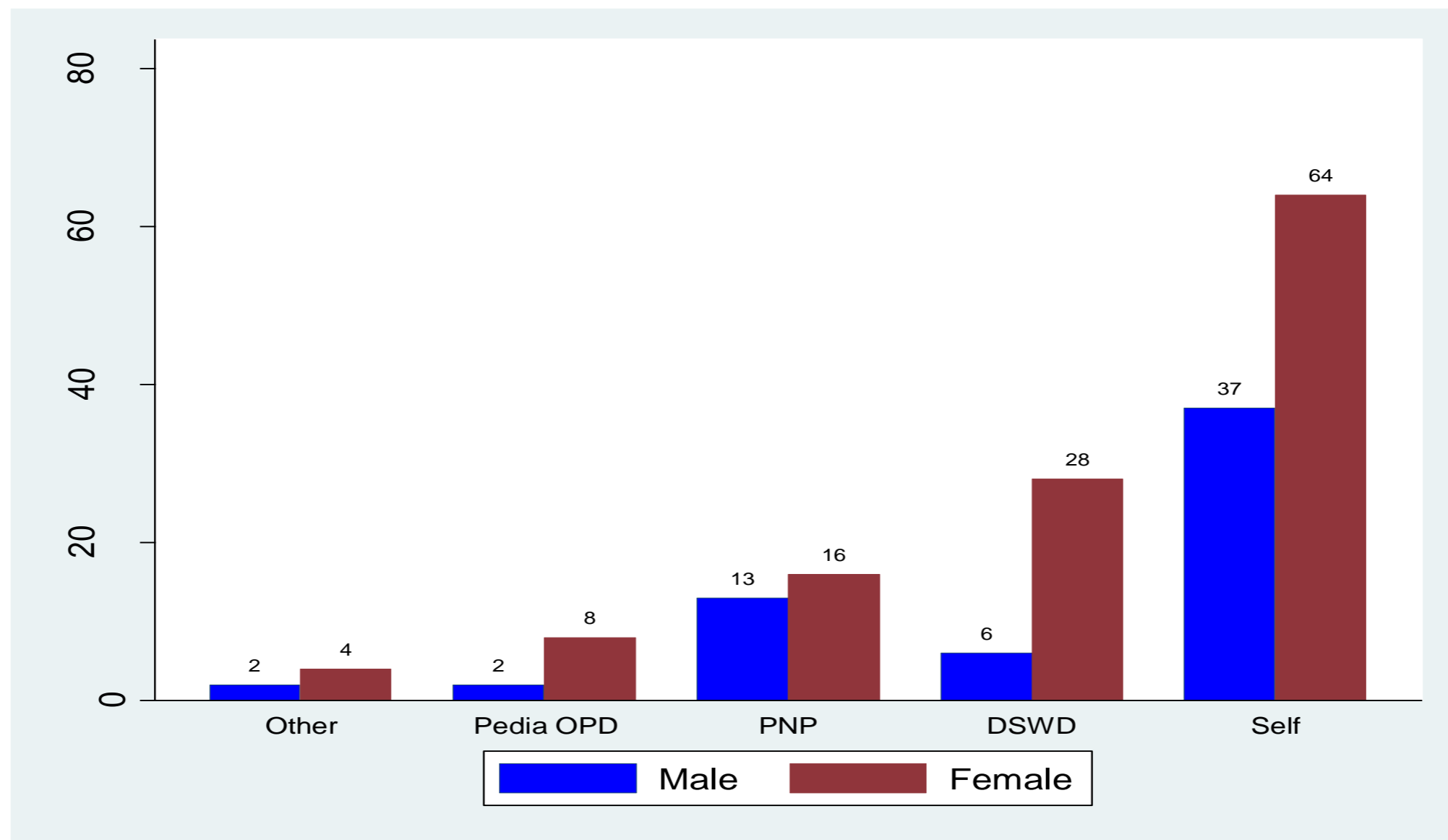
Source of referral among emotionally abused patients by sex (n = 195)

Among sexually abused girls below 13 years old, the most common site of abuse is the child's home. Girls who are at least 13 years old commonly experienced the abuse in the perpetrator's home.
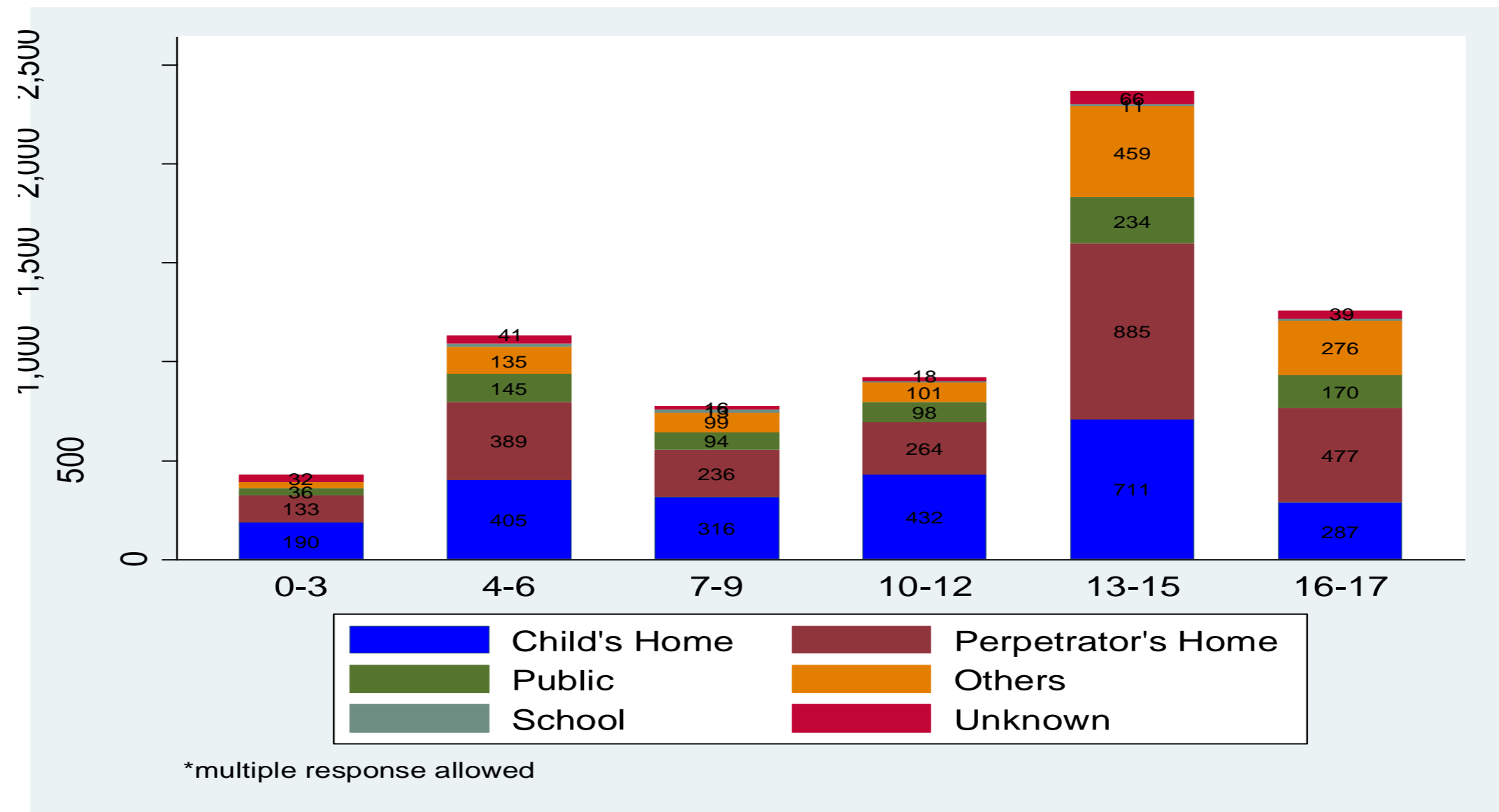
Site of abuse by age of patients among sexually abused females (n = 8,220)

The most common site of sexual abuse among males is the perpetrator's home for all age groups except among 0-3 and 7-9 years old.
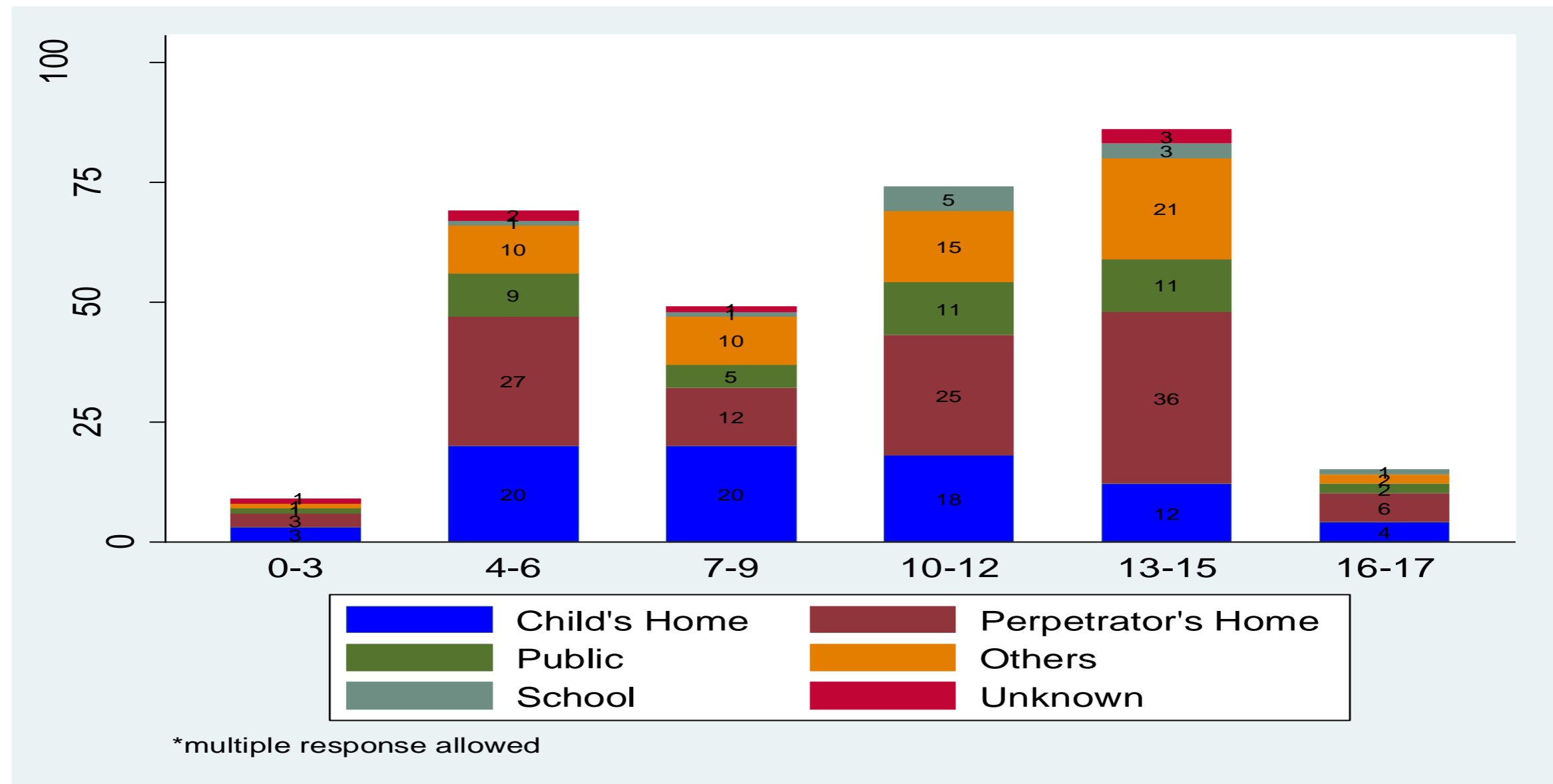
Site of abuse among sexually abused male patients by age (n = 393)

Male and female children brought to CPU for all types of abuse tend to disclose the abuse to their mothers first.

*multiple response may occur
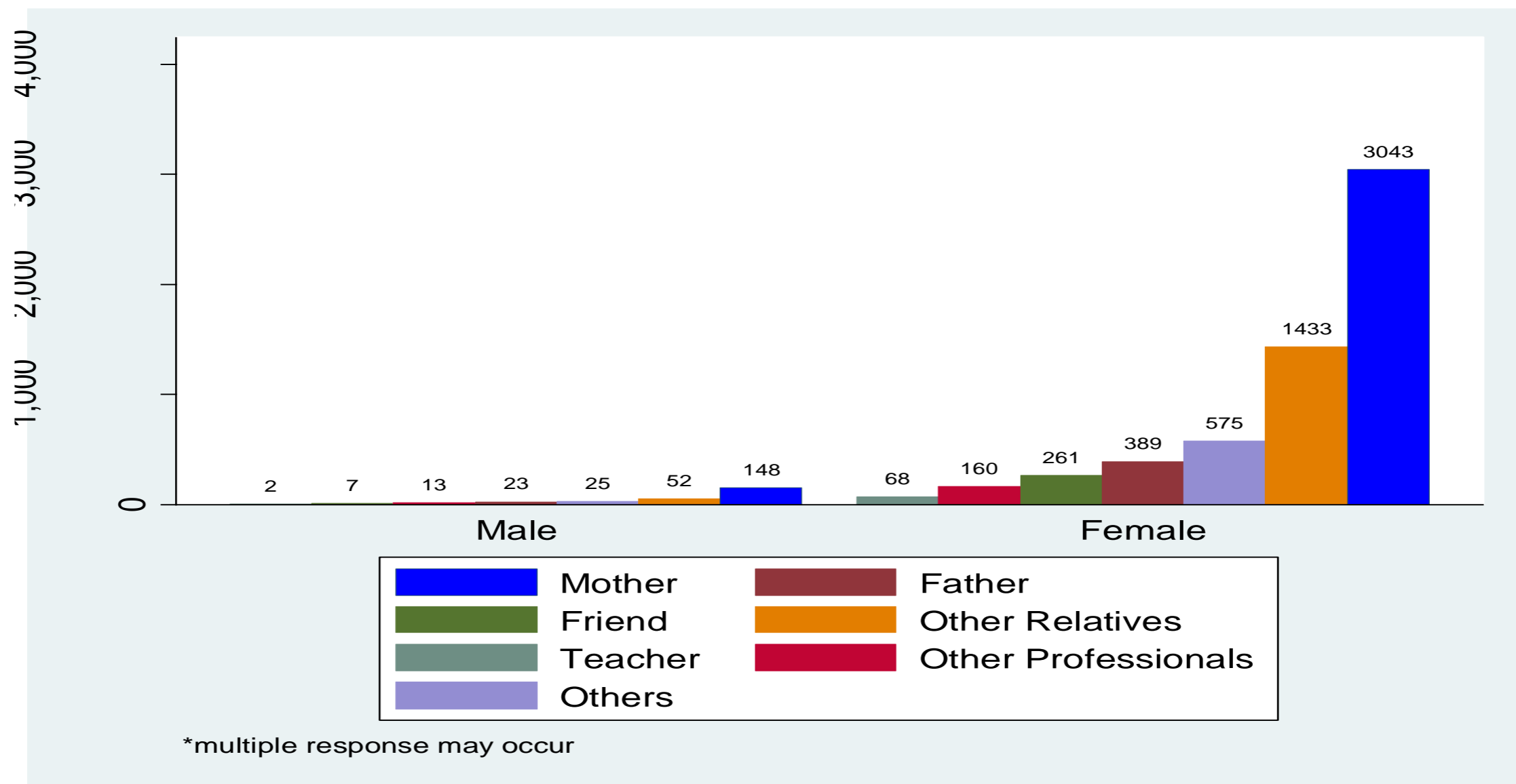
Disclosure among sexually abused patients by sex

- Majority of those who were brought to CPU had somebody who believed in them and who were willing to protect them.

- Only 3% of the children were recommended to be placed under protective custody

Only 16% (62 of 393) of sexually abused males and 24% (1,963 of 8,220) of sexually abused females have undergone medical examination within 72 hours after the incident of abuse.
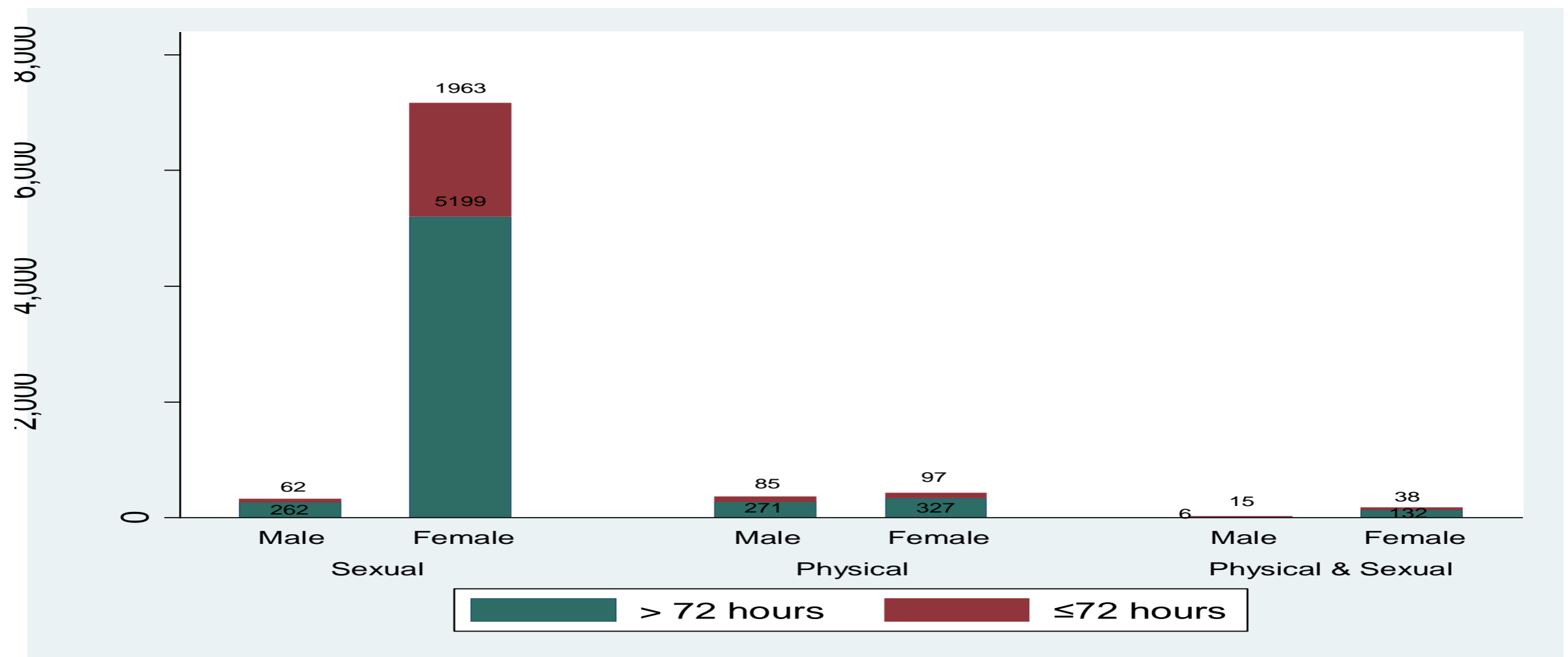
Distribution of patients who underwent medical exam within 72 hours after the abuse by sex and type of abuse (n = 13,245)

There is delay in disclosure and there is delay in seeking care.

SUMMARY OF THE FINDINGS

- The prevalence of the different types of abuse is very high.
- Children do not usually tell anybody about their abusive experiences.
- Most people that children tell do not report the abuse to authorities.
- People react differently to boys and girls of different ages especially with regards sexual abuse.
- There is a delay in both disclosure and in seeking care.
- Only children with somebody who believes them and are willing to protect them receive help.

Recommendations

Recommendations

- Young people need to be equipped with information on how to respond to a friend who makes a disclosure of abuse.

- Professionals dealing with children should be trained to recognize the signs of abuse, ask the right questions, know how to report and refer their suspicions.

- Professionals especially teachers need to respond quickly and appropriately to disclosures. Informing the child what will happen next.

Ask the Question

- Many disclosures are prompted by questions from care-givers, family and friends.
- Being asked directly or indirectly about abuse can provide children with opportunity and purpose for telling.
- Asking children how they are feeling when there are signs of distress can help them disclose.
- Being asked by a parent who is supportive and open to believing and hearing about abuse can help a child disclose.

Office of the Senior Practitioner, New South Wales

www.facs.nsw.gov.au/__data/assets/file/0003/306426/Literature_Review_How_Children_Disclose_Sexual_Abuse.pdf

What to Avoid Doing

- There are many tragic stories where disclosure resulted in the child or youth being made to meet with the perpetrator of the abuse and/or a parent who was part of the abuse or actively ignored the abuse. Within these scenarios, many recanted their disclosure and went on to suffer additional abuse.

What needs to be done

- The child needs to be believed, feel supported and action needs to be taken to protect the child such as reporting to the proper authorities. They also need emotional support as they go through the process of investigation.

- Confidentiality with regards to whom the information will be shared is important.

What needs to be done

For the workforce of the child protection system:
- The whole process of reporting, investigation, preliminary investigation, the trial and the after-care services should be seamless, child-sensitive and timely. This can only be achieved by trained personnel.

What needs to be done

For the general public:

- Better awareness and information about where the general public can seek information is an important strategy for increasing opportunities to intervene and stop abuse.

What needs to be done

For the Children and Youth:

- Knowledge about abuse, and what is "normal" within other families
- Knowledge about a safe and confidential/ anonymous place they could turn to for help in schools
- Knowledge about other services such as Child Helpline or local services such as a Child Protection Unit where they could get help

Debbie Allnock and Pam Miller, 2016
No one noticed, no one heard:
a study of disclosures of childhood abuse
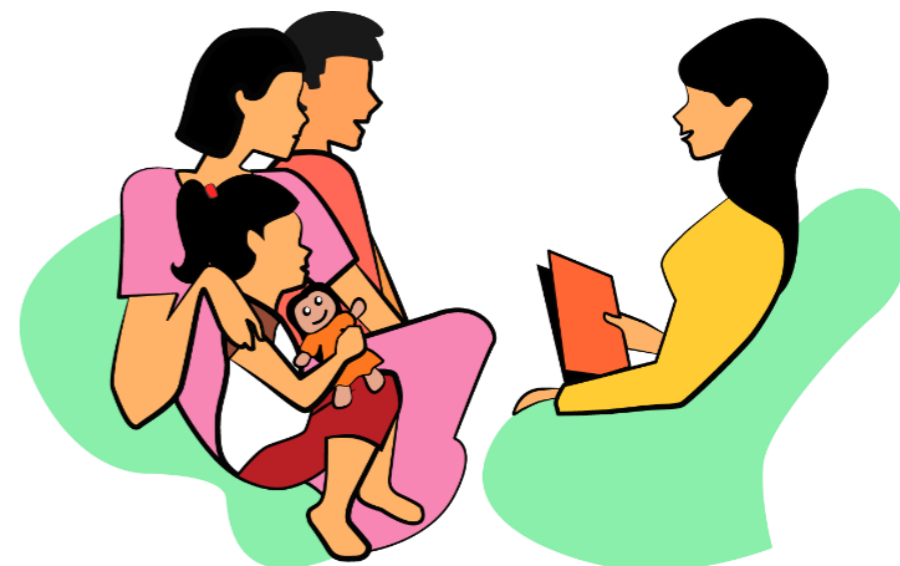
MUSIC THERAPY

IRVIN S. KALUGDAN, MMT, MT-BC
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DR. ROBERTO KALUGDAN, OBGYN

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THEME:
STRESSED?
Coping, Recovery, and Healing

DECEMBER 1-2, 2016
SMX CONVENTION CENTER MANILA

Music Therapy

In practice. In research and In real life.
Plenary Session
10:35am - 11:15am
December 2, 2016

How is music therapeutic to you?

1. Using your electronic device (phone/tablet)

2. Download / Open a QR Code Reader App

3. Scan this QR Code using your QR Code Reader App

4. Open the Link (below) in a Browser

5. Click on the "+" (Plus) symbol

6. Answer the question: How is music therapeutic to you?

https://padlet.com/iskalugdan/fv5mlj5k4ulo

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"ther-a-py"
Increase, Improve, Maintain, Restore

[ˈTHerəpē]   Noun

treatment intended to relieve or heal a disorder.

"a course of antibiotic therapy"

synonyms: treatment, remedy, cure

"a wide range of complementary therapies"

the treatment of mental or psychological disorders by psychological means.

"he is currently in therapy"

Activity #1:   Hello Song

Hello (Hello) Hello Everybody

Ako Para Sa Bata

Hello (Hello) Hello Everybody

Ako Para Sa Bata

We're <u>ALL</u> here to <u>HELP</u> children

Let's remember <u>ALL</u> children.

Why Music?
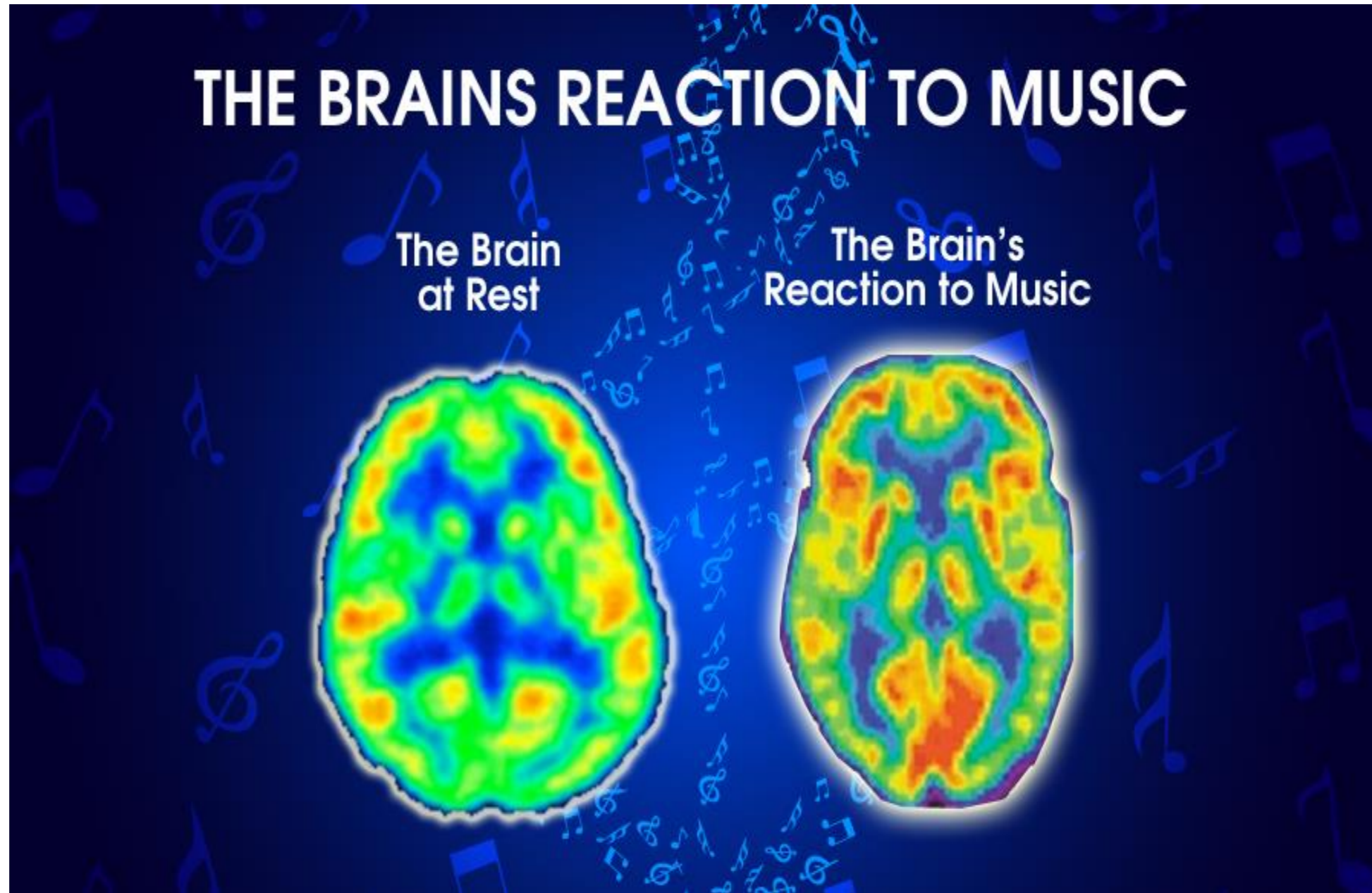
Music Therapy and Traumatic Brain Injury

"Music has always been really important to me," Gabby Giffords says. "While my speech is getting better every day, throughout my recovery, I have been able to sing to some extent." Giffords was injured on the left side of her brain – the hemisphere that controls speech. It's the right side that processes music, she explains.

"Music therapy was so important in the early stages of my recovery because it can help retrain different parts of your brain to form language centers in areas where they weren't before you were injured," says Giffords.

What is Music Therapy?

Music Therapy is the **clinical and evidence-based** use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program.

Who are music therapists?

- Degrees Specific to Music Therapy
  - Bachelor, Equivalency, Masters & PhD
- Clinical Training & Internships,
- Board Certification Exam,
- Additional Credentials & Specializations,
  - RMT, CMT, ACMT, NMT, SPED, LCAT & GIM
- Continuing Education
- Proficiency leading sessions with voice, piano, guitar and percussion instruments.

Music Therapy Coursework

Musical Foundations (45%)
Music Theory
Composition and Arranging
Music History and Literature
Applied Music Major
Ensembles
Conducting
Functional Piano, Guitar, and Voice

Clinical Foundations (15%)
Exceptionality and Psychopathology
Normal Human Development
Principles of Therapy
The Therapeutic Relationship

Music Therapy (15%)
Foundations and Principles
Assessment and Evaluation
Methods and Techniques
Pre-Internship and Internship Courses
Psychology of Music
Music Therapy Research
Influence of Music on Behavior
Music Therapy with Various Populations

General Education (20-25%)
English, Math, Social Sciences, Arts,
Humanities, Physical Sciences, etc.
Electives (5%)

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Music <u>as</u> Therapy VS Music <u>in</u> Therapy

Music AS therapy:

Musical elements are directly connected to and often manipulated to directly affect therapeutic outcomes within a client's treatment plan.

Music IN therapy:

The use of music in it's pre-existing form to help achieve non-musical goals within a therapeutic environment.

Music Therapy: Interdisciplinary Team

Music Therapists in School Settings: Individualized Education Plan team

Medical Settings: Doctors, Nursing, Affiliated Disciplines

Rehabilitation Settings: Physical & Occupational Therapists

Mental Health: Psychiatrists, Psychologists & Social Workers

Complimentary Medicines: Art Therapy, Dance/Movement Therapy, other Music Therapists

Music Therapy in Practice

Referrals for Music Therapy Services

- medical,
- developmental,
- mental health,
- and education professionals;

- family members;
- clients;
- caregivers;
- or others involved and authorized with provision of client services.

Music Therapy: Standards of Practice

1. Referral
2. Assessment
3. Develop Treatment Plan
4. Implementing an Individualized Treatment Plan
5. Evaluating the Client's Response
6. Develop Termination / Transition Plan
7. Least Restrictive Environment
8. Collaborate with Client, Caretakers and Others
9. Perform Services within the Context of the Clinical Setting

Music Therapy: Professional Ethics

The scope of music therapy practice is based on the values of
- non-maleficence,
- beneficence,
- ethical practice;
- professional integrity,
- respect,
- excellence;
- and diversity.

Music Therapy: Types of Services
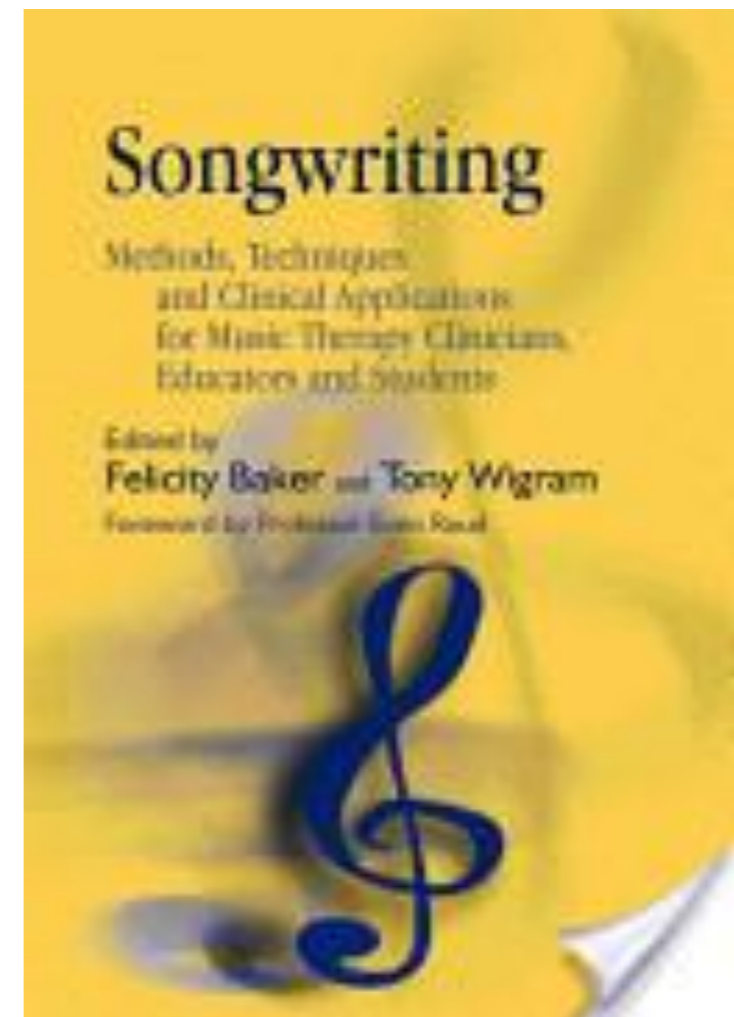
- Therapeutic Session
  - Individual
  - Group
- Assessments
  - Eligibility
  - Consultative
- Consulations
  - Individual
  - Group
  - Progamatic

Non-Musical Goals of a Music Therapist

- promote wellness

- manage stress

- alleviate pain

- express feelings

- enhance memory

- improve communication

- promote physical rehabilitation

- procedural support…

Music Therapy: In Practice

- Examples of Music Therapy Techniques
- music improvisation,
- receptive music listening,
- songwriting,
- lyric analysis/discussion,
- music and imagery

Songwriting

Methods, Techniques and Clinical Applications for Music Therapy Clinicians, Educators and Students

Edited by
Felicity Baker and **Tony Wigram**

Foreword by Professor Even Ruud

Activity # 2: Piggy Back Songwriting

"Sunday Morning" by Maroon 5

1. Today's Day of the Week

2. The weather outside

3. How the weather makes you feel

Back & forth we sway like branches
in the (natural event from #2).

Change of weather, still together
when it ends.

Chorus:

That may be all I need.
In darkness you are all I need.
Come and rest your bones with me.
Driving slow on (#1) morning, I
never want to leave.

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Music Therapy: In Research

Peer Reviewed Publications:

Journal of Music Therapy (Oxford Press & AMTA)

www.Voices.no (online journal based out of Norway)

Music Therapy Today ([online](#) WFMT)

Nordic Music Therapy Journal

Anecdotal Case Studies:

Music Therapy Perspectives (Oxford Press & AMTA)

Alan P. Merriam's 10 functions of music Anthropology & Ethnomusicology

1. Emotional expression.

2. Aesthetic enjoyment.

3. Entertainment.

4. Communication.

5. Symbolic representation (symbols within the text, notation, and cultural meaning of the sounds).

6. Physical response (dancing and other physical activity).

7. Enforcement of conformity to social norms (instruction through song and rhymes).

8. Validation of social institutions and religious rituals (use of music in religious services and state occasions).

9. Contribution to the continuity and stability of culture (music as an expression of cultural values).

10. Contribution to the integration of society (use of music to bring people together).

https://prezi.com/m/2j7iixo_owg-/merriams-10-functions-of-music/

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Typical Music Therapy Populations

AMTA Fact Sheets

http://www.musictherapy.org/research/factsheets/

- Children, adolescents, adults, and the elderly with mental health needs
- Developmental and learning disabilities
- Alzheimer's disease and other aging related conditions
- Substance abuse
- Traumatic brain injuries and physical disabilities
- Acute and chronic pain, including mothers in labor.
- Premature infants
- Individuals who are terminally ill

Therapeutic goals for Trauma, Depression & Substance Abuse

- Specific Outcomes:
- Reduced muscle tension
- Improved self-image/Increased self-esteem
- Decreased anxiety/agitation
- Increased verbalization
- Enhanced interpersonal relationships
- Improved group cohesiveness
- Enhanced self-expression and self-awareness
- Increased motivation
- Improved perception and differentiation of feelings
- Improved ability to titrate abreaction, self sooth, recognize and cope with traumatic triggers

Music Therapy: In Real Life

- Job Opportunities
  - Music Therapy
  - Other Therapeutic Professional Position
- Program Based vs. Contract Services
- Maintaining Therapeutic Environment
- Additional Certifications
- Fundraising
- Grant Writing
- Outreach
- Other duties as assigned

AMTA Member Survey Results 2015

Average salary reported for music therapists in 2014 was $53,735 (an increase of $3,000 from previous year).

An estimated 1.5 million people received music therapy services in 2014.

Music therapists provided services in an estimated 33,330 facilities in 2014.

New: 26% of survey respondents are music therapy business owners.

The average salary increased in 24 states over 2014 reports.

Most commonly reported job title was "Music Therapist," by 59% of survey respondents.

Ninety new music therapy jobs were created in 2014 as reported on the 2015 survey (an increase from 73 created in 2013).

Average rates for individual music therapy services across the country are a reported $65 per hour.

Average salaries increased in six of seven AMTA regions in the United States and also outside the U.S.

29% of survey respondents reported receiving some form of reimbursement for music therapy services.

Annual salary for those with 10 or fewer years' experience was a reported $45,069.

Average rates for group music therapy services across the country are a reported $73 per hour.

Salaries have increased steadily since 1998.

Where do music therapists work?

- psychiatric hospitals,
- rehabilitative facilities,
- medical hospitals,
- outpatient clinics,
- day care treatment centers,
- disability service agencies,
- community mental health centers,
- drug and alcohol programs,

- senior centers,
- nursing homes,
- hospice programs,
- correctional facilities,
- halfway houses,
- schools,
- and private practice.

Think of ways that music can be therapeutic to you and your loved ones.

- Attending a concert or outdoor festival with your family or friends
- A release from a stressful day at work
- To identify with how you're feeling at the time
- Reminiscing over cherished moments
- Finding a deeper meaning in a song
- Song dedications…

Music Therapy in Asia
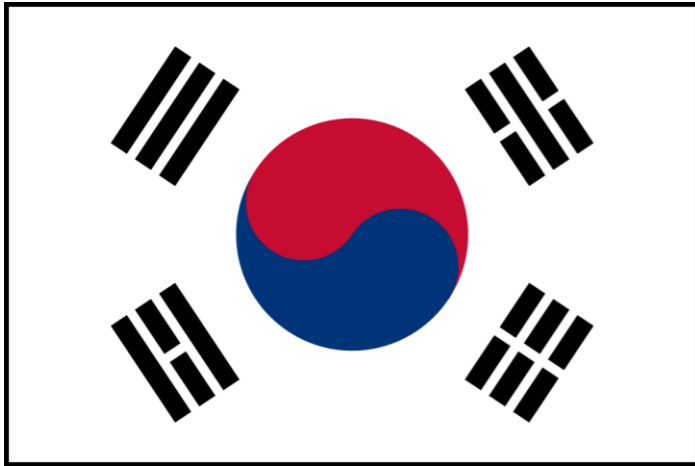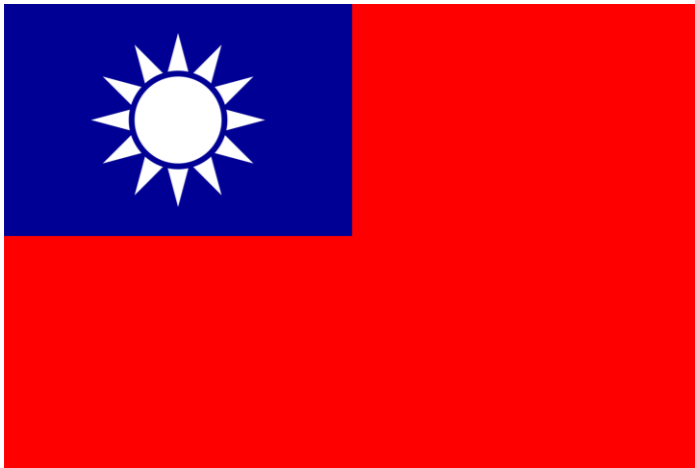
Music Therapy in South Korea
   Korean Association for Music Therapy (www.musictherapy.or.kr),
   Korean Music Therapy Association (www.kamt.com)
   5 Universities in South Korea now offer MT training programs

Music Therapy in India

● Indian Association of Music Therapy

● University of Madras offers a degree in Clinical Music Therapy

Music Therapy in Asia

Music Therapy in Taiwan

Taiwan has a music therapy association:

http://www.musictherapy.org.tw/

There are some articles on MT and Taiwan in Voices:

https://voices.no/index.php/voices/search/search

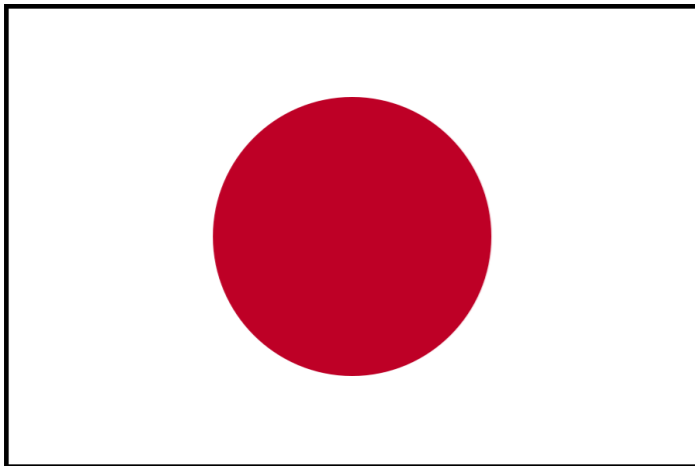**Music Therapy in China**

- Chinese Professional Music Therapy Association gives an RMT credential.

- There are 13 music therapy training programs in China

Music Therapy in Asia

Music Therapy in Japan

The Japanese Music Therapy Association (JMTA) has 15 approved training institutions.

https://voices.no/community/?q=country/monthjapan_may2003

Music Therapy in Thailand

- Mahidol University has a Masters in Music Therapy

- https://voices.no/community/?q=country/monththailand_october2004

Music Therapy in the Philippines

Goal: Recognized professional music therapy services provided by certified music therapists.

Clinical Training: Education, Internships & Professional Development

National Association: Outreach, Oversight & Accountability

Certifying Body: Accreditation, Standards & Ethics

Client Referrals: Primary Care Physicians, Psychiatrists, Teachers, Social Workers, Counselors, and Self-Referral

Insurance Reimbursement: Managed & Private Pay Health Care

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World Federation of Music Therapy

http://www.wcmt2017.com

http://www.wfmt.info/

Fun = Therapeutic

―

"Music is my rock & it rolls my blues away."

Music Therapy Part 2 Workshop
1:00 - 5:00 pm

Thank you for participating and listening!