AKO PARA SA BATA
THE INTERNATIONAL CONFERENCE IN MANILA

THEME:
STRESSED?
Coping, Recovery, and Healing

December 1-2, 2016
SMX Convention Center Manila
TRAUMA AND BRAIN DEVELOPMENT

GERARDO CARMELO B. SALAZAR, MD
WOUNDS THAT TIME WON'T HEAL

TRAUMA AND BRAIN DEVELOPMENT

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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.cremedeacreme.com/preschool_tips/your_childs_brain_development.htm
http://brainmind.com/brainlecture7.html
Experience-dependent Brain Growth and Development
Orbitofrontal Cortex
Social/Emotional Center
Open to change throughout lifespan

Amygdala
Fight, Flight or Freeze

Hippocampus
Short-term memory
Cause and effect
Cortisol
1.1 Synaptogenesis in Neural Development

Synaptogenesis has its peak activity at 18 weeks of gestation and continues 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

Learning and Unlearning: Connecting the Essentials
DEFINITIONS

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
Traumatic Stress and Critical Windows of Brain Development

- 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

Typical Development:
- Cognition
- Social/Emotional
- Regulation
- Survival

Developmental Trauma:
- Cognition
- Social/Emotional
- Regulation
- Survival

Adapted from Holt & Jordan, Ohio Dept. of Education
Childhood Trauma Exposure Disrupts the Automatic Regulation of Emotional Processing

Hilary A Marusak¹,2, Kayla R Martin³, Amit Etkin⁴,⁵ and Moriah E Thomason⁶²,⁶

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a) trauma > comparison emotional conflict

b) anatomically-defined amygdala ROI

c) right amygdala

![Bar chart showing I - C (% signal change) for trauma and comparison groups.](chart)

- I - C (% signal change) range for trauma group: -0.4 to 0.4
- I - C (% signal change) range for comparison group: -0.4 to 0.4

- * indicates significant difference between groups

- Bar height represents magnitude of difference

- Bar width indicates range of I - C (% signal change)

- Comparison group has slightly higher I - C (% signal change)

- Trauma group has wider I - C (% signal change) range

- Comparison group has narrower I - C (% signal change) range

d) right amygdala

![Scatter plot showing reward sensitivity vs. I - C (% signal change).](plot)

- Scatter plot of reward sensitivity vs. I - C (% signal change)
- Trauma group (light blue) and comparison group (light blue)
- Regression line: $r^2 = 0.185$
- Scatter plot shows positive correlation between reward sensitivity and I - C (% signal change)
a) trauma > comparison
emotional conflict regulation

b) trauma > comparison
emotional conflict regulation
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 institutionalized 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.
Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

- Adverse Childhood Experiences
- Disrupted Neurodevelopment
- Social, Emotional, and Cognitive Impairment
- Adoption of Health-risk Behaviors
- Disease, Disability, and Social Problems
- Early Death

Death

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

(van der Kolk & Fisler, 1995)

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.

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.

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.
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).
THE BRAIN IS PLASTIC. RELEARNING IS POSSIBLE.
One second to injure your brain..weeks, months & years to recover.

SALAMAT PO!

GERARDO CARMELO B. SALAZAR, MD

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Before

Before I struggled

After

After I am happy because I don’t struggle that much.
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TRAUMA INFORMED CARE IN THE SCHOOLS

MARLEEN WONG, PH.D. LCSW
• 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
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

Marleen Wong PhD University of Southern California
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
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
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
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.
Cognitive Behavioral Intervention for Trauma in Schools

• School-based intervention

• Delivered by licensed mental health professionals

• Proven effective in research trials

• Visit: Rand.org OR cbitsprogram.org
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
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.
The White House Summit: Rethinking Discipline 2015

The School Pipeline to Prison is REAL. Schools have helped 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)

Marleen Wong PhD University of Southern California
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.

Marleen Wong PhD University of Southern California
How Does Teaching Fail Traumatized Students?

Phillip Goff, UCLA: Educators 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)
Decreased IQ and reading ability (Delaney-Black et al., 2003)

Decreased rates of high school graduation (Grogger, 1997)

More days absent from school (Hurt et al., 2001)

Lower grade point average (Hurt et al., 2001)

More suspensions and expulsions (LAUSD survey, 2006)
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

Marleen Wong PhD University of Southern California
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)

Marleen Wong PhD University of Southern California
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

Marleen Wong PhD University of Southern California
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

Marleen Wong PhD University of Southern California
To the world, you may be just one person,

But to one person, you just may be the world.
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FILIPINO FAMILY UNDER STRESS

MA. LOURDES A. CARANDANG, PHD
FILIPINO CHILDREN UNDER STRESS
Family Dynamics and Therapy

MARIA LOURDES ARELLANO-CARANDANG

Ako Para Sa Bata: The International Conference
SMX Convention Center
December 1, 2016
Ma. Lourdes A. Carandang, PhD
MLAC Institute for Psychosocial Services, Inc.
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
Extramfamilial 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.”

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
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
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
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
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. Warmed by kindness, spiced by curiosity.

  - 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.
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.
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
Find a Support Group

a circle of families supporting each other
“It’s in the shelter of each other that people live.”

Irish Proverb
THANK YOU!

MLAC
Institute for Psychosocial Services, Inc.

Mindfulness, Love and Compassion

For more information, please visit our website at www.mlacinstitute.com
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SPIRITUALITY AND THE RECOVERY FROM TRAUMA

CORNELIO G. BANAAG, JR., M.D.
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
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

Mental Health Foundation 2006
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
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
Spirituality and Health Outcomes

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

- 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
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
Children, Spirituality and Religion

- Children do not make a sharp distinction between spirituality and religion.
- Children see the two concepts as highly related but with blurred boundaries in everyday 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 feelings 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
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
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
Spirituality and Psychotherapy

- Many studies correlate religion/spirituality and mental health of children and adolescents
- Children’s mental well-being directly correlated to their spirituality
- Higher levels of spirituality/religiousness, lower levels of hopelessness, despair, suicide
- Religious core beliefs shape children’s views on the purpose of life, meaning of suffering, moral values
- Spiritual/religious practices and beliefs (prayers, meditation, seeking counseling) help children cope with negative life events
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
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
Levels of Biopsychosocialspiritual 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
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
Thank You!


Bibliography


Further Information and Resources
(Mental Health Foundation)

Further information can be found in the following publications.

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

- **Knowing our own Minds**
  [http://www.mentalhealth.org.uk/publications](http://www.mentalhealth.org.uk/publications)

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

- **Spirituality and Mental Health Care: Rediscovering a Forgotten Dimension**
Further Information and Resources (Mental Health Foundation)

- Mind Guide to Spiritual Practices
  [link]

- Promoting Mental Health: A Resource for Pastoral and Spiritual Care
  Church of England
  [link]

- Spirituality and Mental Illness
  Rethink, 2004
  [link]
AKO PARA SA BOTA
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
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
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.

### National Baseline Study on Violence Against Children (2015)

<table>
<thead>
<tr>
<th>Type of Violence</th>
<th>Lifetime Prevalence</th>
<th>Current Prevalence (Last 12 mos.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Physical Abuse</td>
<td>66.3%</td>
<td>35.1%</td>
</tr>
<tr>
<td>Child Psychological Abuse</td>
<td>59.2%</td>
<td>33.0%</td>
</tr>
<tr>
<td>Child Sexual Abuse</td>
<td>17.1%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>
## 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**

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</tbody>
</table>
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.
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.
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.
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.
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.
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.
Male and female children brought to CPU for all types of abuse tend to disclose the abuse to their mothers first.

Disclosure among sexually abused patients by sex

*multiple response may occur
• 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

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 Allnocks and Pam Miller, 2016
No one noticed, no one heard: a study of disclosures of childhood abuse
Thank You!
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SMX Convention Center Manila
MUSIC THERAPY

IRVIN S. KALUGDAN, MMT, MT-BC
DANIELLE ELISE ZAMAR, BSN, RN, MT-BC
DR. ROBERTO KALUGDAN, OBGYN
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
Irvin Sayoc Kalugdan, MMT, MT-BC
irvin.kalugdan@catxstudio.com

Danielle Elise Zamar, BSN, RN, MT-BC
dzamar7@gmail.com

Dr. Roberto Kalugdan, ObGyn
ifugaomedicalmaternityclinic@gmail.com
“ther-a-py”
Increase, Improve, Maintain, Restore

[ˈθɛrpɪ] 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 ALL here to HELP children
Let’s remember ALL children.
Why Music?

THE BRAINS REACTION TO MUSIC

The Brain at Rest

The Brain’s Reaction to Music
“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%)
Music as Therapy VS Music in 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 its 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
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.
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.
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/
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).
- The average salary increased in 24 states over 2014 reports.
- Ninety new music therapy jobs were created in 2014 as reported on the 2015 survey (an increase from 73 created in 2013).
- Salaries have increased steadily since 1998.
- 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 individual music therapy services across the country are a reported $65 per hour.
- Average rates for group music therapy services across the country are a reported $73 per hour.
- 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.
- Most commonly reported job title was “Music Therapist,” by 59% of survey respondents.
- Average salaries increased in six of seven AMTA regions in the United States and also outside the U.S.
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
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!
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