The Identification, Assessment, and Treatment of Trauma and PTSD at School

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With contributions from Dr. Stephen Brock

Objectives

- From participation in this workshop participants will...
  1. increase their understanding of the impact of traumatic events on children and adolescents
  2. become familiar with specific trauma exposure and PTSD symptoms
  3. Understand the characteristics of acute and complex/toxic (chronic) trauma
  4. differentiate between PTSD and other disorders.
  5. understand the school mental health professionals’ role in the identification and assessment of PTSD
  6. be able to identify strategies designed to prevent, mitigate, and respond to acute and toxic stress, and PTSD

Trauma Exposure

- Trauma is a.
  * "blow to the psyche that breaks through one’s defenses so suddenly and with such force that one cannot respond effectively.”

  Kai Erickson
  In the Wake of a Flood, 1979

ACE Study reported over 50% of adults had experienced at least one form of childhood adversity (www.traumasensitiveschools.org)

National Child Traumatic Stress Network Rates of Childhood Trauma and Adversity

- The original ACES (in red) are among the most commonly reported traumas in studies that look at additional traumas.

- Over 40% of the children and adolescents served by the NCTSN (N = 10,991) experienced 4 or more different types of trauma and adversity.

- Urban Populations
  - Trauma Exposure 82.5% (19-24 yr. olds)
  - PTSD 30%

- Foster Youth
  - Trauma Exposure 80.3% (17-18 yr. olds)
  - PTSD 30%

- 1 out of 10 children ages 0-6 had witnessed a knifing or shooting.

APA (2013); Buka et al. (2001); Bronen et al. (2004); Copeland et al. (2007); Costello et al., 2002; Dyregrov & Yule, 2006; Giacca et al. (1995); Pecora et al. (2009); Taylor et al. (1992)
Exposure to traumatic stressor

- PTSD necessarily involves exposure to a traumatic stressor.
- A traumatic stressor can generate initial stress reactions in just about anyone.
- However, not everyone exposed to these events develops PTSD.
- Typically, the majority of exposed individuals recover and only a minority develop PTSD.
- Among those who develop PTSD, significant impairments in daily functioning (including interpersonal and academic functioning) are observed.
- Developmentally younger individuals are more vulnerable to PTSD.

Range of Possible Traumatic Stress Reactions

<table>
<thead>
<tr>
<th>Not Psychopathological (Common)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Crisis Reactions</td>
</tr>
<tr>
<td>Acute Stress Disorder</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td>Psychopathological (Uncommon)</td>
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</table>

Impact of Trauma

- Childhood trauma is among the most relevant and significant psychosocial factors affecting education today (Blaustein, 2013)
- Traumatized students are often focused on survival, which hampers their ability to learn, socialize, and develop the skills needed to thrive (Cowan & Rossen, 2013)
- Significantly lower test scores on standardized tests & more likely to need individualized educational plans (IEP).
- 8.6% of students without an IEP had traumatic stress vs. 23.4% with an IEP (Goodman, Miller, & West-Olatunji, 2011)

Impact of Trauma

- Adverse Childhood Experiences (ACES):
  - Higher rates:
    - drop out
    - suspension and expulsion rates
    - lower academic achievement
  - As adults, increased risk health and mental health problems (e.g., heart disease, diabetes, liver disease, and obesity, substance abuse, depression, and suicide)
- Trauma exposure:
  - Lead to lasting changes in brain structure (e.g., reduced overall size and underdeveloped cortex) and function (e.g., irritability, excitability, and impulsivity).
  - Overproduction of the hormones adrenaline and cortisol. -- overproduction can impede normal development, cognition, memory, and learning.
  - suspend the higher-order skills needed for learning, getting along with others, and succeeding at school.

Trauma Exposure and Lack of Services

- 35 million children exposed to trauma
  - only around 8 million have access to a school psychologist.
  - LGBTQ; or are non-English native speakers, and in addition if they are also of color, often have multiple traumas
  - 2013-14, nearly 3 million students were suspended out of school
  - little attention paid to trauma and long-term violence exposure as a contributing factor
- Minority Youth:
  - 38% of African American children, 32% Hispanic children, and 35% Native American children live in poverty, many experiencing multiple traumatic events.
  - Black children are 3x’s as likely to be victims of abuse or neglect, 3x’s less likely to receive mental health care, and 4x’s as likely to be suspended for minor misconduct.
  - Native American youth 2x’s likely to commit suicide.
  - Over 90% in juvenile detention have symptoms of PTSD or another mental health condition.

Impact of Trauma

- Academics/Cognitive
  - organization
  - comprehension
  - memory
  - ability to produce work
  - engagement in learning
  - attend to classroom tasks and instructions
  - grasping of cause-and-effect relationships
  - language

- Behavioral
  - self-regulation
  - attention
  - emotions – act out or withdraw; depression, anxiety
  - behavior

- Social and Personal
  - development of language and communication skills
  - difficulties processing social skills
  - establishment of a coherent sense of self
  - trust

Center for American Progress’ (CAP, 2016) http://www.nasponline.org/about-school-psychology/media-room/press-releases/naspr-epilepsy-report-calling-for-increased-access-to-school-psychologists

Perfect, Turkot, Carlson, Yo hannan, & Satin Gilles (2016)
Mental Health Consequences

Mental Illness
- Anxiety disorders
- Substance-related disorders
- Dissociative disorders
- Mood disorders
- Disorders of infancy, childhood, or adolescence
- Sleep disorders
- Adjustment disorders

Note. Brock & Jimerson (2004); Cohen et al. (2010).

Need for Mental Health Supports

- Approximately 1 in 3 students report being bullied each year
  - Bullying and harassment is associated with increased depression and anxiety for bullies, victims, and bystanders
- Approximately 2.2 million adolescents aged 12 to 17 reported a major depressive episode in the past year
- Nearly 6 out of 10 of these adolescents did not receive any treatment
- Overall, 1 in 5 of children and adolescents in the U.S. experience signs and symptoms of a mental health problem and 5% experience “extreme functional impairment”

Role School MH Professional

- The role of the school-based mental health professional is to be …
  - able to recognize and screen for trauma and PTSD symptoms.
  - aware of the fact that trauma exposure and PTSD may generate significant school functioning challenges.
  - knowledgeable of effective treatments for PTSD and appropriate local referrals.
  - cognizant of the limits of their training.
- It is not necessarily to …
  - diagnose PTSD.
  - treat PTSD.

DSM 5, CHARACTERISTICS, CAUSES, & CONSEQUENCES

Traumatic Stress: Defined

- Distinction between crisis and trauma
  - Crisis - event, experience, or condition that leads to danger or the potential for danger
  - Trauma - result of an individual’s reaction to adversity or stress

Traumatic Stress: Defined

- Positive Stress
- Tolerable Stress
  - Potentially harmful, but short-lived acute stressors.
- Toxic Stress
  - Strong, frequent, prolonged activation of stress mechanisms.
Traumatic Stress: Defined

- Three Core Concepts in Early Development
  - Experiences Build Brain Architecture
  - Serve & Return Interaction Shapes Brain Circuitry
  - Toxic Stress Derails Health Development

- Question: Given your understanding of Toxic Stress, what are your thoughts regarding how the school should support trauma exposed students?

Center on the Developing Child (Harvard)

Acute vs. Complex Trauma

- Acute Trauma
  - A time-limited (typically tolerable) stressor e.g., car accident, natural disaster
  - In response to an acute stressor the body releases stress hormones that decrease digestive & immune functioning and increase heart rate and blood pressure.
  - When the threat is gone the body should return to baseline

- Complex Trauma (Toxic Stressors)
  - Exposure to multiple traumatic events; and the wide-ranging, long term impact of this exposure.
  - e.g., long-term physical/sexual abuse, chronic/ongoing exposure to community violence

- Frequent/long exposure to stress results in the stress response being activated more easily.
- Body does not return to baseline as quickly.
- Stress hormones negatively effect health, brain development.

Cicchetti & Gill (2016)

Ecological model of violence

- Person
  - Perceived threat
  - Adrenaline & cortisol prepare the body to respond

- Fight or Flight

- Body returns to baseline (homeostasis)

- In response to threat
- Frequent/long exposure to stress results in the stress response being activated more easily.
- Body does not return to baseline as quickly.
- Stress hormones negatively effect health, brain development.


Characteristics of PTSD

- A Trauma- and Stressor-Related disorder that develops secondary to exposure (experiencing, witnessing, or learning about) to an "extreme traumatic stressor."
- An event that involves actual or threatened death or serious injury, or threat to ones physical integrity.

**does not include exposure via electronic media**

APA (2013)
Characteristics of PTSD

**DSM-5**

- **Core Symptoms**
  1. Intrusion symptoms.
  2. Persistent avoidance of stimuli associated with the trauma.
  3. Negative alterations in cognitions and mood
  4. Alteration in arousal and reactivity.
- Duration of the disturbance is more than one month.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Intrusion Symptoms**

1. Recurrent/intrusive distressing memories.
2. Recurrent distressing dreams.
3. Acting/feeling as if the event were recurring.
4. Psychological distress at exposure to cues that symbolize/resemble the traumatic event.
5. Physiological reactivity on exposure to cues that symbolize/resemble the traumatic event.

**Avoidance Symptoms**

1. Avoids distressing memories, thoughts or feelings
2. Avoids external reminders that arouse distressing memories, thoughts, or feelings

**Negative alterations in cognitions and mood**

1. Inability to remember an important aspect of the event
2. Persistent and exaggerated negative beliefs or expectations
3. Persistent, distorted cognitions about cause or consequence of the event
4. Persistent negative emotional state
5. Diminished interest/participation in significant activities.
6. Feelings of detachment or estrangement
7. Inability to experience positive emotions

**Increased Arousal Symptoms**

1. Irritability or outbursts of anger.
2. Reckless/self-destructive
3. Hypervigilance.
4. Exaggerated startle response.
5. Difficulty concentrating.
6. Difficulty falling or staying asleep

PTSD may be specified as
- Acute
- Chronic
- Delayed onset
### Posttraumatic Stress Disorder for Children 6 & Younger

**A.** The child (≤6 years old) exposure to actual/threatened death, serious injury, or sexual violation, in one or more of the following ways:
- Direct exposure
- Witnessing (does not include exposure via electronic media)
- Learning that the event(s) occurred (to close relative/close friend)

**B.** Intrusion Symptoms associated w/ traumatic event (began after the event), evidenced by 1+ of the following:
- Recurrent, involuntary, intrusive distressing memories
  - Note: spontaneous/intrusive memories don’t necessarily appear distressing, may be expressed as play reenactment
- Recurrent distressing dreams
  - Note: may not be possible to connect content to the event
- Dissociative reactions wherein the child feels/acts as if the event(s) were occurring
  - Note: reactions occur on a continuum w/most extreme being complete loss of awareness of surroundings
- Intense/prolonged psychological distress with exposure to internal/external cues that symbolize/represent the event
  - Marked physiological reactions to reminders

**C.** One (or more) from below:
- Persistent avoidance of stimuli associated with the event (began after the event), evidenced by efforts to avoid:
  - Activities, places or physical reminders, that arouse recollections of the event
  - People, conversations, or interpersonal situations that arouse recollections of the event
- Negative alterations in cognitions & mood associated with the event (began or worsened after the event), as evidenced by 1+ of the following:
  - Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame or confusion)
  - Markedly diminished interest/participation in significant activities (e.g., constriction of play)
  - Socially withdraw
  - Reduction in expression of positive emotions

**D.** Alterations in arousal/reactivity associated w/ event (began or worsened after the event), as evidenced by 2+ of the following:
- Irritable/angry/aggressive behavior (e.g., extreme temper tantrums)
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance (e.g., difficulty falling or staying asleep, or restless sleep)

**E.** Duration of disturbance is more than one month

**F.** Disturbance causes clinically significant distress or impairment in relationships w/ sibs, peers or caregivers, or school behavior

**Specifier:** with dissociative symptoms: Depersonalization or Derealization

Specify if with delayed expression: full diagnostic criteria not met until 6 months after event (although onset & expression of some symptoms may be immediate)

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### DSM 5 Changes

<table>
<thead>
<tr>
<th>Change from DSM-IV-TR/DSM-5</th>
<th>Rationale for Change</th>
<th>Consequences of Change</th>
<th>Implications for School Psychologists</th>
</tr>
</thead>
</table>
| Requirement of fear, helplessness or horror immediately following the trauma removed | Better description of cognitive, emotional, behavioral and functional implications of PTSD | Opera the door to attributing own symptoms to a past event | Still no clear definition of trauma event
| Exposure to event can be via learning about it or repeated exposure to details (e.g., from responders) | Addresses the different symptomology with younger children | May receive diagnosis whether or not symptoms are actually related to event | Still using adult criteria for elementary and secondary age students
| 4 symptom clusters: intrusion, avoidance, negative alterations, arousal/reactivity | Gives more specific examples to clarify and also make more culturally appropriate | Focusing on reaction to trauma rather than unscoping developmental vulnerability to stress (oversimplifies) | Need to be well-informed of proven therapies to help if a referral is needed
| PTSD symptoms for age 6 and younger | | Boundary with normally is blurred | |

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### Differential Considerations

<table>
<thead>
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<th>Alternative Diagnosis</th>
<th>Differential Consideration</th>
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<tr>
<td>PTSD Symptoms without PTSD</td>
<td>Typical PTSD symptoms are present, but not at a level to cause clinically significant distress/impairment</td>
</tr>
<tr>
<td>Acute Stress Disorder</td>
<td>Symptoms confined to the first month after trauma exposure</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>Reaction to stress, but symptomatic reaction is subthreshold</td>
</tr>
<tr>
<td>Other causes of flashbacks</td>
<td>Perceptual distortions come from substance use, head injury, Bipolar or Depressive Disorder, or Psychotic Disorder</td>
</tr>
<tr>
<td>Malingering</td>
<td>When stressor is marginal and/or there is financial or other gain from having diagnosis of PTSD.</td>
</tr>
</tbody>
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### Acute Stress Disorder

- Direct or indirect exposure to actual or threatened death, serious injury, or sexual violation
- Intrusion symptoms
- Negative Mood
- Dissociative Symptoms
- Avoidance Symptoms
- Arousal Symptoms
- Duration: 3 days to one month
- Clinical Distress
### DSM 5 Changes

#### Acute Stress Disorder
- Must be explicit if experienced directly.
- Witnessed or experienced indirectly.
- Minimized emphasis on dissociative disorders.

#### Rationale for Changes
- Better describe the cognitive, emotional, behavioral, and functional implications of PTSD.
- Give more specific examples to clarify and also make more culturally appropriate.
- Provided better examples for each of the criteria to clarify.

#### Consequences of Changes
- Understand the differences between ASD and PTSD (ASD only within the first month of event & more focus on dissociative symptoms).
- Need to be well informed of proven therapies to help if a referral is needed.
- Does ASD develop into PTSD?

## Adjustment Disorders
- Response to an identifiable stressor occurring within 3 months of onset.
- Marked distress out of proportion.
- Significant impairment.
- Specifiers – With:
  - Depressed mood
  - Anxiety
  - Mixed anxiety and depressed
  - Disturbance of conduct
  - Mixed disturbance of emotions and conduct
  - Unspecified

## Characteristics of PTSD
### DSM-5
- Associated Features
  - Survivor guilt
  - Auditory hallucinations & paranoid ideation
  - Impaired affect modulations
  - Self-destructive and impulsive behavior
  - Somatic complaints (e.g., headaches)
  - Shame, despair, or hopelessness
  - Hostility
  - Social withdrawal

### Associated Mental Disorders
- Major Depressive Disorder
- Substance-Related Disorders
- Panic Disorder
- Agoraphobia
- Obsessive-Compulsive Disorder
- Generalized Anxiety Disorder
- Social Phobia
- Specific Phobia
- Bipolar Disorder

## Consequences of PTSD
### Conditions Co-morbid with Child PTSD
- AD/HD
- Depression
- Obsessive/Compulsive Disorder
- Oppositional/Defiant Disorder
- Anxiety Disorder
- Conduct Disorder
Causes of PTSD

- Traumatic Event Variables
  - Type
  - Predictability
  - Assaultive Interpersonal Violence
  - Fatalities
  - Severity
  - Duration
  - Intensity
  - Exposure
  - Physical Proximity
  - Emotional Proximity

- Environmental Factors
  - Parental Reactions
  - Social Supports
  - History of Environmental Adversity/Traumatic Stress
  - Family Atmosphere
  - Family Mental Health History
  - Poverty

Nickerson et al., (2009); Brock et al., (2011)

Traumatic Stress: Neurobiology

- Toxic Stress Affects the Brain
  - Neural circuits for dealing with stress are particularly malleable early in development.
  - Learning to respond to stress is essential to normal development.
  - However, frequent/sustained activation of the neurobiological mechanisms responsible for responding to stressors may increase vulnerability to a range of behavioral and physiological disorders over a lifetime.

Nickerson et al., (2009); Brock et al., (2011)


Toxic Stress Affects the Brain

- Sustained activation of the neurobiological mechanisms (hypothalamus-pituitary-adrenocortical [the HPA axis]) responsible for the stress response (and sustained levels of cortisol or corticotropin-releasing hormone [CRH]) can damage the hippocampus (a brain structure critical to learning and memory).


Your Brain on Stress and Anxiety

- Adrenaline – mobilizes energy stores and alters blood flow.
- Cortisol – mobilizes energy stores, enhances certain types of memory, activates immune responses.
- "... long-term elevations in cortisol levels can alter the function of a number of neural systems, suppress the immune response, and even change the architecture of regions in the brain that are essential for learning and memory" (p. 3).

The Impact of Early Adversity on Children’s Development

- 3 Areas:
  - Prefrontal Cortex (PFC) = “Thinking Center” (underactivated)
  - Anterior Cingulate Cortex (ACC) = “Emotion Regulation Center” (underactivated)
  - Amygdala = “Fear Center” (overactivated)


https://www.psychologytoday.com/blog/workingswellbeing/201703/heres-your-brain-trauma
Dr. Melissa Reeves

Causes of PTSD

Threat Perceptions

- Personal Vulnerabilities
  - Internal Personal Factors
    - Psychological
    - Initial Reactions
    - Mental Illness
    - Developmental Level
    - Coping Strategies
    - Locus of Control
    - Self-Esteem
  - Genetic
  - Neurobiological

Brock et al. (2009), Nokson et al. (2009)

Traumatic Stress: Consequences

- Traumatic stress affects...
  - Attachment and relationships
  - Physical health
  - Emotional responses
  - Dissociation
  - Behavior
  - Cognition
  - Self-Concept & Future Orientation

NCTSN (http://www.nctsn.org/trauma-types/complex-trauma/effects-of-complex-trauma)

Traumatic Stress: Consequences

- Psychological
  - Increased risk for mental illness
    - Depressive disorders
    - Anxiety disorders (e.g., specific phobia, social anxiety disorder, panic disorder)
    - Trauma- and stressor-related disorders (i.e., disinhibited social engagement disorder, posttraumatic stress disorder, acute stress disorder, adjustment disorders)
    - Dissociative disorders (e.g., dissociative identity disorder, dissociative amnesia, depersonalization/derealization disorder)
    - Sleep-wake disorders (e.g., insomnia disorder, nightmare disorder)
    - Substance-related and addictive disorders

APA (2013); Brock et al. (2016)

Traumatic Stress: Consequences

- Psychological
  - Affects how the brain processes information.
  - What emotion do you see?

Pollak et al. (2010)

Traumatic Stress: Consequences

- Psychological
  - Physically abused children recognized anger sooner than did controls (who had not been abused).
Dr. Melissa Reeves

Traumatic Stress: Consequences

- Psychological
  - Affects how the brain processes information.
  - Which faces are angry or which are sad?

  When asked to identify faces that showed angry or fearful or angry or sad, abused children over identified anger relative to fear and sadness.
  - Controls tended to under identify anger.
  - “… maltreatment may sensitize children to certain emotional information that may be adaptive in abusive contexts but maladaptive in more normative interpersonal situations.”

  Pollak & Kistler (2002)

- Behavioral
  - With increased trauma exposure the odds that an adolescent will display problem behavior increases.
  - attachment difficulties
  - skipping school
  - running away from home
  - substance abuse
  - self-injury
  - suicidality
  - criminally/involved with juvenile justice system
  - involvement with child welfare system
  - victim of sexual exploitation

  Layne et al. (2014); NCTSN & SAMSHA (2016)

- Educational
  - Decline in academic performance (Kruczek, 2006; Gahen, 2005), lower GPA (Borofsky et al., 2013; Mathews et al., 2009; NCTSN & SAMSHA, 2016)
  - Decreased IQ (Kira et al., 2012)
  - Dropping out of high school (Porche et al., 2011)

  Rossen & Cowan (2013)

Pollak et al. (2009, p. 6)

Layne et al. (2014); NCTSN & SAMSHA (2016)

McCoy et al., 2015, p. 3

Rossen & Cowan (2013)
Consequences of PTSD

- Affects on cognitive functioning
  1. Motivation and persistence in academic tasks
  2. Development of short- and long-term goals
  3. Sequential memory
  4. Ordinal positioning
  5. Procedural memory
  6. Attention

- Executive functioning difficulties
  - Frontal lobes are "off line"
  - Should not be attributed to negative personal characteristics such as laziness, lack of motivation, apathy, irresponsibility, or obstinance
  - State problems in clear behavioral terms that indicate a behavior that can be changed.
  - Intervention focuses on promoting positive, specific behavior change(s).

Consequences of PTSD

- Emotional and behavioral consequences depend upon
  - Chronological age
  - Developmental stage
  - Whether/not death involved
  - Proximity to event
  - Support System

- PTSD & LD
  - Childhood trauma creates difficulty with:
    - Focus (Traweek, 2006)
    - Social functioning (Rucklidge, 2006)
    - Decline in academic performance (Kruczek, 2006; Gahen, 2005)
    - Outbursts of anger, hyperactivity, impulsivity (Glod & Teicher, 1996)
  - All are symptoms often associated with LD

Traumatic Stress: The Achievement Gap

- Growing up in poverty is often associated with high stress hormone levels.
  - Chronic poverty is frequently associated with adverse conditions such as exposure to violence.
  - In communities more affected by poverty, homelessness, and social vulnerabilities, the majority of students experience significant stress

Toxic Stress: Physiological, Psychological, & Behavioral Disturbances

- Zero-Tolerance Policies
- Poor Learning & Academic Achievement

Porche et al. (2011); McCoy et al. (2015, p.1)
ASSESSMENT & IDENTIFICATION

Initial Assessment of PTSD

Crisis Event Type
a) Human Caused (vs. Natural)
b) Intentional (vs. Accidental)
c) Fatalities

*Risk factors that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Brock (2011); Brock et al. (2009)

Initial Assessment of PTSD

Crisis Exposure
a) Physical proximity
   - Intensity of crisis experience
b) Emotional proximity

*Risk factors that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Brock (2006, 2011); Brock et al. (2009)

Trumatic Stress: Demographics

Homicides (by Ward): Chicago 2016

Statistically significant decreases in students' cognitive performance scores the week following a homicide that occurred on their block (regardless of connection to victim)

McCoy et al. (2015)

How many weeks during the year would students at your schools be affected?

http://gis.chicagopolice.org/clearmap_crime_sums/startpage.htm#

Initial Assessment of PTSD

Physical Proximity
- Residents between 110th St. and Canal St.
  - 6.8% report PTSD symptoms.
- Residents south of Canal St (ground zero)
  - 20% report PTSD symptoms.
- Those who did not witness the event
  - 5.5% had PTSD symptoms.
- Those who witnessed the event
  - 10.4% had PTSD symptoms.

Galea et al. (2002)
Initial Assessment of PTSD

Physical Proximity
PTSD Reaction Index X Exposure Level

- On Playground
- In School
- On Way Home
- In Neighborhood
- At Home
- Absent
- Out of Vicinity

Reaction Index Score
(12 >= Severe PTSD)

Emotional Proximity
PTSD and Relationship to Victim X Outcome
(i.e., injury or death)

- Person Injured
- Person Died

- Parent/Sibling
- Other Family
- Friend
- Other Person
- No one

52% 15% 15% 12% 8% 52% 25% 18% 11% 9%

Personal Vulnerabilities*
- Internal vulnerability factors
- External vulnerability factors

*Risk factors that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

External Vulnerability Factors
- Family resources
  - Not living with nuclear family
  - Ineffective & uncaring parenting
  - Family dysfunction (e.g., alcoholism, violence, child maltreatment, mental illness)
  - Parental PTSD/maladaptive coping with the stressor
  - Poverty/financial Stress
- Social resources
  - Social isolation
  - Lack of perceived social support

Brock (2006, 2011); Brock et al. (2009)
Initial Assessment of PTSD

Threat Perceptions*
- Subjective impressions can be more important than actual crisis exposure.
- Adult reactions are important influences on student threat perceptions.

* Risk factor that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Brock (2006, 2011); Brock et al. (2009)

Crisis Reactions*
Severe acute stress reactions predict PTSD. Reactions suggesting the need for an immediate mental health referral
- Dissociation
- Hyperarousal
- Persistent re-experiencing of the crisis event
- Persistent avoidance of crisis reminders
- Significant depression
- Psychotic symptoms

*Warning signs that provide concrete indication of psychological trauma

Brock (2006, 2011); Brock et al. (2009)

Identification/Assessment of PTSD

Warning Signs
- Acute Stress Disorder (ASD)
  - Like PTSD, ASD requires
    - Traumatic event exposure
    - Similar symptoms
  - Unlike PTSD, ASD requires
    - No symptom decline after two days
    - Emphasizes dissociative symptoms (i.e., Psychic numbing and detachment, depersonalization, de-realization).
    - Has fewer avoidance and hyperarousal requirements

Identification/Assessment of PTSD

**Warning Signs: Preschoolers**

- Decreased verbalization
- Increased anxious behaviors
- Bed wetting
- Fears (e.g., darkness, animals, etc.)
- Loss of increase in appetite
- Fear of being abandoned or separated from caretaker
- Reenactment of trauma in play
- Cognitive confusion
- Regression in skills (e.g., loss of bladder/bowel control; language skills, etc.)
- Thumb sucking
- Clinging to parents/primary caretakers
- Screaming, night terrors
- Increased anxiety

**Warning Signs: School-aged**

- Irritability
- Whining
- Clinging
- Obsessive retell
- Night terrors, nightmares, fear of darkness; sleep disturbances
- Withdrawal
- Disruptive behaviors
- Regressive behaviors
- Depressive symptoms
- Emotional numbing
- Increase in aggressive or inhibited behaviors
- Psychosomatic complaints
- Overt competition of adult attention
- School avoidance
- Increased anxiety
- Loss of interest and poor concentration in school
- Decrease in academic performance
- Feelings of guilt

**Warning Signs: Adolescents**

- Emotional numbing
- Flashbacks
- Sleep disturbances
- Appetite disturbance
- Rebellion
- Refusal
- Agitation or decrease in energy level (apathy)
- Avoidance of reminders of the event
- Depression
- Antisocial behaviors
- Revenge fantasies
- Increase in aggressive or inhibited behaviors
- Difficulty with social interactions
- Psychosomatic complaints
- School difficulties (fighting, attendance, attention-seeking behaviors)
- Increased anxiety
- Loss of interest and poor concentration in school
- Decrease in academic performance
- Feelings of guilt

**Assessment and Evaluation**

- Screening
  - Trauma Symptom Checklist for Young Children
  - Trauma Symptom Checklist of Children
  - Child PTSD Symptoms Scale
  - Parent Report of Posttraumatic Symptoms
  - Child/Adolescent Report of Posttraumatic Symptoms
  - Children’s Reactions to Traumatic Events Scale
  - Children’s PTSD Inventory
  - Pediatric Emotional Distress Scale
  - UCLA PTSD Reaction Index of DSM-IV

- Diagnosis
  - Diagnostic Interviews
  - Kiddie Schedule for Affective Disorders and Schizophrenia for School-age Children
  - Structured Clinical Interview of DSM IV
  - Clinician Administered PTSD Scales
Identification/Assessment of PTSD

Assessment and Evaluation

- **Diagnosis**
  - Self-Report Measures
    - Impact of Events Scale
    - Child Post-Traumatic Stress Disorder Inventory
    - Child PTSD Symptoms Scale
  - Support and Coping
    - Social Support Scale for Children and Adolescents
    - KidCope

Nickerson et al. (2009)

Identification/Assessment of PTSD

Assessment and Evaluation

- **Diagnosis**
  - Acute Stress Disorder
    - Stanford Acute Stress Reactions Questionnaire
    - Peritraumatic Dissociative Experiences Questionnaire
  - Comorbidity
    - Strengths and Difficulties Questionnaire
    - Revised Childhood Manifest Anxiety Scale
    - Children's Depression Inventory
    - State-Trait Anxiety Inventory for Children

Nickerson et al. (2009)

Identification/Assessment of PTSD

Assessment and Evaluation

- **Diagnosis**
  - Differential Diagnosis from disorders associated with trauma exposure.
    - Generalized Anxiety Disorders
    - Panic Disorders
    - Specific Phobia
    - Major Depressive Disorder
    - Bipolar Disorder
    - Somatization Disorder
    - Sleep Disorder
    - Adjustment Disorder
    - Substance-Related Disorder

Nickerson et al. (2009)

Identification/Assessment of PTSD

Assessment and Evaluation

- **Diagnosis**
  - Differential Diagnosis from disorders not associated with trauma exposure (but with overlapping symptoms).
    - ADHD
    - Oppositional Defiant Disorder
    - Borderline Personality Disorder

Nickerson et al. (2009)

Identification/Assessment of PTSD

Assessment and Evaluation

- **Psycho-Educational Evaluation**
  - ED Eligibility (must document adverse effects)
  - Psychometric Assessment
  - Interviews
  - Observations

Nickerson et al. (2009)

Identification/Assessment of PTSD

Assessment and Evaluation

- **Psycho-Educational Evaluation (continued)**
  - Broadband Behavior Rating Scales
    - Achenbach System of Empirically Based Assessment
    - Behavioral Assessment System for Children-2nd ed.
  - Narrowband Behavior Rating Scales
    - Multidimensional Anxiety Scale for Children
    - Screen for Child Anxiety Related Emotional Disorders
    - Revised Children’s Manifest Anxiety Scale
    - Anxiety Inventory for Children

Nickerson et al. (2009)
MITIGATION & INTERVENTION

Responding To Acute Traumatic Stress: Research

- Introduction
  - Meta-analysis findings suggest that early interventions should involve psycho-education, provide individual coping-skills, and probably involve some kind of trauma exposure.
  - Also, a stepped procedure that includes an initial risk screen and the provision of multiple sessions to those children at risk is a promising strategy.

Kramer & Landolt (2011)

Preventing/Mitigating PTSD

Strengthen Resiliency

- Internal Resiliency
  - Promote active (or approach oriented) coping styles.
  - Promote student mental health.
  - Teach students how to better regulate their emotions.
  - Develop problem-solving skills.
  - Promote self-confidence and self-esteem.
  - Promote internal locus of control.
  - Validate the importance of faith and belief systems.
  - Others?

Brock (2006), Brock et al. (2009)

Preventing/Mitigating PTSD

Strengthen Resiliency

- Foster External Resiliency
  - Support families (i.e., provide parent education and appropriate social services).
  - Facilitate peer relationships.
  - Provide access to positive adult role models.
  - Ensure connections with pro-social institutions.
  - Others?

Brock (2006), Brock et al. (2009)

Preventing/Mitigating PTSD

Ensure Objective/Psychological Safety

- Remove students from dangerous or harmful situations.
- Implement disaster/crisis response procedures (e.g., evacuations, lockdowns, etc.).
- “The immediate response following a crisis is to ensure safety by removing children and families from continued threat of danger” (Joshi & Lewin, 2004, p. 715).
- “To begin the healing process, discontinuation of existing stressors is of immediate importance” (Barenbaum et al., 2004, p. 48).
- Facilitate the cognitive mastery

Brock (2006), Brock et al. (2009)

Preventing/Mitigating PTSD

Minimize Trauma Exposure

- Avoid Crisis Scenes, Images, and Reactions of Others
  - Direct ambulatory students away from the crisis site.
  - Do not allow students to view medical triage.
  - Restrict and/or monitor television viewing.
  - Minimize exposure to the traumatic stress reactions seen among others (especially adults who are in care-giving roles)

Brock (2006), Brock et al. (2009), Dynegov & Yule (2006)
Preventing/Mitigating PTSD

Shape Traumatic Event Perceptions
- Reunite children with their primary caregivers.
- Monitor adult reactions
- Stimulate family communication and support

Responding to Acute Trauma

School-Based Interventions
- Psychological First Aid
  - Clarify trauma facts
  - Normalize reactions
  - Encouraging expression of feelings
  - Provide education to the child about experience
  - Encourage exploration and correction of inaccurate attributions regarding the trauma
  - Stress management strategies

School-Based Interventions
- Immediate Crisis Intervention
  - General Issues
    1. Cultural differences
    2. Body language
    3. Small groups
    4. Genders
    5. Appropriate tools
    6. Frequent breaks
    7. Develop narrative

Acute Trauma: Levels of School Crisis Interventions

Responding to Chronic Trauma
Responding to Complex Traumatic Stress

- **Primary Prevention**
  - Address/minimize the ongoing stressor(s).
  - Keep the school as the 6 hours during the day when the student is free of the ongoing stressor.
  - Interrupt hyperarousal and the stress response
  - Remove students from dangerous or harmful situations.
  - Practice disaster/crisis response procedures (e.g., evacuations, lockdowns).
  - Give students some control over crises that impact the school
  - Students know how to keep themselves safe

- **Build External Resiliency**
  - Facilitate school connectedness and engagement
  - Support families (i.e., provide parent education and appropriate social services).
  - Facilitate peer relationships.
  - Provide access to positive adult role models.
  - Ensure connections with pro-social institutions.
  - Others?

**Resiliency Building**

- “It’s not something you are born with. It’s something that is build over time.” Dr. Jack Shonkoff
- Most effective approaches: Early intervention and working with parents
  - “We tend to divide the work of mental health separate from the world of physical health, but the body doesn’t do that.” Dr. Nadine Burke Harris
- Research now showing the presence of supportive relationships is more critical than the absence of ACE’s in promoting well-being.
- Science shows the effects of ACE’s is not permanent.

**The Ongoing Universal Response**

- Students are primed to learn when they feel safe, connected and supported at school best achieved through a whole school approach (Ristuccia, 2013).
- Trauma Informed Approach: 4 Assumptions
  1. Realizes the widespread impact of trauma and understands potential paths for recovery
  2. Recognizes signs and symptoms of trauma
  3. Responds by fully integrating knowledge into policies, procedures, practices
  4. Seeks to actively resist re-traumatization

**Creating trauma informed schools**

- A shared understanding among all staff
- The school supports all children to feel safe physically, socially, emotionally, and academically.
- The school addresses students needs in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional well-being.
- The school explicitly connects students to the school community and provides multiple opportunities to practice newly developing skills
- The school embraces teamwork and staff share responsibility for all students.
- Leadership and staff anticipate and adapt to the ever-changing needs of students.

Responding to Complex Traumatic Stress

Creating Trauma-Informed Schools

- The Ongoing Universal Response
  - Creating Trauma Informed Schools
    - Teachers
      - ARTIC – Attitudes Related to Trauma-Informed Care
        - https://traumastressinstitute.org
      - Assesses extent to which staff attitudes are consistent with trauma-informed approaches
      - Used as initial indicator of staff readiness for system shift to trauma-informed approaches
      - Can be used to progress monitor changes in staff attitudes in response to professional development
    - Students
      - Evaluate degree of exposure and identify need for services.

- Teachers

- Prioritize IEP goals.
- Provide a predictable, positive, and flexible classroom environment.
- Be aware of and manage medication side effects.
- Develop social skills.
- Be prepared for episodes of intense emotion.
- Consider alternatives to regular classroom.

Responding to Complex Traumatic Stress

- The Ongoing Universal Response
  - Consider universal mental health screening
    - Some symptoms of traumatic stress are internal
    - Thus, we can’t always assume traumatized students will immediately come to our attention
    - C-BITS Trauma Exposure Checklist (19 items)
    - Child PTSD Symptom Scale (19 items)

- Classroom wide mindfulness exercises
- SEL curriculum

Brock et al. (2016)

Fox et al. (2001)
Mitigating: Creating Trauma Informed Schools

1. A shared understanding among all staff
2. The school supports all children to feel safe physically, socially, emotionally, and academically.
3. The school addresses students needs in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional well-being.
4. The school explicitly connects students to the school community and provides multiple opportunities to practice newly developing skills
5. The school embraces teamwork and staff share responsibility for all students.
6. Leadership and staff anticipate and adapt to the ever-changing needs of students.


Creating Trauma-Informed Schools

- Select: Psychological interventions to remediate adverse effects and avoid re-traumatization
- Universal: Strategies to build positive adaptive systems
- Recognize: Understanding benefits to positive climate and reducing adverse environments
- Respond: Developing social problem-solving and coping skills
- Realize: Teaching common behavioral expectations

Creating Capacity for Trauma-Informed School Schools

- Technical support for school/district administrators.
  - Need to build organizational competencies and supporting infrastructure, including ability to engage in data-based decision making for the system-wide adoption and monitoring of trauma-informed approaches.
- Pre-service training for mental health service providers.
  - Greatest challenge to trauma-informed service delivery models is the lack of professionals who have the expertise to provide trauma-specific treatment services to children exposed to trauma (U.S. Attorney General, 2013).
  - The development and adoption of trauma competencies alongside the larger competency movement in psychology holds great potential to advance our ability to identify and systematically assess core competency benchmarks in trauma-focused practice (Cook & Newman, 2014).

Screenings

- Teachers
  - ARTIC – Attitudes Related to Trauma-Informed Care
    - http://traumaticstressinstitute.org/artic-scale/
    - Assesses extent to which staff attitudes are consistent with trauma-informed approaches
    - Used as initial indicator of staff readiness for system shift to trauma-informed approaches
    - Can be used to progress monitor changes in staff attitudes in response to professional development
  - Students
    - Evaluate degree of exposure and identify need for services


School-Based Interventions

- Psychological First Aid
  - Clarify trauma facts
  - Normalize reactions
  - Encouraging expression of feelings
  - Provide education to the child about experience
  - Encourage exploration and correction of inaccurate attributions regarding the trauma
  - Stress management strategies

Brock (2006), Brock et al. (2009), Nickerson et al. (2009)
**School-Based Interventions**

- Maintain Academic and Behavioral Standards
- Discourage Avoidance
- Encourage Sharing
- Help Students Cope with Triggers

Nickerson et al. (2009)

**School-Based Interventions**

- Specific Recommendations
  1. Build, maintain, and educate the school-based team.
  2. Prioritize IEP goals.
  3. Provide a predictable, positive, and flexible classroom environment.
  4. Be aware of and manage medication side effects.
  5. Develop social skills.
  7. Consider alternatives to regular classroom.

Lothhouse & Fristad (2006, pp. 220-221)

**School-Based Academic Interventions**

1. Use a constructivist approach
2. Include discovery of competence
3. Hunter’s Lesson Plan Model
4. Cooperative learning

Reeves (2008)

**School-Based Academic Interventions**

Executive Functioning (cont.)
- Holding = maintain information in working memory until can process and act upon
  1. Shorten multi-step directions
  2. Post the directions on board/in classroom
  3. Provide visual aides
  4. Use visualization or "seeing" the information as a teaching strategy
  5. Allow them to take pictures of the board to facilitate delayed recall

**School-Based Academic Interventions**

Executive Functioning (cont.)
- Inhibition = resistance to act upon first impulse
  1. Modeling, teaching, and practicing mental routines encouraging child to stop and think
    - Stop! Think. Good choice? Bad Choice?
  2. Anticipate when behavior is likely to be a problem
  3. Examining situations/environments to identify antecedent conditions that will trigger disinhibited behavior – alter those conditions
  4. Explicitly inform student of the limits of acceptable behavior
  5. Provide set routines with written guidelines

Reeves (2008)
Dr. Melissa Reeves

School-Based Academic Interventions

Executive Functioning (cont.)
- Monitoring = ability to check for accuracy
  1. Model, teach, and practice use of monitoring routines
  2. Prompt student if they fail to self-cue
  3. Provide opportunities for guided practice


School-Based Interventions

- Counseling
  - Individual or group?
    - Will it be part of the IEP as a Designated Instructional Service (DIS)?
      - Goal(s)...Education, Coping skills, Social skills, decreasing suicidal ideation/behaviors, substance use
    - Crisis Intervention
      - Will it be written into the BSP?

Psychological Interventions for PTSD

Group Approaches
- Group-Delivered Cognitive-Behavioral Interventions
  - The effectiveness of group interventions has been proven effective among refugee children and with CBITS curriculum.
  - Benefits of a group approach included:
    - Assisted a large number of students at once.
    - Decreased sense of hopelessness.
    - Normalizes reactions.

Einhorn et al. (2005)  

C-BITS: Cognitive Behavioral Interventions for Trauma in Schools

- CBITS teaches six cognitive-behavioral techniques:
  - Education about reactions to trauma
  - Relaxation training
  - Cognitive therapy
  - Real life exposure
  - Stress or trauma exposure
  - Social problem-solving

Includes two parent education sessions and one teacher education.
- Average = 10 sessions
- Reduces symptoms of PTSD depression, behavior prob

Free online training: https://cbitsprogram.org/

http://www.rand.org/health/projects/cbits/  

Behavioral Regulation: Zones of Regulation

- Red Zone: extremely heightened states of alertness and intense emotions.
  - May be elated or experiencing anger, rage, explosive behavior, devastation, or terror when in the Red Zone.
  - A person is described as “out of control” if in the Red Zone.
- Yellow Zone: heightened state of alertness and elevated emotions; has some control
  - May be experiencing stress, frustration, anxiety, excitement, silliness, the wiggles, or nervousness
- Green Zone: calm state of alertness;
  - May be as happy, focused, content, or ready to learn
  - Zone where optimal learning occurs.
- Blue Zone: low states of alertness; one feels sad, tired, sick, or bored.

http://www.zonesofregulation.com

Kimochis:
http://kimochiseducation.tumblr.com/curriculum

http://www.zonesofregulation.com

http://www.kimochiseducation.tumblr.com/curriculum

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Dr. Melissa Reeves

Responding to Complex Traumatic Stress

- **Intensive Interventions**
  - Make use of grounding techniques for the acutely distressed student.
  - National Center on Domestic Violence, Trauma & Mental Health
  - Human Performance Resource Center

  **Interrupt hyperarousal!!!**
  **Apps that support mindfulness and relaxation**

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Intensive School and Community Supports

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<th>Intensive School Interventions</th>
<th>Intensive Community Interventions</th>
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<td>More restrictive environment</td>
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Systems of Care

Six practices are integral to the success of schools as part of systems of care:

1. Use clinicians or other student support providers in the schools to work with students, their families, and all members of the school community.
2. Use of school-based and school-focused Wraparound services to support learning and transition.
3. Use of school-based case managers
   - determine needs; identify goals, resources, and activities; link children and families to other services; monitor services to ensure that they are being delivered appropriately; and advocate for change when necessary.
4. Schoolwide prevention and early intervention programs.
5. Creation of centers within the school to support students and their families.
6. Use of family liaisons or advocates to strengthen the role of and empower family members in their children's education and care.

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Wraparound Services

10 Essential Elements of Wraparound Services:

- Community-based.
- Individualized and strengths-based.
- Culturally competent.
- Families involved as full and active partners in every level of the Wraparound process.
- Team-driven process, involving the family, child, natural supports, agencies, and community services.
- Flexible funding and creative approaches.
- A balance of formal services and informal community and family resources.
- Unconditional commitment.
- A service/support plan developed and implemented based on an interagency, community-neighborhood collaborative process.
- Determined and measured outcomes.

Burns & Goldman, 1999; Kendziora, Bruns, Osher, Pacchiano, & Mejia, in press

Psychological Interventions for PTSD

Empirically Supported Cognitive Behavioral Approaches

- CBT
- Exposure Therapy
  - Imaginal Exposure
    - Repeated re-counting of (or imaginal exposure to) the traumatic memory; uses imagery or writing
  - In Vivo Exposure
    - Visiting the scene of the trauma
    - Habituation


Psychological Interventions for PTSD

Other Approaches
- Eye Movement Desensitization and Reprocessing (EMDR)
- Uses elements of cognitive behavioral and psychodynamic treatments
- Employs an Eight-Phase treatment approach
- Principals of dual stimulation set this treatment apart: tactile, sound, or eye movement components
- Narrative Exposure Therapy
- Art Therapy

Apps
- PTSD Coach
- PFA Tutorial
- SAMSHA Disaster App
- SAMSHA-Suicide Safe
- PFA Mobile
- Mindshift (Anxiety)
- Suicide
- ASK (Mental Health America for Texas)
- Lifeguard (Missouri Suicide Prevention Project)
- Also includes section for military and veterans
- Lifebouy
- Daily mood diary

*these are just a sample of the apps available – there are many more

Resources
- Adapted from...

References


References
References


References


References


