

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

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Melissa A. Reeves, Ph.D., NCSP, LPC
Winthrop University
President – National Association of School Psychologists
mereev@aol.com or reevesm@winthrop.edu



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 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

Trauma Exposure



- Divorce
- Financial difficulties
- Homelessness
- Sickness
- Violence
- Deployment
- Death
- Unemployment
- Bullying
- Academic Difficulties

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.

Trauma Type	Percent % Reported
Traumatic Loss/Bereavement/Separation	48.7
Domestic Violence	45.1
Impaired Caregiver	36.4
Emotional Abuse	31.4
Neglect	28.8
Physical Abuse	26.2
Sexual Abuse	20.1
Community Violence	14.1
Sexual Assault/Rape	13.3
Serious Injury/Accident	10.4
School Violence	10.6
Other	9.7
Illness/Medical Trauma	5.5
Physical Assault	4.9
Natural Disaster	5
Extreme Interpersonal Violence	4.6
Kidnapping	3.2
Forced Displacement	1.7
War/Terrorism/Political Violence (Non-U.S.)	1.1
War/Terrorism/Political Violence (U.S.)	1.0

Percent % Reported

Pinoos et al. (2014). Psychological Trauma: Theory, Research, Practice and Policy 6:50-513. Overstreet, 2014. CANumbans.org

Traumatic Stress: Incidence

- The need for trauma informed care
 - General Population
 - Trauma Exposure 43% (18 yr. olds)
 - PTSD Lifetime Prevalence 8.7% (U.S.)
 - PTSD 12 month Prevalence 3.5% (U.S.)
 - Urban Populations
 - Trauma Exposure 82.5% (19-24 yr. olds, U.S.)
 - 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); Breslau et al. (2004); Copeland et al. (2007); Costello et al., 2002. Dyregory & Yule, 2006; Giaconia 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.

7

Range of Possible Traumatic Stress Reactions

Not Psychopathological (Common)

Initial Crisis Reactions
Acute Stress Disorder
Post-Traumatic Stress Disorder

Psychopathological (Uncommon)

8

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.

10

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.

Center for American Progress' (CAP, 2016) <http://www.nasponline.org/about-school-psychology/media-room/press-releases/nasp-applauds-report-calling-for-increased-access-to-school-psychologists>

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



www.traumasensitiveschools.org
Perfect, Turley, Carlson, Yohanna, & Satin Gilles (2016)

12

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).

13

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.

Cook-Cattone (2004)

15

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

Factors Impacting Response to Adverse Experiences

Individual Factors	Experience Factors
<ul style="list-style-type: none"> ■ Previous experiences ■ Developmental level ■ Poverty level ■ Parental substance use or mental illness ■ Presence of a disability ■ Community characteristics 	<ul style="list-style-type: none"> ■ Physical proximity ■ Severity ■ Availability of social support ■ Availability and quality of intervention services ■ Presence of stigma (e.g., sexual abuse) ■ Chronic (ongoing) or acute (single-event) ■ Interpersonal (e.g., an assault) or noninterpersonal (e.g., a natural disaster)

Rossen & Cowan, 2013

17

Traumatic Stress: Defined

- Positive Stress
 - Moderate, short-lived stress responses. Essential for normal development.
- Tolerable Stress
 - Potentially harmful, but short-lived acute stressors.
- Toxic Stress
 - Strong, frequent, prolonged activation of stress mechanisms.

Center on the Developing Child (Harvard); National Scientific Council on the Developing Child (2014)

18

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?*



19

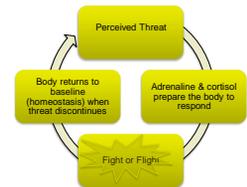
Center on the Developing Child (Harvard)

Traumatic Stress: Defined

- **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



National Center for PTSD (2016). <http://www.ptsd.va.gov/professional/PTSD-overview/complex-ptsd.asp>
The National Child Traumatic Stress Network. (n.d.). <http://nctsn.org/trauma-types/complex-trauma>
Cicchetti & Gill (2016).

20

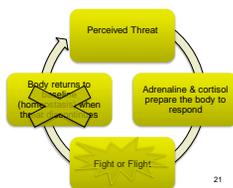
Traumatic Stress: Defined

- Acute vs. **Complex Trauma**
 - 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.

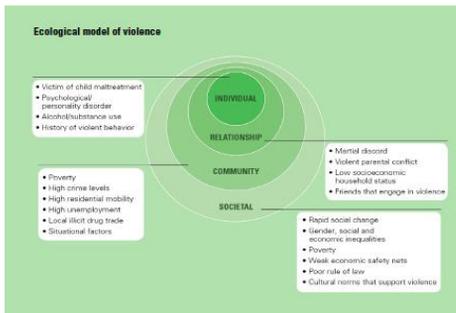
• Stress hormones negatively effect health, brain development.



21

Cicchetti & Gill (2016)

Complex Trauma



Bultrago, K, Rynell, A. & Tuttle, S. (2017). Cycle of Risk

22

DSM 5: Trauma and Stressor Related Disorders



23

Characteristics of PTSD

DSM-5

- 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)

24

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.

APA (2013)

25

Characteristics of PTSD

DSM-5

• 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.

APA (2013)

26

Characteristics of PTSD

DSM-5

• Avoidance Symptoms

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

APA (2013)

27

Characteristics of PTSD

DSM-5

• 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

APA (2013)

28

Characteristics of PTSD

DSM-5

• 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

APA (2013)

29

Characteristics of PTSD

DSM-5

• PTSD may be specified as

- Acute
- Chronic
- Delayed onset

APA (2013)

30

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:

1. Direct exposure
2. Witnessing (does not include exposure via electronic media)
3. 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 recurring

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/resemble the event

Marked physiological reactions to reminders

31

Posttraumatic Stress Disorder for Children 6 & Younger



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

32

Posttraumatic Stress Disorder for Children 6 & Younger



D. Alterations in arousal/reactivity associated w/ (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)

33

Differential Considerations



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

34

DSM 5 Changes

	Changes from DSM-IV-TR to DSM-5	Rationale for Changes	Consequences of Changes	Implications for School Psychologists
PTSD	<ul style="list-style-type: none"> • Requirement of fear, helplessness or horror immediately following the trauma removed • Exposure to event can be via learning about it or repeated exposure to details (e.g. first responders) • 4 symptom clusters: intrusion, avoidance, negative alterations, arousal/reactivity • PTSD symptoms for age 6 and younger 	<ul style="list-style-type: none"> • Better description of cognitive, emotional, behavioral and functional implications of PTSD • Addresses the different symptomology with younger children • Gives more specific examples to clarify and also make more culturally appropriate 	<ul style="list-style-type: none"> • Opens the door to attributing one's symptoms to a past event • May receive diagnosis whether or not symptoms are actually related to event • Focuses on reaction to trauma rather than uncovering temperamental vulnerability to stress • Boundary with normality is blurred • Much heterogeneity so research is challenging 	<ul style="list-style-type: none"> • Still no clear definition of a traumatic event • Still using adult criteria for elementary and secondary age students • Really should be reserved for those with traumatic memories and avoidance many months after • Can provide validation for reactions to adversity/trauma • Has led to school-based intervention that help minimize PTSD symptomology • For preschoolers – has allowed for more age and developmentally sensitive diagnostic criteria • Need to be well-informed of proven therapies to help if a referral is needed

35

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

36

DSM 5 Changes

	Changes from DSM-IV-TR to DSM-5	Rationale for Changes	Consequences of Changes	Implications for School Psychologists
Acute Stress Disorder	<ul style="list-style-type: none"> Must be explicit if experienced directly. Witnessed or experienced indirectly Minimized emphasis on dissociative disorders 	<ul style="list-style-type: none"> Better describe the cognitive, emotional, behavioral, and functional implications of PTSD Gives more specific examples to clarify and also make more culturally appropriate 	<ul style="list-style-type: none"> Provided better examples for each of the criteria to clarify 	<ul style="list-style-type: none"> 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 month 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

DSM 5 Changes

Adjustment Disorders

- Changes from DSM-IV-TR to DSM-5
- Now falls under Trauma & Stressor Related Disorders (previously a separate category)
- No substantial changes to criteria
- Moved to this new section and reconceptualized as heterogeneous stress-response syndromes

Characteristics of PTSD

DSM-5

- Associated Features
 - Survivor guilt
 - Impaired social/interpersonal functioning**
 - Auditory hallucinations & paranoid ideation
 - Impaired affect modulations
 - Self-destructive and impulsive behavior
 - Somatic complaints (e.g., headaches)**
 - Shame, despair, or hopelessness
 - Hostility
 - Social withdrawal**

APA (2013)

Characteristics of PTSD

DSM-5

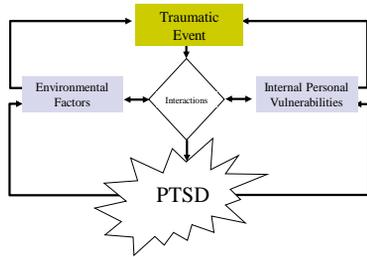
- Associated Mental Disorders
 - Major Depressive Disorder
 - Substance-Related Disorders
 - Panic Disorder
 - Agoraphobia
 - Obsessive-Compulsive Disorder
 - Generalized Anxiety Disorder
 - Social Phobia
 - Specific Phobia
 - Bipolar Disorder

APA (2013)

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



Nickerson et al., (2009)

43

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.

National Scientific Council on the Developing Child (2005/2014)

44

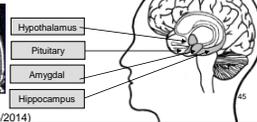
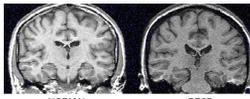
Traumatic Stress: Neurobiology

• 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



National Scientific Council on the Developing Child (2005/2014)

45

Traumatic Stress: Neurobiology

• Toxic Stress Affects the Brain

- The response to stress includes the activation of hormone and neurochemical systems.
 - 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)

National Scientific Council on the Developing Child (2005/2014)
<https://www.psychologytoday.com/blog/workings-well-being/2013/07/heres-your-brain-trauma>

46

Causes of PTSD

• Traumatic Event Variables

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

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

47

Causes of PTSD

• Environmental Factors

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

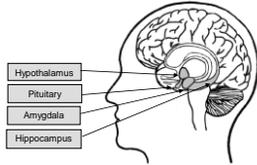
Nickerson et al., (2009)

48

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), Nickerson 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>)

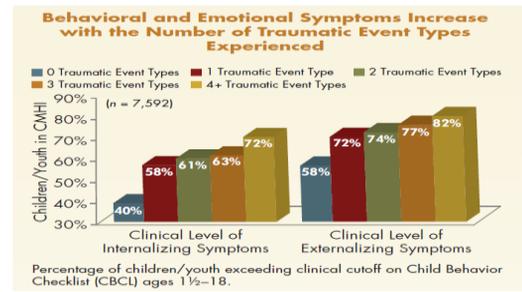
Traumatic Stress: Consequences

- 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
 - Increased risk for mental illness



Traumatic Stress: Consequences

- Psychological
 - Disturbed sleep
 - Alcohol and drug use
 - Avoidant behavioral responses
 - Fearfulness
 - Self-blame
 - Decreased self-efficacy

Cooley-Quille & Lorion (1999) Kliever & Sullivan (2008); Margolin & Gordis (2000)

Traumatic Stress: Consequences

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



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

Pollak et al. (2009)

Traumatic Stress: Consequences

• Psychological

- Affects how the brain processes information.
- Which faces are *angry* and 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.

Pollak & Kistler (2002)

55

Traumatic Stress: Consequences

• Psychological

- Affects how the brain processes information
 - "... *maltreatment may sensitize children to certain emotional information that may be adaptive in abusive contexts but maladaptive in more normative interpersonal situations.*"

Pollak et al. (2009, p. 6)

56

Traumatic Stress: Consequences

• 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
 - criminality/involvement with juvenile justice system
 - involvement with child welfare system
 - victim of sexual exploitation

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

57

Traumatic Stress: Consequences

• Behavioral

- Problems focusing/concentrating (Compas & Boyer, 2001; Pynoos & Nader, 1998; Trawick, 2006)
- Poor social functioning (Rucklidge, 2006)
- Outbursts of anger, hyperactivity, impulsivity (Glod & Teicher, 1996; NCTSN & SAMSHA, 2016)
 - "... *when this stress exposure occurs repeatedly or in the context of high social biological vulnerability, children begin to experience a 'wear and tear' process known as allostatic load. Allostatic load is characterized by less activation in brain regions like the prefrontal cortex that are responsible for reflective self-regulation and sustained attention and increased activation in regions of the limbic system that are associated with automated, emotion-related responses to threat.*" (McCoy et al., 2015, p. 3)

58

Traumatic Stress: Consequences

• 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)

59

Traumatic Stress: Consequences

Common Trauma Symptoms & Related Disorders

Behaviors and Symptoms of Trauma	Related Disability/Disorder
<ul style="list-style-type: none"> ■ Difficulty processing instructions ■ Decreased attention, memory, and focus ■ Reduced executive functioning ■ Difficulty solving problems ■ Difficulty understanding consequences of actions 	<ul style="list-style-type: none"> ■ Learning disability/learning disorder ■ Attention Deficit/Hyperactivity Disorder (ADHD)
<ul style="list-style-type: none"> ■ Heightened vigilance ■ Inaccurate perception of danger (i.e., viewing innocuous glances or gestures as threats) ■ Rapid response to perceived threats ■ Self-protective behaviors (e.g., aggression or withdrawal) 	<ul style="list-style-type: none"> ■ Anxiety disorder ■ Panic disorder ■ Emotional disability ■ ADHD (impulsivity) ■ Oppositional Defiant Disorder/Conduct Disorder
<ul style="list-style-type: none"> ■ Interpersonal difficulties (e.g., social withdrawal, difficulty making friends, untrusting) 	<ul style="list-style-type: none"> ■ Depression
<ul style="list-style-type: none"> ■ Inconsistent mood ■ Easily overwhelmed or upset 	<ul style="list-style-type: none"> ■ Mood Disorder
<ul style="list-style-type: none"> ■ Failure to thrive ■ Rigidity and perfectionism 	<ul style="list-style-type: none"> ■ Developmental Disorder ■ Obsessive Compulsive Disorder
<ul style="list-style-type: none"> ■ Need-fulfilling behaviors (e.g., stealing or hoarding food, oversexualized behaviors, overeating, and demanding adult attention) 	<ul style="list-style-type: none"> ■ Eating Disorder ■ Sexualized behavior

Rossen & Cowan (2013)

60

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

61

Consequences of PTSD

- 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).

62

Consequences of PTSD

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

63

Consequences of PTSD

- PTSD & LD
 - Childhood trauma creates difficulty with:
 - Focus (Traweck, 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

64

Traumatic Stress: The Achievement Gap

“... children’s experiences of their communities as unsafe or threatening are likely to affect their mental health through increasing their psychological stress, disrupting their processing of social information, and altering the ways in which they selectively engage with – or disengage from their environments.” (McCoy et al. 2015, p.1)



Porche et al. (2011)

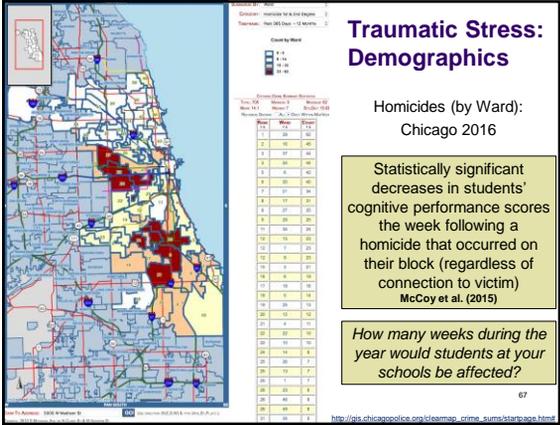
65

Traumatic Stress: Consequences

- Demographics
 - 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

National Scientific Council on the Developing Child (2005/2014); Blaustein (2013)

66



Traumatic Stress: Demographics

The disappearing front porch

Children, but the porch is the intersection of their lives

CYCLE OF RISK:
THE INTERSECTION OF POVERTY, VIOLENCE, AND TRAUMA

HEARTLAND ALLIANCE

68

ASSESSMENT & IDENTIFICATION

69

Initial Assessment of PTSD

Crisis Event Type*

- Human Caused (vs. Natural)
- Intentional (vs. Accidental)
- 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)

70

Initial Assessment of PTSD

Crisis Exposure*

- Physical proximity
 - Intensity of crisis experience
- 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)

71

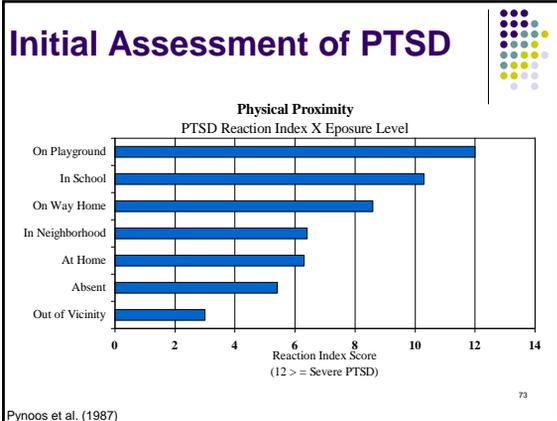
Initial Assessment of PTSD

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)

72

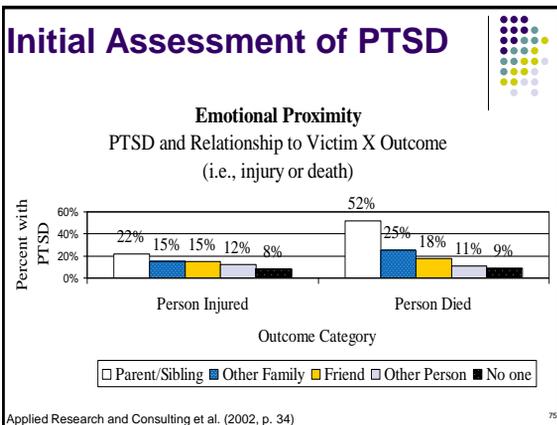


Initial Assessment of PTSD

Emotional Proximity

- Individuals who have/had close relationships with crisis victims should be made crisis intervention treatment priorities.
- May include having a friend who knew someone killed or injured.

Brock (2006); Brock et al. (in preparation)



Initial Assessment of PTSD

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.

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

Initial Assessment of PTSD

Internal Vulnerability Factors

- Avoidance coping style
- Pre-existing mental illness
- Poor self regulation of emotion
- Low developmental level and poor problem solving
- History of prior psychological trauma
- Self-efficacy and external locus of control

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

Initial Assessment of PTSD

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)

79

Initial Assessment of PTSD

Crisis Reactions*

Severe acute stress reactions predict PTSD. Reactions suggesting the need for an immediate mental health referral

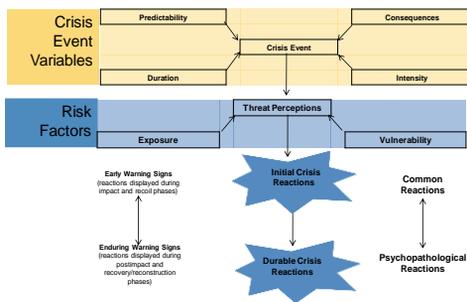
- Dissociation
- Hyperarousal
- Persistent re-experiencing of the crisis event
- Persistent avoidance of crisis reminders
- Significant depression
- Psychotic symptoms

*Warning signs that provide concrete indication of psychological trauma

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

80

Initial Assessment Trauma Exposure



Brock et al. 2009 & 2016.

81

Initial Assessment of PTSD

Multi-Method & Multi-Source

- "Traumatized youths do not generally seek professional assistance, and recruiting school personnel to refer trauma-exposed students to school counselors can also leave many of these students unidentified."
- "These findings suggest that a more comprehensive assessment of exposure parameters, associated distress, and impairment in functioning is needed to make informed treatment decisions, especially given the possibility of inaccuracies in child and adolescent reports of the degree of exposure and the great variability in responses to similar traumatic events observed among survivors."

Saltzman et al. (2001, p. 292)

82

Initial Assessment of PTSD

Primary Evaluation of Psychological Trauma

- Takes place immediately after the crisis

Secondary Evaluation of Psychological Trauma

- Begins as soon as school crisis interventions begin to be provided.
- Assess risk factors and warning signs

Tertiary Evaluation of Psychological Trauma

- Screening for psychiatric disturbances (e.g., PTSD)

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

83

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

APA (2000), Brewin, Andrews, & Rose (2003)

84

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

Pfohl et al. (2002)

85

Identification/Assessment of PTSD



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

Pfohl et al. (2002)

86

Identification/Assessment of PTSD



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

Pfohl et al. (2002)

87

Identification/Assessment of PTSD



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

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

88

Identification/Assessment of PTSD



Assessment and Evaluation

• Diagnosis

- Background Information
 - www.csus.edu/indiv/b/brocks/Courses/EDS%20243/student_materials.htm
- Interviews
 - Students
 - Caregivers

Nickerson et al. (2009)

89

Identification/Assessment of PTSD



Assessment and Evaluation

• Diagnosis

- Diagnostic Interviews
 - *Diagnostic Interview of Children and Adolescents*
 - *Kiddie Schedule for Affective Disorders and Schizophrenia for School-age Children*
 - *Structured Clinical Interview of DSM IV*
 - *Clinician Administered PTSD Scales*

Nickerson et al. (2009)

90

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) 91

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) 92

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) 93

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) 94

Identification/Assessment of PTSD

Assessment and Evaluation

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

Nickerson et al. (2009) 95

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) 96

MITIGATION & INTERVENTION

97

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)

98

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)

99

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)

100

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)

101

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), Dyregov & Yule (2006)

102

Preventing/Mitigating PTSD

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

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

RESPONDING TO ACUTE TRAUMA

School-Based Interventions

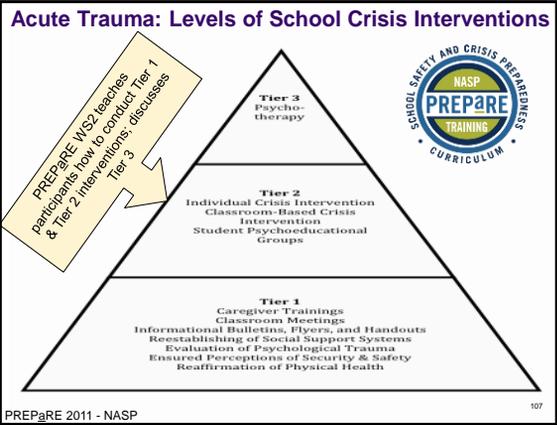
- Psychological First Aid**
 - Clarify trauma facts
 - Normalize reactions
 - Encouraging expression of feelings
 - Provide education to the child about experience
 - Encourage exploration and correction of inaccurate attributions regarding the trauma
 - Stress management strategies

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

School-Based Interventions

- Immediate Crisis Intervention**
 - General Issues
 - Cultural differences
 - Body language
 - Small groups
 - Genders
 - Appropriate tools
 - Frequent breaks
 - Develop narrative

Reeves (2008)



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

109

Brock et al. (2016)

Responding to *Complex* Traumatic Stress

- Primary Prevention
 - 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?

110

Brock et al. (2016)

Responding to *Complex* Traumatic Stress: Documentary “Resilience”

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.

111

KPJR Films; preventchildabuse.org/resource/resilience

Responding to *Complex* Traumatic Stress

- 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



112

Available: <http://traumasensitiveschools.org/trauma-and-learning/the-problem-impact/>
SAMSA (2014)

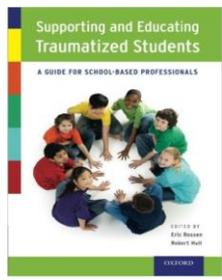
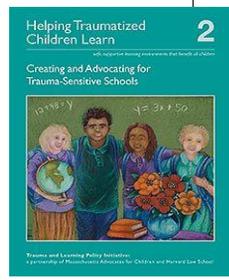
Responding to *Complex* Traumatic Stress

- The Ongoing Universal Response
 - Create 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.

113

From <http://traumasensitiveschools.org/trauma-and-learning/the-problem-impact/>

Responding to *Complex* Traumatic Stress

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Free download: <http://traumasensitiveschools.org/tlpi-publications/>

114

Responding to **Complex** Traumatic Stress

Creating Trauma-Informed Schools

Select
Psychological interventions to remediate adverse effects and avoid re-traumatization:
+ Cognitive-behavioral therapy
+ Community-based services
+ Wrap-around care

Targeted
Strategies and interventions that address:
+ Psychoeducation about trauma signs and impact
+ Reinforcing social support systems
+ Strengthening self-regulation skills

Universal
Strategies to build positive adaptive systems:
+ Understanding benefits to positive climate and reducing adverse environments
+ Developing social problem-solving and coping skills
+ Facilitating growth mindset
+ Teaching common behavior expectations

RESIST
RESPOND
REALIZE

115
Chafouleas et al. (in preparation)

Responding to **Complex** Traumatic Stress

- The Ongoing Universal Response
 - 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.
 - 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.

Slide from Chafouleas et al. (in preparation)

116

Responding to **Complex** Traumatic Stress

- 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.

117
Baker, Brown, Wilcox, Overstreet, & Arora (2016)

Responding to **Complex** Traumatic Stress

- The Ongoing Universal Response
 - Creating Trauma Informed Schools
 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.
 6. Be prepared for episodes of intense emotion.
 7. Consider alternatives to regular classroom.

118
Lofthouse & Fristad (2006, pp. 220-221)

Responding to **Complex** Traumatic Stress

- The Ongoing Universal Response
 - Facilitate the development of 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?
 - Classroom wide mindfulness exercises
 - SEL curriculum

119
Brock et al. (2016)

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)

Available: https://cbitsprogram.org/_static/cbits/uploads/files/Trauma%20E%20exposure%20Checklist.pdf
Foa et al. (2001)

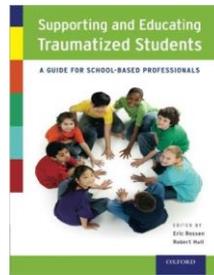
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Mitigating: Creating Trauma Informed Schools

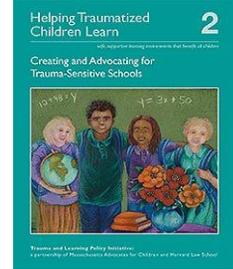
1. A shared understanding among all staff
2. The school supports all children to feel safe physically, socially, emotionally, and academically.
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4. The school explicitly connects students to the school community and provides multiple opportunities to 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.

<http://traumasensitiveschools.org/trauma-and-learning/the-problem-impact/>

Mitigating: Creating Trauma Informed Schools



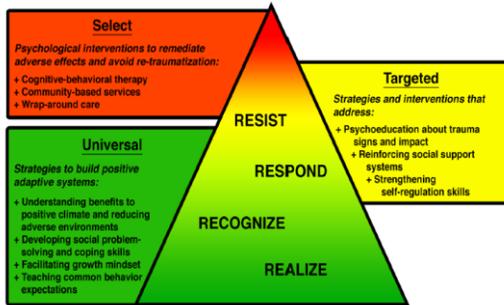
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Creating Trauma-Informed Schools



Chafouleas et al. (in preparation)

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).

Chafouleas et al. (in preparation)

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

Baker, Brown, Wilcox, Overstreet, & Arora, 2016

125

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)

126

School-Based Interventions



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

Nickerson et al. (2009)

127

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.
 6. Be prepared for episodes of intense emotion.
 7. Consider alternatives to regular classroom.

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

128

School-Based Academic Interventions



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

129

School-Based Academic Interventions



- Academic Interventions
 - Promote Initiation/Focus
 1. Increase structure
 2. Consistent and predictable daily routines
 3. Short breaks and activities
 4. External prompting (cues, oral directions)
 5. Allow time for self-engagement instead of expecting immediate compliance

Reeves (2008)

130

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

131

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

132

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

<http://www.ptsd.va.gov/public/videos/children-trauma.asp>

133

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?

134

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.

Ehnholt et al. (2005) <http://www.ptsd.va.gov/public/videos/children-trauma.asp>

135

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/>

<http://www.socio.com/srhc/summary/cedeta/ced04.htm>

(Jaycox, et al 2010)

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>

The Fourth R: Relationships



THE KIMOCHIS® EDUCATOR'S TOOL KIT

- 296-page *Kimochis® Feel Guide: Teacher's Edition*
- 5 *Kimochis® Characters* (Bug, Cat, Cloud®, Haggston, Lovey, Dover)
- Mixed Bag of Feelings—includes 33 feeling pillows

THE KIMOCHIS® MIXED BAG OF FEELINGS

- includes 33 feeling pillows each with a word on one side and a facial expression on the other
- Use in the classroom, principal's office, at recess, and in the psychologist, counselor, and SLP's office with the downloadable PDF *Kimochis® Feelings for Schools—Build a Positive School Culture and Climate One Feeling at a Time*
- Includes: Happy, Mad, Sad, Brave, Left Out, Curious, Cranky, Silly, Frustrated, Hopeful, Proud, Optimistic, Disappointed, Nervous, Insecure, Jealous, Loved, Grateful, Scared, Shy, Kind, Hurt, Sorry, Uncomfortable, Friendly, Sleepy, Surprised, Embarrassed, Guilty, Excited, and 3 blank Place-Your-Own (works with any washable marker)



Kimochis

BEAR is a bit nosy and unpredictable.

CATERPILLAR is a caterpillar who is shy and afraid of change.

CAT is a decisive leader, but she can be a bit bossy.

FROG is friendly, affectionate and sometimes too silly.

BIRD is nurturing and patient, but can get overly worried.

FLOWER is sensitive and nervous and closes up like a bud when her feelings get hurt.

FROG is a bit absent-minded, but is resilient and bounces back.

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

Intensive School and Community Supports

Intensive School Interventions	Intensive Community Interventions
Individual Counseling	Long Term Therapy
Functional Behavioral Assessment	Family Counseling
Special Education Consideration	Involvement with Social Services
Individualized Behavior Plan	Community Mentoring
More restrictive environment	

Systems of Care

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

- Use clinicians or other student support providers in the schools to work with students, their families, and all members of the school community
- Use of school-based and school-focused Wraparound services to support learning and transition.
- 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.
- Schoolwide prevention and early intervention programs.
- Creation of centers within the school to support students and their families.
- Use of family liaisons or advocates to strengthen the role of and empower family members in their children's education and care.

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

<http://www.youtube.com/watch?v=dX75QED4ASA> – earthquake & plane – recovery

Carr (2004), NIMH (2007)

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

145

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...

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154