Riverside County Special Education Local Plan Area (SELPA)

Promoting Trauma Informed Care in Schools

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Introduction

Studies have demonstrated that traumatic experiences are more pervasive than many educators currently recognize (Tishelman, Haney, Greenwald O'Brien, & Blaustein, 2010). Trauma is widespread, harmful and has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. By viewing student's academic challenges and behaviors through a "trauma lens," educators can help children learn and thrive (Cole, Eisner, Gregory, & Ristuccia, 2013). Trauma has many definitions. The one adopted herein was generated by a panel of experts:

> *"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014, p. 7).*

Individuals with trauma experiences are found in multiple service sectors: behavioral health, juvenile and criminal justice system, child welfare system, and our school systems. Unfortunately, these public institutions and service systems are often themselves trauma inducing (SAMHSA, 2014). As examples, consider the effect of the abrupt removal of a child from his or her family, the use of invasive procedures in the medical field, the intimidating practices used in the criminal justice system, and harsh disciplinary actions in schools. Given the variety of settings in which trauma can occur, addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education awareness, prevention, early identification and effective trauma-specific treatment interventions (SAMHSA, 2014).

The evidence is clear that, with appropriate supports and intervention, people can overcome trauma. This push for promoting trauma-informed care in schools should not be seen as a new initiative but as one that integrates well with existing initiatives. The same legal and policy conditions necessary for trauma sensitivity are also necessary for the promotion of behavioral health, bullying prevention, dropout prevention, truancy reduction, social and emotional learning, positive approaches to discipline, and others. These are all essential components of creating safe and supportive schools.

Statement of Need

Trauma can come in many forms. Traumatic events can include a wide range of occurrences that are experienced, learned of, or witnessed (Perry, 2007). Usually it is not the event itself but rather a response to a highly stressful experience in which a person's ability to cope is dramatically undermined (Cole et al., 2013). Traumas can reverberate down the generations and be accompanied by poverty, isolation and physical illness. Problems can be found together (e.g., substance abuse, mental illness, family violence, child abuse and neglect). For example, many think of childhood sexual abuse as an isolated incident but it frequently coexists with other adverse circumstances in a child's life (Gaskill & Perry, 2012). While the majority of neglected and/or traumatized children do not become violent, a malignant combination of experiences can create various challenges for a person.

In traumatic situations, one experiences an immediate threat to self or to others, often followed by serious injury or harm. A person may feel terror, helplessness, or horror because of the extreme seriousness of what is happening and the failure of a way to protect against or reverse the harmful outcome. The powerful, distressing emotions go along with strong, even frightening physical reactions, such as rapid heartbeat, trembling, stomach dropping, and a sense of being in a dream (The National Child Traumatic Stress Network [NCTSN]). From a biological perspective, fear causes an automatic, rapid protective response enabling the individual to escape immediate danger – often referred to as the "fight, flight, or freeze" response. Following a traumatic event, people, particularly children, often have difficulty making sense of their feelings, managing them, and accepting them. This confusion can also cross over into multiple aspects of the person's life, interfering with the person's capacity to cope.

The most common diagnoses associated with stress are Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD) (SAMHSA TIP, 2014). ASD represents a normal response to stress, most often associated with a one-time event. The person often appears overwhelmed by the experience, which can cause clinically significant impairment in functioning. Symptoms usually last three days to one month and most people who have ASD never develop further impairments. In contrast, PTSD continues for a much longer period of time, typically becomes a primary feature of an individual's life, and can have a profound effect on a person's perceptions of safety, sense of hope for the future, relationships with others, physical health, appearance of psychiatric symptoms, and their patterns of substance use and abuse (SAMHSA TIP, 2014).

The correlation between trauma and low academic achievement is very strong (see Oehlberg, 2008). Childhood exposure to maltreatment or other traumatic experiences is particularly common among children and adolescents who enter the child welfare and juvenile justice systems (AOC, 2014). In the child welfare population, 60-80% of children served reported at least one traumatic event; 70% of children served by community behavioral health agencies have reported exposure to at least one traumatic event; children served through the foster care system have a much higher rate of exposure (DCF, 2013). This may be related to the finding that every time a child has a disrupted placement, behaviors tend to worsen; the child will often blame him or herself and come to believe he/she is unlovable and unwanted and that it is not safe to get close to others; the child may end up in higher levels of care and come to feel powerless and resentful of authority figures and rigid rule systems (Hendricks, 2013d).

Purpose of this Document

The field of education cannot ignore the issues associated with traumatic stress. "Schools, the communities in which children spend so much of their time, hold tremendous potential to become powerful factors in not only mitigating the negative impacts of exposure to traumatic experiences, but actually providing a community that is an "ecological fit" (Cole et al., 2013, p. 112). Interventions that achieve ecological fit are those that enhance the environment-person relationship —i.e., those that reduce isolation, foster social competence, support positive coping, and promote belongingness in relevant social contexts. Our goal in developing this document is to help schools become trauma-sensitive learning environments that can improve educational outcomes for all children. Looking at students' learning, behaviors, and relationships through a "trauma lens" can help explain both staff and student behavioral responses in a new way. It can reveal systemic barriers that need to be addressed school-wide so that an integrated and coordinated approach to service delivery is made possible.

Even though integrating trauma sensitivity into the educational system has minimal costs, moving to action can be difficult. Below are some highlights from the research on the positive outcomes associated with becoming a trauma-informed organization:

- *Improved* academic achievement and test scores, school climate, teacher sense of satisfaction, sense of safety in being a teacher, retention of new teachers (Oehlberg, 2008).
- *Reduced* student behavioral out-burst and referrals to the office, stress for staff and students, absences, detentions, suspensions, student bullying and harassment, need for special education services/classes, drop-outs (Oehlberg, 2008).
- Students in schools that have made trauma sensitivity an essential aspect of instruction and their school-wide educational mission have shown greater academic achievement, more time spent on learning, reduced disciplinary referrals, improved relationships with peers and adults, and more supportive teaching in the classroom (Cole, et al., 2013).

The above results have also been replicated! Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness, in that services are more appropriately matched to student needs from the outset (SAMHSA TIP, 2014). It is important to use a

school-wide or a universal approach that crosses regular and special education because “most children who experience traumatic events will not require special education” (Cole et al., 2013, p.113).

This document is designed to help educators understand trauma informed care, create a trauma informed system, and to provide trauma informed services. The National Center for Trauma Informed Care (NCTIC, 2013) defines these as follows:

- *Trauma Informed Care* is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
- *A Trauma Informed System* is one in which all components of services given have been reconsidered and evaluated in light of a basic understanding of the role that violence plays in the lives of people seeking mental health services.
- *Trauma Informed Services* are not specifically designed to treat symptoms or syndromes related to abuse or other trauma but they are informed about and sensitive to trauma related issues present in others.

A framework of four assumptions and six key principles is often used to describe the meaning of “trauma-informed care” (SAMHSA, 2014). The *assumptions* focus on four “R’s”: A program, organization, or system that is trauma informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. The *key principles* of a trauma-informed approach include (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice and choice; and (6) cultural, historical, and gender issues.

Trauma informed care has also been conceptualized as revolving around three main concepts (Hodas, 2006): understanding, commitment, and practices. Understanding includes definitions of trauma, its prevalence and consequences, the person, and focusing on strengths; services, the service relationship, using a collaborative partnership approach, and consistency with self-direction and person-centered approaches. Commitment on the part of administrative staff is essential. It is considered when identifying “trauma champions”, hiring practices, staff training, and the flow of resources. Practices focus on empowerment vs. management and control; use of person-first language with decreased emphasis upon symptoms and behaviors; and the aim to build upon strengths and promote resiliency.

The best approach is to make sure trauma-sensitive learning environments are provided for all children. Since each school is a complex ecosystem and has its own culture, “school-wide thinking and planning must grow from within rather than be imposed from outside” (Cole et al., 2013, p. 10). In trauma-informed systems of care, staff members understand the impact of traumatic stress both on youth and families, and provide services and supports that prevent, address, and ameliorate the impact of trauma (AOC, 2014). The essential elements of a trauma-informed system include:

- Maximizing the child’s and family’s sense of physical and psychological safety;
- Identifying the trauma-related needs of children and families;
- Enhancing the child’s and family’s well-being and resiliency;
- Partnering with families and system agencies; and,
- Enhancing the well-being and resiliency of the workforce (DCF, 2013).

Trauma-informed approaches need to be applied across multiple child-serving systems, including education, mental health, child welfare and juvenile justice (Chadwick, 2013). Cultural change in any organization begins with administrators/leaders clearly endorsing that all children and youth will be safe

and then building a framework of security, particularly emotional security, as a primary focus in all situations and actions (Oehlberg, 2008). This can be met by providing all staff with an understanding of trauma informed care, systems and services. To that end, this document provides information about what trauma is; the prevalence of trauma; how it affects individuals psychologically and developmentally; and techniques / strategies to employ to prevent, intervene, and improve outcomes for victims of trauma. This document also provides guidance on how to implement these approaches within an organization. Training is also available upon request.

Understanding Trauma

There are many forms and causes of trauma. By their very nature, traumatic events set up a power differential where one entity (an individual, an event, or a force of nature) has power over another. Disaggregating SAMHSA's (2014) conceptual definition, events and circumstances may include the actual or extreme threat of physical or psychological harm or severe, life-threatening neglect for a child that imperils healthy development. It can be a single occurrence or repeated over time. An individual's experience of these events or circumstances depends on how he or she labels, assigns meaning to, and is disrupted physically and psychologically. Thus, the interpretation of the event contributes to whether or not it is experienced as traumatic. How the event is experienced may be linked to the individual's cultural beliefs, availability of social supports, and/or to the developmental stage of the individual. The long lasting effects of the event are also a critical component of trauma. Adverse effects may occur immediately or may have a delayed onset and the duration of the events can also vary from short to long term impact.

Definitions

Events that disrupt homeostasis are, by definition, stressful. However, stress during childhood development is not necessarily a bad thing (Perry, 2007), as learning how to cope with stress is an important part of child development (Gaskill & Perry, 2012). When a child feels threatened, the body activates a variety of physiological responses (e.g., increasing heart rate, blood pressure, and stress hormones). The development of stress-response neural systems depends upon exposure to moderate, controllable levels of stress via opportunities to explore, discover, and experience novelty.

When protected by supportive relationships with adults, the child learns to cope with everyday challenges and his or her biological system returns to baseline – often referred to as *positive stress*. Even when more serious difficulties arise (e.g., loss of a loved one, natural disaster, frightening injury), when buffered by caring adults, the child experiences *tolerable stress*. When strong, frequent, or prolonged adverse conditions are experienced without adult support, *toxic stress* ensues. The National Child Abuse and Neglect Data Systems include specific definitions on various types of trauma. The types are listed below, with details in Appendix A.

- sexual maltreatment/abuse
- sexual assault/rape
- physical abuse/maltreatment
- physical assault
- neglect
- domestic violence
- emotional abuse /psychological maltreatment
- war/terrorism/political violence inside the U.S>
- war/terrorism/political violence outside the US
- kidnapping
- illness/medical
- injury/accident
- natural disaster
- traumatic loss or bereavement
- forced displacement
- impaired caregiver
- extreme personal/ interpersonal violence (not reported elsewhere)
- community violence (not reported elsewhere)
- school violence
- vicarious trauma
- other trauma

In addition to being categorized into types of events, trauma can also be grouped by intensity. *Type I Trauma* is reacting to an unanticipated single event and can evoke reactions typical of PTSD (e.g., re-experiencing the trauma, avoidant behavior, and hyper-arousal). In contrast, *Type II Trauma* includes trauma reactions as a result of long-term or repeated exposure to extreme external events. Similarly, some people experience *complex trauma*, which describes both exposure to chronic trauma, often inflicted by parents or others who are supposed to care for and protect the child, and the long-term impact of such exposure on the child (Cook, Spinazzola, Ford, Lankgree, Blaustein, Cloitre, & van der Kolk, 2005).

Prevalence of Trauma

The National Child Traumatic Stress Network (NCTSN) reports that, by age 16, approximately 25% of children and adolescents in the U.S. experience at least one potentially traumatic event, including life threatening accidents, disasters, maltreatment, assault, and family and community violence. A national study focusing on foster youth, found that more than 70% of the children met the criteria for exposure to complex trauma (Gresson, Ake, Howard, Briggs, Ko, Pynoos, Kisiel, Gerrity, Fairbank, Layne & Steinberg, 2011). In fiscal year 2011, nationwide, 9.1 out of every 1,000 children were victims of maltreatment. Of these, 79% of these experienced neglect; 18% were physically abused; 9% were sexually assaulted; 10% experienced "other" types of maltreatment; and, in 81% of the cases, the source of maltreatment was the child's caregiver (AOC, 2014).

There are approximately forty-two million adult victims/survivors of child sexual abuse in America (Banner, 2014) and, according to the Centers for Disease Control and Prevention, one in four women and one in six men were victims of sexual abuse before they reached the age of eighteen years. A child with a developmental delay or other disability is more likely to be a victim of child abuse, particularly sexual abuse, and may have more difficulty reporting the experience than a nondisabled peer (Herschkowitz, Lamb, & Horowitz, 2007). In addition, childhood sexual abuse seldom occurs as an isolated event – it is more likely to co-exist among a host of other adverse circumstances in a child's life (Anda et al., 2006).

Impact on Children Exposure to Trauma

Not all children who experience trauma are adversely affected. How a child responds and how long reactions linger are a result of the objective nature of the events plus the child's subjective response to those events. A child's responses to trauma are shaped by the extent to which his or her support system is disrupted during and after the trauma. Other factors that can influence a child's responses to trauma include the following:

- The child's age and developmental stage;
- The adversities the child faces in the aftermath of the trauma;
- Preexisting psychopathology;
- The child's perception of the danger faced or sense of threat;
- The presence/availability of adults who can offer help and protection;
- Whether the child was the victim or a witness;
- Parental psychopathology and distress;
- The child's relationship to the victim or perpetrator;
- Genetic predisposition;
- Interactions with first responders and other helping professionals;
- Previous history of traumatic experiences (Chadwick, 2013).

Since children's reactions to trauma are varied and complex, reactions may manifest at different periods following the event or the child's removal from the traumatic situation. There can be immediate reactions to traumatic stress and long-term reactions to child traumatic stress (Chadwick, 2013).

Brain Development

Although as educators we cannot see into one's brain, it is important to know that the timing of a traumatic experience can impact the brain differentially. The brain is constructed through interplay between nature (genetics) and nurture (environment), thereby becoming uniquely designed to support the survival of the young child in the world he or she experiences (Gaskill & Perry, 2012). More than 80% of the major structural organization and changes within the brain occur within the first four years of life (Perry, 1997). Since the brain undergoes it most rapid development during this period of time, is a considered a *sensitive period* for emotional and cognitive development. Converging evidence from neurobiology and epidemiology suggests that early life stress such as abuse and related adverse experiences can cause enduring brain dysfunction that, in turn, affects health and quality of life throughout the lifespan (Anda et al., 2006). Thus, it is argued, early developmental trauma and neglect can have a "disproportionate influence on brain organization and later brain functioning" (Perry & Hambrick, 2008).

Typically the systems required for survival develop first while higher brain regions develop later and more slowly. The brainstem controls heart rate, body temperature, and other survival-related functions. It also stores anxiety or arousal states associated with a traumatic event. The limbic system stores emotional information and the neocortex controls abstract thought and cognitive memory. Critical development in the pre-frontal cortex, considered the executive manager of the neurological system, is stimulated by early relationships that are predictable, soothing, and include frequent eye contact, smiles, and touching (Oehlberg, 2008).

Because the human brain develops and organizes in a systematic and hierarchical fashion, a child typically progressively displays new skills, called *developmental milestones*, as the various parts of the brain mature (Gaskill & Perry, 2012). The Harvard University Center on the Developing Child has demonstrated that the number of significant adversity incidents a child experiences in the first three years of life has an increasing effect on developmental impairments. A child can become particularly vulnerable when exposed to inappropriate or abusive caregiving, a lack of nurturing, chaotic and cognitively or relationally impoverished environments, unpredictable stress, persistent fear, and/or persistent physical threat. In such cases, the child may not have developed the neurological structure necessary for self-regulation (Dobson & Perry, 2010). When such *toxic stress* is experienced early in life, a cumulative toll on an individual's physical and mental health can occur (Harvard). Such individuals have a greater likelihood of developmental delays and for developing health problems (e.g., alcoholism, depression, heart disease, and diabetes) as adults.

A child may appear "developmentally stuck" and delayed in their maturity when his or her body has redirected resources normally used for growth to survival (see Chadwick, 2009). For example, prenatal drug exposure puts the child at greater risk for developmental delays. Prenatal cocaine exposure has been found to adversely impact social-emotional interactions between infants and their mothers and to be associated with difficulty in sustaining attention and behaviorally managing emotion in school-aged children (Conradi, 2013, p. 20). In addition, the quality and quantity of sensory experiences can enhance or inhibit cognitive development of the cortex, which is the part of the brain that develops complexity, makes synaptic connections, and is responsible for complex functions such as language and memory. Trauma can also impact the brain's ability to "cross-talk" between hemispheres, including the parts of the brain that control emotions.

The Development of Attachment

Since the systems in the human brain that allow us to form and maintain emotional relationships also develop during infancy and the first years of life, one's experiences during this period of life are critical to shaping one's capacity to form intimate and emotionally healthy relationships (Perry, 2013). The child who was emotionally neglected early in life may exhibit attachment problems and can carry their scars in different ways. For example, "children with early neglect histories and subsequent attachment-

related problems rarely feel safe when placed in new, healthy caregiving situations. Instead, they work to avoid close relationships, often becoming aggressive and controlling as a way to protect themselves from further hurt" (Dobson & Perry, 2010, p.38). However, early life relational experiences can also be protective and reparative. Healthy relational interactions with safe and familiar individuals can buffer and heal trauma-related problems. Social connectedness can be another protective factor against many forms of child maltreatment as well as a means of promoting prosocial behavior (Dobson & Perry, 2010).

Attachment can be defined as (a) a special enduring form of "emotional" relationships with a specific person; (b) involves soothing, comfort and pleasure; (c) loss or threat of loss of the specific person evokes distress; and (d) the child finds security and safety in context of this relationship (Perry, 2013). *Bonding* is the process of forming an attachment (Perry, 2013). The core attachment capabilities formed in infancy and early childhood include empathy, caring, sharing, inhibition of aggression, capacity to love and other characteristics of a healthy, happy and productive person. A solid and healthy relationship with a primary caregiver appears to be associated with a high probability of healthy relationships with others while poor attachment appears to be associated with a host of emotional and behavioral problems later in life. Individual attachment capabilities are continuous but, based on research of infants, can fall into four categories, each of which responds differently in strange situations (Perry, 2013).

Classification of Attachment	**Responses in Strange Situations**
Securely attached	Explores with mom in room; upset with separation; warm greeting upon return; seeks physical touch and comfort upon reunion
Insecure: avoidant	Ignores mom when present; little distress on separation; actively turns away from mom upon reunion
Insecure: resistant	Little exploration with mom in room; stays close to mom; very distressed upon separation; ambivalent or angry and resists physical contact upon reunion with mom
Insecure: disorganized and disoriented	Confusion about approaching or avoiding mom; most distressed by separation; upon reunion acts confused and dazed – similar to approach-avoidance confusion in animal models

"Attachment disruptions" (Conradi, 2013a) can be caused by a traumatic event alone and/or from removal from a known caregiver. Any factors that interfere with bonding experiences can interfere with the child's development of attachment capabilities. These can include the infant's personality or temperament, the caregiver's behaviors, environmental factors that engender fear, and the "fit" between the temperament and capabilities of the infant and the mother. When the interactive, reciprocal "dance" between the caregiver and infant is disrupted or difficult, bonding experiences are difficult to maintain. A maltreated child with attachment problems may demonstrate developmental delays, eating problems, soothing behavior, limited or impaired social-emotional functioning, inappropriate modelling, and aggression (Perry, 2009).

Parental Pathology or Distress

Numerous studies cited by Hendricks (2013c) indicate intergenerational transmission of trauma can occur through caregiver symptoms (e.g., depression and PTSD), impaired parenting practices, and problems in the caregiver-child relationship. Adults who were maltreated as children often did not have positive role models for establishing and maintaining trusting relationships, learned inappropriate and

harmful parenting styles (e.g., using threats and violence), may treat their own children the way that they were treated, and have difficulty forming healthy attachments with their children. There are three primary themes observed in abusive and neglectful families:

1. Maltreated children are, essentially, rejected – most common effect;
2. This rejection and abuse can be transgenerational – the neglectful parent was neglected and they pass on the way they were parented;
3. "Parentification" of the child – when the infant is treated as a playmate or friend by a young single mom or when an immature parent treats their child like an adult or other parent – the false sense of maturity in children interferes with the development of same-age friendships (Perry, 2013).

The behavioral symptoms often associated with individuals who have experienced trauma can become even more complicated for those exposed to a home life with substance abuse. Children in such environments often experience chaotic and unpredictable home lives, parental abandonment, inconsistent parenting and lack of supervision, physical or emotional abuse, and inconsistent emotional responses from parents (Breshears, Yeh, & Young, 2009). Interfamilial abuse also contributes to *complex trauma*, involving chronic affect dysregulation, and destructive behavior against self and others, learning disabilities, dissociative problems, somatization, and distortions in concepts about self and others.

A child with a disability can be at increased risk for experiencing trauma when there are higher emotional, physical, economic, and social demands on the family. There may be greater caregiver stress because the child may not respond to traditional means of reinforcement or the child's behavioral characteristics (e.g., aggression, noncompliance, communication difficulties) become quite frustrating. Intellectual limitations may prevent the child from being able to discern an experience as abuse and impaired communication abilities may prevent the child from disclosing the abuse to others (Hibbard, Desch, & American Pediatrics, 2007).

Previously secure attachments can also change suddenly following abuse and neglect. In such cases, the child's perception of a consistent and nurturing world no longer fits their reality. Experiencing interpersonal violence tends to be more traumatic than natural disasters because it is more disruptive to one's fundamental sense of trust and attachment, and is typically experienced as intentional rather than an accident of nature.

The Child's Response to Perceptions of Danger

When the brain is faced with traumatic experiences it doesn't shut down, it shifts. The "reasoning" part of the brain gives way to the more primitive mid-brain, where everything is about instinct and survival. Cognitive processes become limited while the sensory reactions to terror dominate. Fight, flight or avoidance reactions are common. When traumatized, memories and behaviors are reframed in ways that may not make sense to others, or even to the individual, but make perfect sense to a brain grappling to protect itself from danger. There is a continuum of adaptive responses to threat and different children have different adaptive styles (Perry, 2004):

- A child adopting a hyperarousal response (e.g., fight or flight), may display defiance, appear resistant or even aggressive, hypervigilance, anxiety, panic, or increased heart rate. This response is more common in older children, males, and in circumstances where trauma involves witnessing or playing an active role in the traumatic event.
- Some use a dissociative response, essentially "tuning out" the threat using avoidance, psychological flight, or withdrawing from the outside world and focusing on the inner. In extreme cases, the child may withdraw into a fantasy world. The child may be detached, numb, have a low heart rate, appear compliant (almost robotic), or display rhythmic self-soothing

motions such as rocking. Dissociation is more common in young children, females, and during traumatic events characterized by pain or inability to escape.
- In most traumatic events, a combination of the two is used.

While the rational brain is able to organize feelings and impulses, it does not seem to be particularly well equipped to abolish emotions, thoughts and impulses (van der Kolk, 2006). This explains why trauma survivors are prone to display irrational responses that might be irrelevant, unproductive, or even harmful in the current context. Intervening with such behaviors can be difficult when this type of dysfunctional relational interaction is beyond the awareness and understanding of the developing child (Perry, 2006). However, research has shown that, from a neurological stance, repetition of safe experiences will in time replace the unsafe, sensory memories associated with traumatic experiences, resulting in improved emotional regulation –the ability to maintain a well-regulated emotional state to cope with everyday stress (Kuban, 2013).

Variance with Developmental Age/Status

Trauma in school-aged children can impact the parts of the brain that are responsible for managing fears, learning, and impulse control. In adolescent children, trauma can impact the development of the prefrontal cortex, which is the part of the brain responsible for connecting behaviors and consequences, problem solving, inhibitions, and impulse control. When this part of the brain has not been fully developed, the adolescent may engage in more risk-taking behavior, make poor decisions, not perform well at school and become involved in criminal activity. Similarly, children typically demonstrate different responses to separation and loss based on their age/developmental range (TLC, 2013d).

Age Range	Developmental Responses to Separation/Loss
Infancy - 3 years	• Increased irritability, due to change in environment, caregiver, and routine • Change in appetite/sleep patterns • Sense trauma and change through senses (i.e. touch of others)
3 - 6 years **Magical Thinking Stage**	• Increased separation anxiety (More "clingy" behavior) • Regression • Increased irritability, due to change in environment, caregiver, and routine
7 - 9 years **Concrete Thinking Stage**	• Believe they caused death • Interested in physical aftermath of body • Increased physical activity, especially males • Violent play, even if the death was not violent
10 - 13 years **Needs Answers NOW Stage**	• Constantly waiting for something else to happen (hypervigilance) -unsafe/daring behaviors • Increased physical activity, especially males • Needs to know answers regarding death immediately • Suicidal ideations
14 and up **Problem Solving & Abstract Thinking Stage**	• Intense & increased emotions • Constantly waiting for something else to happen (hypervigilance) -unsafe/daring behaviors • Depression • Suicidal ideations • Questioning own morbidity • May refuse to discuss death or grief issues, DO NOT pressure them to talk

The signs of a grieving child can also vary with age (Konarz, 2013). Infants and pre-verbal toddlers may show a decrease in activity level, decrease in appetite, increase in irritability and/or change in personality, and sleeplessness. Toddlers, preschools and school-aged children may demonstrate an increase or decrease in appetite, severe increase in activity level, severe decrease in social activities, hyper vigilance, dreams and nightmares, sleeplessness, breakdown in communication (especially in adolescence). There is also a variety of research on children's ability to cope with loss (see Briggs-Gowan, Carter, Clark, Augustyn, McCarthy, & Ford, 2010; Conradi, 2013a).

- An infant or young child is at particularly high risk of later mental health problems because his or her ability to manage emotions and use coping skills are not fully developed; he or she is also more dependent on caregivers for protection.
- Since the preschool child is still developing the skills necessary to cope with stressful situations, he or she may feel helpless, powerless, and unable to protect him or herself when experiencing loss. Since a preschool aged child tends to be strongly affected by the reactions that his or her parents or caregivers have to a traumatic event, adult response levels can influence the impact on the child's development of stress-related difficulties.
- Preschool and elementary aged children may show a regression in behaviors, appearing to loose skills or behaviors that had previously been mastered (e.g., thumb sucking, fear of going to new places, asking an adult to assist with feeding or dressing).
- A school-aged child may not understand why the loss or traumatic event occurred and subsequently withdraw from his or her friends, show increased competition for attention, refuse to go to school, behave more aggressively, be unable to concentrate and/or show a decline in school performance.
- After experiencing a traumatic event, an adolescent may exhibit some behavioral changes also seen in other age groups. However, his or her developmental age can also bring forth tendencies to place more importance on peer groups, to rebel against authority, and to feel immune from physical danger. These can motivate the youth to experiment with high-risk behaviors such as substance use, promiscuous sexual behavior, driving at high speeds, picking fights, etc. (SAMHSA). An adolescent may also feel extreme guilt if he/she were not able to prevent injury to or loss of loved ones; fantasize about revenge against those he/she feels/knows caused the trauma; be reluctant to discuss his/her feelings or even deny any emotional reactions to the trauma, in part because an adolescent will typically feel a very strong need to fit in with his/her peers; show traumatic responses similar to those seen in adults, including flashbacks, nightmares, emotional numbing, avoidance of reminders of the trauma, depression, suicidal thoughts, and difficulties with peer relationships (Briggs-Gowan et al., 2010). In addition, an adolescent with traumatic stress symptoms may begin to exhibit delinquent and/or self-destructive behaviors; changes in school performance; detachment and denial; shame about feeling afraid and vulnerable; abrupt changes in or abandonment of former friendships; and, pseudo-mature actions, such as getting pregnant, leaving school, or getting married (Conradi, 2013a).

Long Term Outcomes

If stress is severe, unpredictable, prolonged or chronic, compensatory mechanisms can become over-activated, fatigued and incapable of restoring the previous state of equilibrium. This can result in new dysfunctional brain patterns influencing the organization and functioning of the brain, which can ultimately result in psychopathology (see Gaskill & Perry, 2012). Likewise, *Type II Trauma* can lead to fundamental personality changes based on adaptive reactions often associated with long-term coping mechanisms such as denial, repression, dissociation, and identification with the aggressor in order to "survive" the ongoing traumatic experiences. Similarly, *complex trauma* can lead to emotional

dysregulation, loss of safety, and an inability to detect and respond appropriately to signs of danger (Chadwick, 2009). Finally, "the effect of trauma exposure is cumulative – the more types of trauma experienced by a child, the greater the risk to that child's development" (AOC, 2014, p. 5).

It is clear that traumatic events can impact the developing child and increase his or her risk of emotional, behavioral, academic, social and physical problems throughout life (Anda et al., 2006). The Adverse Childhood Experiences (ACE) study was conducted with over 17,000 Kaiser Permanente members to find out how stressful or traumatic experiences during childhood affected their adult health. The study revealed that 63% of the people who participated in the study had experienced at least one category of childhood trauma. 68% reported experiencing one or more adverse effects, with the most frequent being physical abuse, exposure to parental substance abuse, parental separation, and sexual abuse. Over 20% experienced three or more categories of adverse childhood experiences. This subgroup accounted for one-half to two-thirds of the serious problems with drug use and displayed mental health disorders such as depression, hallucinations and post-traumatic stress disorders. Below are their statistics:

- 11% experienced emotional abuse
- 21% experienced sexual abuse
- 10% experienced physical neglect
- 27% grew up with someone in the household using alcohol and/or drugs
- 23% lost a parent due to separation or divorce
- 28% experienced physical abuse
- 15% experienced emotional neglect
- 13% witnessed their mothers being treated violently
- 19% grew up with a mentally-ill person in the household
- 5% grew up with a household member in jail or prison

Another aspect of the ACE study was to analyze data based on the presence of specific household risk factors that the child may have been exposed to. Results revealed that 25% of child victims had been exposed to domestic violence, 10% to parental alcohol abuse, and nearly 20% to parental drug abuse (AOC, 2014). The more categories of ACEs experienced, the greater the negative impact on physical, mental and behavioral health outcomes. For example, "in comparison with those with no adverse childhood experiences, those who had experienced four or more ACEs were twice as likely to be smokers, twelve times more likely to have attempted suicide, seven times more likely to be alcoholic, and ten times more likely to have injected street drugs" (AOC, 2014, p. 7).

Another study revealed that, "among the comorbid neuropsychiatric diagnoses associated with childhood trauma are major depression, dissociative disorder, oppositional defiant disorder, conduct disorder, dysthymia, obsessive-compulsive disorder, phobic disorder, PTSD, substance abuse, borderline personality disorder, attention deficit and hyperactivity disorder, various developmental disorder, schizophrenia, and ultimately nearly all DSM IV diagnoses" (Gaskill & Perry, 2012, p. 30).

School Behaviors Associated with Trauma Experience

In a study of elementary school children, exposure to adverse events was the strongest predictor for health, attendance, and behavior problems and the second strongest predictor (after special education status) for academic failure (Blogett, 2012). The problems associated with abuse, maltreatment, and/or violence will vary upon the nature, intensity, duration and timing of the incident (Perry, 2013). A child with a brain adapted for an environment of chaos, unpredictability, threat, and distress can be ill-suited to the modern classroom or playground (Perry, 2004). Compared to their peers, traumatized children have less capacity to tolerate the normal demands of school, home, and social life. This is because, when faced with a challenge, they struggle to stay calm and their emotions can become elevated to a

state of fear, thereby retrieving information differently than one who feels calm. As such, children may display different symptoms of trauma, especially in the classroom, and these, in turn, can become related to discipline and delinquency.

Symptoms of Trauma

While all violent behavior impacts the children involved, there can be a differential impact on the child based on the type of violence, the pattern of violence, the presence (or absence) of supportive adult caretakers and other support systems, and the age of the child. Survival reactions such as fight, flight, or freeze are often generated by memories of terror and loss, often without specific word associations. A child in this state may not be able to communicate his or her sense of fear and doom with words so do so through behavioral outbursts and class disruptions (Oehlberg, 2008). *Chronic exposure* is more problematic than episodic exposure (Perry, 2004). Similarly, children and youth who have experienced *complex trauma* may display the following types of impairments (Cook et al., 2003):

Attachment	Boundary problems, social isolation, difficulty trusting others, interpersonal difficulty
Biology	Sensorimotor developmental problems, hypersensitivity to physical contact, somatization, increased medical problems, problems with coordination and balance
Affective Regulation	Problems with emotional regulation, difficulty describing emotions and internal experiences, difficulty knowing and describing internal states, problems with communicating needs
Behavioral Control	Poor impulse control, self-destructive behavior, aggressive behavior, oppositional behavior, excessive compliance, sleep disturbance, eating disorders, substance abuse, reenactment of traumatic past, pathological self-soothing practices
Cognition	Difficulty paying attention, lack of sustained curiosity, problems processing information, problems focusing on and completing tasks, difficulty planning and anticipating, learning difficulties, problems with language development
Self-Concept	Lack of continuous and predictable sense of self, poor sense of separateness, disturbance of body image, low self-esteem, shame and guilt

Similarly, studies cited by Gaskill and Perry (2012) identified the following as common symptoms of children who have been traumatized: intrusive recollections; persistent avoidance of associated stimuli or numbing of general responsiveness; and symptoms of hyperarousal, hypervigilance, startle response, sleep difficulties, irritability, anxiety, and physiological hyperactivity. Other symptoms include behavioral impulsivity, increased muscle tone, anxiety, a focus on threat-related cues (often non-verbal), affect regulation difficulties, language problems, fine and gross motor delays, disorganized attachment, dysphoria, attention difficulties, memory problems, and hyperactivity. These behavioral symptoms can also be disaggregated into age groupings:

- Preschoolers: thumb sucking, bedwetting, clinging to parents, sleep disturbances, loss of appetite, fear of the dark, regression in behavior, withdrawal from friends and routines;
- Elementary School Children: irritability, aggressiveness, clinginess, nightmares, school avoidance, poor concentration, withdrawal from activities and friends;

- Adolescents: sleeping and eating disturbances, agitation, increase in conflicts, physical complaints, delinquent behavior, and poor concentration (Gaskill & Perry, 2012).

A child who has experienced trauma and/or maltreatment may have disrupted attachment patterns, poor relationships, and/or display insecure attachment styles (i.e., avoidance, ambivalence, disorganized) (APA; Cook et al., 2003). A child who has not had the opportunity to complete the attachment process during early childhood will likely have a reduced capacity for self-regulation, stress management, and empathy (see Oehlberg, 2008). This child's ability to attach and appropriately interact with others then influences how he or she engages in therapy and in other areas of life (Chadwick, 2009). Typically the diagnosis of Reactive Attachment Disorder (RAD) indicates that attachment patterns will likely have a devastating and long-term effect on subsequent relationships. Youth who have had a high number of placements are also of concern as each placement may strengthen the child's experience of rejection and lack of constancy and predictability (Chadwick, 2013).

Children with attachment problems may demonstrate developmental delays, odd eating behaviors, use of immature or bizarre soothing behaviors (biting self, head banging, rocking, chanting, scratching or cutting themselves) that increase during distress, emotional problems such as depressive and anxiety symptoms, assumption of inappropriate modeling such that abusive behavior is the "right" way to interact with others, and aggression and cruelty (associated with lack of empathy or remorse and poor impulse control) (Perry, 2013).

Symptoms of Trauma in the Classroom

Since research has confirmed that overwhelming traumatic events can alter a child's brain development, attachments, and world-views, it is not be surprising that traumatic experiences can profoundly affect memory, language development, and writing (Cole, et al., 2013). These can in turn affect a child's ability to master the basic subject matter that is the core curriculum. Some children may respond fearfully to people and situations, may have difficulty with trusting peers and/or adult relationships, and may have difficulties in their ability to self-regulate emotions, behavior, and attention (Cole, Greenwald O'Brien, Gadd, Ristuccia, Wallace, & Gregory, 2005). Instead of acting out from a hyperarousal state of mind, some traumatized students may appear very numb, passive, and frequently daydreaming –signs of dissociation. It can be difficult to motivate students caught up in a sense of internal confusion and sense of helplessness. Although not upsetting class routines, such students are not actively engaged in cognitive learning and hear about half the words spoken by their teachers, causing them to fall behind year after year (Perry, 2004).

Children exposed to trauma may also display the following difficulties in a classroom or school setting:

- Disrupted ability to process verbal information and use language to communicate; difficulty following instructions.
- Less skilled in using language to forge social relationships and more skilled using language to build walls between themselves and those perceived to be dangerous or threatening.
- Limited problem solving skills.
- Struggles with sequential ordering and organizing things like thoughts, feelings, if-then events, and multi-step tasks. This can in turn result in difficulty reading, writing and with critical thinking. It can also interfere with a student's understanding of behavior and consequences.
- Not have internalized cause and effect relationships, difficulty or even an inability to easily predict events, sense their power over events or make meaning of "consequences."
- Struggles to see the world from the point of view of another.

- Struggles to focus and attend to what is happening in the classroom because their brains are preoccupied with ensuring safety and warding off danger.
- Struggles to self-regulate attention.
- Struggles to self-regulate and recognize emotions, resulting in poor impulse control, trouble reading social cues, and an unpredictable sense of self.
- Low executive functioning.
- Slow to trust adults or peers.
- Struggles to effectively engage with academic material (McVittie, 2005).

Relevance to Discipline and Delinquency

Children react to trauma in different ways, often by turning inward or acting out. Children exposed to trauma struggle to accurately perceive safety; self-regulate their attention, behavior, and emotions; hold a self-image that includes the belief that they matter, and to succeed academically and/or socially in school (McVittie, 2005). Children who don't perceive safety – who over perceive danger – may devote much more of their brain energy toward ensuring safety. They tend to overreact to stimuli (which are misperceived as threats) and struggle in the classroom setting. School personnel might see some of the following:

- Inability to focus
- Very wary, suspicious, not trusting
- Lack of impulse control (blurting out)
- Repetitive behaviors
- Clingy/Needy behaviors
- Appear anxious (twirls hair, sucks thumb)
- Acute awareness of any negative body language
- Misinterpretation of events, where the child feels that their actions caused the problem
- Deep withdrawal
- Apparently random body movements
- Inability to sit still (getting out of seat)
- Over-reaction to peer movements
- Lack of boundaries (hugging strangers)
- Explosive behavior that does not have a clear cause
- Avoidant behavior (not coming or refusing to participate or go places)
- Trouble with transitions and/or with any change in schedule

These behaviors may actually be defense mechanisms to help the child cope with the environment or trauma. At the time the trauma occurred, such behaviors may have been adaptive and served the child well. However, they can become problematic if they remain. Sometimes the fight response behavior is interpreted as oppositional or defiant and leads to school suspension or expulsion, community violence, and criminal arrests. When emotional regulation becomes difficult, it can lead to unproductive behavior responses such as truancy, fighting, substance abuse, aggression, eating disorders, and self-harm (Kuban, 2013).

Self-destructive behaviors (e.g., substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior) may have no immediate negative impact of the behavior on the individual. However, *self-harm behaviors* are often used in an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and "damaged". It tends to occur more in people who have experienced repeated and/or early trauma (e.g., childhood sexual abuse). "Among the self-harm behaviors reported in the

literature are cutting, burning skin by heat (e.g., cigarettes) or caustic liquids, punching hard enough to self-bruise, head banging, hair pulling, self-poisoning, inserting foreign objects into bodily orifices, excessive nail biting, excessive scratching, bone breaking, gnawing at flesh, interfering with wound healing, tying off body parts to stop breathing or blood flow, swallowing sharp objects, and suicide" (SAMHSA TIP, 2014, p. 71).

If a traumatized child acts out in school, their reaction might be misinterpreted as willful disobedience, inappropriate conduct or indicative of ADHD (see Chadwick, 2009). An elementary age child may demonstrate disruptive and unsettling behaviors due to separation distress and not having the neurological structure necessary to self-regulate. When the teacher thinks the child has greater controls over his or her behavior than he or she does, behaviors may be misinterpreted as misbehaviors of disrespect and defiance, not stress behaviors, and are reacted to with disciplinary actions. Such reactions are then interpreted by the child as another rejection, "setting in motion a pattern of emotional insecurity and behavioral issues that greatly interfere with learning for the rest of the student's education" (Oehlberg, 2008, p. 2).

Some students come to school from a home environment that lacks nurturing, is chaotic and cognitively impoverished, wherein the person who is strong and most violent gets what he wants, and where the same aggressive and violent use of power is idealized on television. For such youth, the degree to which threat is perceived to be predictable influences how traumatic the situation is perceived to be. Per Perry (1997), a child who has been a victim of unpredictable sexual or physical abuse learns that if it is going to happen anyway, it is far preferable to control when it happens. As a result, the youth may engage in provocative, aggressive behavior in an attempt to elicit a predictable response from the environment. This behavior can be misinterpreted, result in a seclusion or restraint situation, and subsequent school punishment, thereby reinforcing the child's view of the world that adults are aggressive and solve problems using force.

Screening and Assessment

Not all children who have experienced a traumatic event will develop traumatic stress symptoms or trauma responses. However, "it is essential that children who are experiencing traumatic stress responses receive effective mental health screening, assessment and treatment to recover" (DCF, 2013, p. 4). *Screening* provides the means to determine the depth of assessment needed. Screening instruments are brief questionnaires that are administered to all youth at point of intake [e.g., into juvenile justice or child welfare system]; they can be administered by nonclinical staff; they can be used in making initial decisions regarding placement and immediate needs, including the need for further evaluation (AOC, 2014). The Child and Adolescent Needs and Strengths (CANS), Traumatic Events Screening Inventory (TESI), and the Child Welfare Trauma Referral Tool are three such examples.

Within the child welfare system, trauma screening tools usually evaluate the presence of two critical elements: (1) exposure to potentially traumatic events or experiences, and (2) presence of traumatic stress symptoms or reactions (Conradi, Wherry, & Kisiel, 2013). For the Department of Children and Family Services, the purposes of a trauma screening are (1) to determine imminent danger requiring immediate response, and (2) to determine, document and respond to the need for a mental health referral (DCF, 2013). While screening serves as a valuable tool, the results are only useful if there are processes in place to address "positive screens" (SAMHSA TIP, 2014).

In contrast, *assessment instruments* are part of an in-depth evaluation of a youth's needs – the instruments are usually longer and more comprehensive; some may be completed by nonclinical staff while others require clinical training (AOC, 2014). Typically such an evaluation includes multiple domains and several methods of data collection including clinical interviews with the child, caregivers, collateral informants (e.g., teachers, clergy, neighbors); administration of standardized measures; and behavioral observations (DCF, 2013). Using trauma-specific standardized clinical measures can help obtain a thorough history, guide development of appropriate goals within an intervention plan, and be

used to monitor progress over time. If trauma is the focus of the assessment, look in Appendix C, which provides some standardized measure options. The Trauma Symptom Checklist for Children (TSC-C), UCLA PTSD Reaction Index, The Child PTSD Symptom Scale (CPSS), Trauma Symptom Checklist for Young Children (TSCYC), and the Child Sexual Behavior Inventory (CSBI) are examples of standardized clinical measures specific to trauma (Conradi, 2013b).

It is always important to *consider the context* (McVittie, 2005). What do you know about the student's family? What do you know about the student's history at school? What do you know about his or her culture (e.g., unspoken rules about eye contact, personal space, gender roles, and role of the individual versus group)? What are the family's ideas, experiences, and values around education? What constitutes "success" in this student's family or culture? Several things factor into the effect of a traumatic event for a child and should be considered when assessing that child's history: age and developmental level of the child at the time of the incident; how the child perceived the danger; the role the child played in the event (e.g., victim or witness); previous trauma experienced by the child; and protective capacities of adults involved in the child's life. Assessing the child's caregiving system is important to determine the needs of the parent and/or caregiver and his or her capacity to support the child to recover from the traumatic experience (Conradi, 2013b).

When considering *data gathering approaches*, children are more likely to report trauma exposure when asked directly about their experiences. Although a child is typically able to read and understand a screening tool by age 8, the examiner will need to determine if it is better to use a written question and answer or interview-style format. The opportunity to verbalize responses aloud is one benefit to the interview approach. It is also likely to be more accurate since research suggests children can be more accurate reporters of internalizing symptoms (e.g., anxiety, depression) than their parents may be (Conradi, Wherry, & Kisiel, 2013).

Incorporating caregiver-completed tools into the assessment process has benefits and barriers. They can be helpful for detecting exposure to trauma in young children who cannot verbalize information themselves, particularly for infants, toddlers, children younger than 8, and older children with developmental delays. However, if the caregiver is a foster parent, he or she may not know the child's history or be able to provide a complete picture of the child's experiences (Conradi, Wherry, & Kisiel, 2013). If a foster parent or social worker who has known the child for a short period of time is the only source of information, *"interpret the test results with caution"* (Chadwick, 2009, p. 14).

Consider Cultural Factors

Did you know? "Approximately 60% of the foster care population in the United States is comprised of children of color, representing families with diverse cultural, socio-economic, and educational backgrounds. Furthermore, there are well-documented disparities in outcomes and access to relevant services experienced by children of color and their families" (Hendricks, 2013a, p. 27).

Culture is an integrated pattern of behavior within a racial, ethnic, religious, social, or political group. It is typically transmitted across generations and includes the following aspects:

- Thoughts
- Beliefs
- Values
- Worldviews
- Spirituality
- Communications
- Languages
- Traditions
- Practices
- Customs
- Rituals
- Manners of interacting
- Social roles
- Relationships
- Expected behaviors

Cultural values and practices can serve as protective factors for a child and family; *Cultural identity and references* can influence the ways in which a child and his or her family identifies with a traumatic event, how it is interpreted, and how distress is manifested; *Cultural rituals and practices* can shape the healing process (Hendricks, 2013a). Similarly, SAMHSA TIP (2014, p. 27) makes the following points:

- Some populations and cultures are more likely than others to experience a traumatic event or a specific type of trauma (e.g., rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence).
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- Traumatic stress symptoms vary according to the type of trauma within the culture.
- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.
- In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

To be culturally competent, it is important to (1) recognize that culture has a broad impact; (2) respect a family as the expert on its members' needs and priorities; (3) increase sensitivity to behavior that can be alienating; (4) include family and community members in decision-making processes; (5) commit to structural and policy changes that support cultural diversity; and (6) allow for fluidity in policies and practices to adapt to changes over time (Regional Research Institute for Human Services, 2003). In addition, knowledge about cultural differences in symptom presentation, nonverbal and verbal communication styles, and family interaction patterns are essential to an accurate and culturally competent assessment (Chadwick, 2009). For example, the following factors may be incorporated into the assessment of children from diverse ethnic groups:

- Learn about the culture the child comes from;
- Modify the way the assessment is introduced and conducted to better accommodate the individual's needs and characteristics;
- Consider the potential value of collecting information from a broad range of informants;
- Conduct a comprehensive background assessment to include social, educational, legal, medical, and mental health history;
- Have a solid understanding of the family's culture to help guide interview questions about background events;
- State questions about traumatic experiences in behaviorally specific ways; and,
- Incorporate measures of acculturation and associated stress.

In addition, there are a few things to consider when assessing trauma history, including: (1) how the family and child communicate; (2) how the family responds to the trauma (shame, guilt, blame, denial, acceptance); (3) any stress or vulnerability the child and/or family is experiencing because of their culture (discrimination, stereotyping, poverty, less access to resources); and (4) how the child and family feel about interventions regarding the trauma.

Develop an "Assessment Pathway"

Effective assessment of the emotional, behavioral, cognitive, social and physiological functioning of the child is required to determine appropriate intervention strategies. An *"assessment pathway"* (Chadwick,

2009) can help identify areas for further investigation. It is important to identify specific areas of concern (e.g., anxiety, depression, trauma symptoms, sexual behaviors, behavioral problems, family stress and parenting concerns) to guide development of an assessment plan. Baseline information can be utilized to determine if a concern is not a problem, somewhat or sometimes a problem, or very much/often a problem so that more in-depth assessment is only conducted in identified areas. For example, the National Child Traumatic Stress Network (see www.NCTSN.org) has created a chart to consider and record the following factors:

- Trauma Type (identify from the list provided)
- Has the child experienced this trauma (no, yes, suspected, unknown)
- Age (in years)
- Frequency (one time event, repeated exposure, unknown)
- Type(s) of exposure (experienced, witnessed, vicarious, unknown; check all that apply)
- What reportedly happened (emotional abuse, emotional neglect, verbal abuse, excessive demands, other – specify, unknown; check all that apply)
- Setting(s) of traumatic experience (home, school, community, other – specify, unknown; check all that apply)
- Perpetrator(s) (parent, other adult relative, unrelated but identifiable adult, sibling, other youth, stranger, unknown; check all that apply); Perpetrator gender (male, female)
- Legal action regarding trauma: Report filed with police? (No, yes, unknown); Report filed with Child Protective Services (CPS)? (No, yes, unknown); If a CPS report was filed, was it (not substantiated, substantiated, unknown)

The National Council for Community Behavioral Healthcare has identified the following symptoms of trauma that can be utilized as a quick checklist in getting started. The team members can ask and/or look for the following behaviors as potential symptoms of trauma experience:

- headaches, backaches, stomachaches, etc.
- changes in sleep patterns, appetite, interest in sex
- sudden sweating and/or heart palpitations
- constipation or diarrhea
- outbursts of anger or rage
- nightmares and flashbacks – re-experiencing the trauma
- difficulty trusting and/or feelings of betrayal
- diminished interest in everyday activities
- easily startled by noises or unexpected touch
- increased use of alcohol or drugs and/or overeating
- greater susceptibility to colds and illnesses
- fear, depression, anxiety
- emotional swings
- tendency to isolate oneself or feelings of detachment
- self-blame, survivor guilt, or shame

Appendix C includes a variety of standardized measurement options that can be utilized to evaluate the impact of trauma on a child. Using standardized, well-established measures helps to ensure efficient assessment and diagnosis, as well as providing critical information for treatment design. It aids in the identification of co-morbid conditions. It also enables tracking of symptom progression in the recovery process and return-to-baseline functioning. It is beneficial to have different people report on the same symptoms because significant individuals in a child's life do not always agree on the problems the child displays and, multiple measures provides information on how the child functions in different environments, helps determine the significance of the symptoms or problems, and can aid in understanding system dynamics available to the child (see Chadwick, 2009). A comprehensive list of measures that are frequently used with those affected by trauma is available in a searchable database created by NCTSN (www.nctsn.org). The database includes information on psychometric properties, length, administration, informant information, scoring and interpretation guidelines, as well as cultural and language options for over 100 measures.

Forms and measures are informative but insufficient for understanding the child's story from his or her perspective and from the caretaker's perspective. Looking at body language, affect, and choices about what is shared (or not shared) provides insights into how the child is coping, how receptive he or she is to receiving help, and the words or attributes used to describe their experiences. Watching the child and family members together provides information on family roles, development and attachment. An analysis of external and internal assets can also be very valuable. For example, The Developmental Assets® (see Appendix D) are 40 research-based, positive qualities that influence young people's development, helping them become caring, responsible, and productive adults. The external assets checklist provides a picture of one's support, empowerment, boundaries and expectations, and we as constructive use of time. The internal assets checklist includes topics such as one's commitment to learning, positive values, social competencies, and positive identity.

Analyze the Data

Once measures are scored, it is time to make sense of them. Sometimes this is a simple process because the data from various sources support one another. Other times it may be more challenging due to differences in the ways reporters characterize the child's functioning and/or because of the complexity of the child's background experiences. Things to consider include:

- What information are you getting from your measures?
- Do the measures score the individual in a consistent manner (reliability)?
- Do the measures assess that they are intended to measure (validity)?
- Do the measures endorse critical items that might impact the child's safety?

Identify clinically elevated scores (refer to the manual) and the meaning of such scores. Hypotheses about the primary causes of a child's problems are created by analyzing all information, looking for patterns among the child's behaviors, reactions, and emotional responses. The *Trauma Assessment Pathway (TAP)* model (Chadwick, 2009) recommends using the following types of questions to help synthesize the information.

- Do any problematic behaviors/emotional responses appear to be associated with specific times, places, events, noises, people, and other stimuli?
- Is there a temporal pattern that can be identified?
- Did problematic behaviors/emotional responses become more pronounced following one or more traumatic experience?
- Did problematic patterns develop during a specific developmental period?

- Do problems appear to be associated with family or system dynamics?
- How are problems viewed by the child, family, school, and community culture?

The highlights garnered from the analysis can also be organized into the following general domains to create a unique picture of the child:

1. Developmental History: How old is the child chronologically and developmentally? Who has the child attached to (an important individual in his or her life)? How does the child's developmental level influence his or her reaction to traumatic experiences and the way he or she will heal?
2. Trauma History: What types of trauma has the child experienced? How complex were the trauma experiences? Has the child experienced multiple forms of trauma? Has the trauma been experienced on multiple occasions (e.g., Trauma I or Trauma II)?
3. Symptom Presentation: What symptom(s) is the child currently experiencing and how open the lines of communication, and collaboratively develop goals together. Encouraging child and family engagement in developing the goals together can help increase a sense of ownership in the process, increase motivation, and reduce resistance (as demonstrated by canceling or not showing for appointments) (Hawley & Weisz, 2005).

Once assessment team members have a unique picture of the child, identified the problem(s), made clinical hypotheses about which symptom areas are the most problematic for the child (i.e., dysregulation of affect, maladaptive cognitions, behavioral problems, unresolved trauma), they can recommend interventions that will have the most impact on the child's healing. Since key people in the child's life have been involved in the assessment process, they will likely be invested in understanding the results. It is also important to get everyone's involvement in developing a *crisis prevention plan* – an individualized plan developed proactively by the student, family, and staff before a crisis occurs (Gillece, 2012).

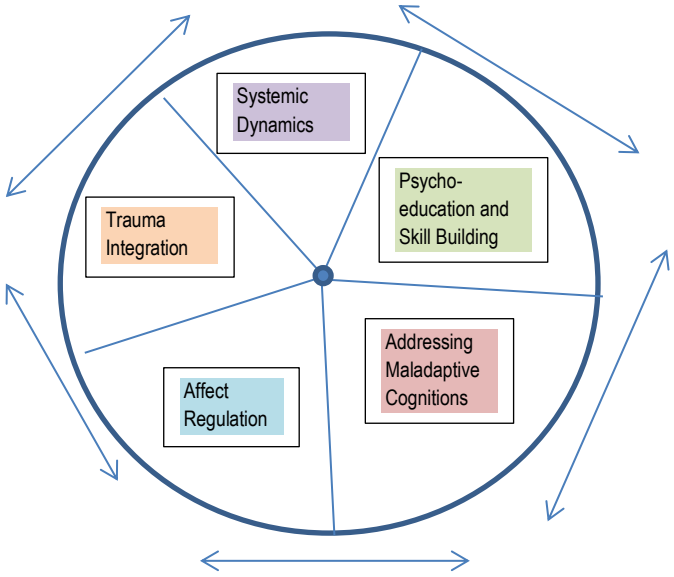
When making recommendations for interventions, it is important to remember that every child comes to school with a unique history, family system, and level of developmental, cognitive, and emotional functioning. The impact of cultural factors at the child, family and community level must also be considered. It is critical that the written report – and its presentation – is provided in a way to set a positive tone for therapy, open lines of communication, and increase buy-in for involvement in the program plan. The specific treatment goals and intervention plan should be developmentally and culturally sensitive; incorporate the family's values, natural healing practices, and sources of support; and individualized to meet the specific needs of the child. Furthermore, setting goals together can increase a sense of ownership in the treatment process, increase motivation, and reduce resistance to participating in appointments (see Chadwick, 2009). Trauma-focused treatment goals frequently include reestablishing a sense of physical and psychological safety; helping the child and family manage emotions, particularly in the presence of trauma reminders; and, helping the child and family gain an understanding of the traumatic experience (Conradi & Wilson, 2013).

Assessment-Based Treatment Model

Assessment-based treatment (ABT) (Chadwick, 2009) refers to the development of an integrated plan of prioritized intervention that is based on the diagnosis and psychosocial assessment of a person to address mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries and social problems. Integrating ABT into all phases of the clinical and/or educational process includes developing a comprehensive understanding of the student, identifying high-risks, establishing treatment goals, selecting appropriate treatment interventions, monitoring and re-evaluating the student's functioning throughout the course of therapy. This model is best demonstrated as a wheel wherein current assessment identifies primary concerns with affect

regulation, problematic behaviors, maladaptive cognitions, family or other system disruption, and unresolved trauma.

Safety and high-risk issues (i.e., suicidal intent, cutting on oneself, eating disorder, violence in the home) must be dealt with first. This requires commitment from the family and surrounding adult systems to care for and protect the child, especially at younger ages. After the child is stable and safe, the treatment pathway continues by addressing the primary concerns identified through assessment.



Affect Regulation

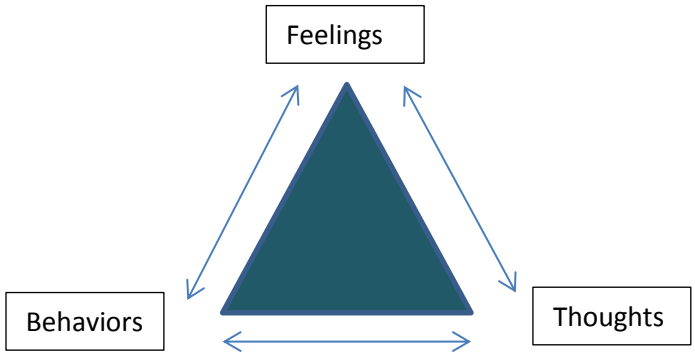
When a child lacks an appropriate caregiver and/or experiences a trauma during the early years when he/she is forming attachments, affect dysregulation may occur because the child does not have the opportunity to learn appropriate self-regulation skills. Affect dysregulation is often identified as the primary concern when a child has difficulty identifying, coping, and managing feelings in a healthy, productive, and appropriate manner (Cook et al., 2003). Affect/emotional regulation can also be identified as the ability to tolerate and cope effectively with distress (Chadwick, 2009). In such cases, the child may not be able to inhibit inappropriate behaviors in response to positive or negative affect, have difficulty using self-soothing techniques, and be unable to focus and organize emotions in order to cope with feelings. To decrease the intensity and intrusiveness of emotions and/or resolve negative feelings associated with an event, feelings must be processed by identifying, experiencing, and expressing those emotions in a safe environment. Identifying feelings is typically a safe starting point with children and then, as trust is developed, the child can share a fuller range of emotions. In trauma treatment, affect regulation is based on the following assumptions:

- Successful resolution of a trauma involves an emotional processing of the experience;
- Behaviors are associated with underlying feelings and impact future behavior and social relationships;
- Symptoms are associated with underlying experiences and related feelings; and,
- There is a need to validate, understand, and experience feelings before resolution can occur (Chadwick, 2009).

In working with children, it is important to help them learn to manage their feelings appropriately, regain a sense of emotional equilibrium, develop positive self-feelings, and to accept and cope with troubling emotions regarding others (Chadwick, 2009). Since self-regulation is a learned behavior, it can be learned later in life but it requires a lot of practice (McVittie, 2005).

Maladaptive Cognitions

Cognitive distortions are the primary concern when a child makes thinking errors (inaccurate or maladaptive cognitions) or exhibits thought patterns that may be accurate but unhelpful (Cohen, Mannarino, & Deblinger, 2006). Thus, helping a person cognitively understand the connection among thoughts, feelings and behaviors is a core component of this approach. Helping to change thoughts around false or unhelpful beliefs (i.e., guilt and self-blame) can lead to changes in feelings and behavior as well. Chadwick (2009) indicates cognitive treatment approaches are among the most effective interventions for addressing maladaptive cognitions because they help the person change their view of the world and themselves. Such thought distortions can be corrected by helping the child understand that thoughts, feelings, and behaviors are related, and that by changing one's thought, he or she can also change his or her feelings and behaviors. This connection is known as the cognitive triangle (Deblinger & Heflin, 1996):



Cognitive-behavioral therapy (CBT) techniques have been shown to be effective in treating children and adolescents who have persistent trauma reactions. The following assumptions guide cognitive treatment techniques in trauma treatment:

a) Successful evolution of a trauma involves a cognitive reprocessing of the experience;

b) Maladaptive thoughts about an experience prohibit resolution of that experience and may sustain the trauma related symptoms;

c) Thinking errors occur with limited awareness and information;

d) When inaccurate or maladaptive attributions are challenged and replaced with accurate and beneficial thoughts, the child's feelings and behaviors can become more positive and adaptive (see Chadwick, 2009).

Problematic Behaviors

This becomes the primary concern for treatment when a child's behavior problems overshadow other treatment issues and prevent the child and his or her family from focusing on other treatment issues. Behavior problems may include recurrent patterns of negative, defiant, disobedient, and hostile behavior toward authority figures, including temper tantrums, arguing with adults, actively defying requests, refusing to follow rules, deliberately annoying other people, blaming others for one's own mistakes or misbehavior, being touchy, easily annoyed, easily angered, resentful, or vindictive (APA). Risky behavior problems can include avoidant behaviors, sexual reactivity or sexual acting out behavior, stealing, cutting, or any other self-destructive behaviors.

When these are the primary concerns, look to system (i.e., family) dynamics and implement psychoeducational and skill building strategies. Such strategies are based on the assumptions that the child and his or her family lack the skills to effectively cope with the behavioral problems. The goals are to (1) increase information and skills to help the child see the links between their traumatic experience and their behavior and (2) improving the caregiver's behavioral management techniques (i.e., charting, using time outs effectively) (Chadwick, 2009).

Disruptions in the Family System

The family system becomes the focus when there are significant problems in roles, boundaries, and/or relationships that are influencing the child's ability to heal from a traumatic experience. The following assumptions can guide the therapist treating a traumatized child's family system:

a) The child requires a family system to keep him or her safe and to provide support and nurturance throughout trauma treatment;

b) Including a caretaker in treatment reinforces the child's improved or newly-learned coping skills and behaviors;

c) The caretaker(s) and other significant individuals in a child's life can help challenge inaccurate cognitive attributions about responsibility regarding the trauma;

d) The behavior of any family member greatly influences the behaviors of other family members; and,

e) Addressing systemic dynamics can change an unhealthy system to a more effective system that better meets the needs of its members (Cook et al., 2003; Cohen et al., 2006).

Chadwick (2009) identifies specific strategies to use in such a scenario. To help the family regain its equilibrium, it is important to change maladaptive roles (i.e., problem or parentified child), change problematic behaviors (i.e., attention-seeking, neglectful or abusive), alter the distribution of power within the family, improve communication patterns, and/or solidify healthy and supportive relationships within the family. If the child perceives that a community agency (i.e., police, school personnel, emergency workers, the courts) has failed him or her, it is important to work together to regain faith or trust in the community and the system designed to support and protect the child.

Unresolved Trauma

The traumatic experience is identified as the primary concern for treatment when unresolved issues related to the experience are impairing the child's ability to function appropriately and causing problematic symptoms. When an individual experiences feelings, thoughts and behaviors that have not been identified, processed, and/or understood, post-traumatic responses such as flashbacks and/or nightmares may occur. Creating a trauma narrative or detailed recounting of the trauma is a means to helping the individual integrate the trauma. This task is based on the assumptions that:

a) Creating a trauma narrative helps change cognitive misattributions and decreases the intensity of reminders and negative emotions such as terror, horror, extreme helplessness, and rage (Cohen et al., 2006);

b) Exposure to traumatic details and related feelings (i.e., anxiety and fear) allows the individual to gain a greater sense of control, learn new coping skills, and gain an understanding of the traumatic event and his or her own reactions to the trauma; and,

c) Making sense of the trauma allows the individual and his or her family to have a more positive view of themselves, their future, and the community in which they live – thereby promoting resiliency and integration into the social network (Cook et al., 2003).

In conclusion, wherever the focus of concern lands on the clinical pathway wheel, NCTSN experts report there is consensus that treatment should be phase-based or sequential in nature so that earlier phase information can be built upon later, the individual can build upon skills learned, and the person won't feel overwhelmed with information that he or she is not yet capable of processing. This phase-based process is not linear and it is often necessary to revisit earlier phases of treatment in order to remain on the overall trajectory (Cook et al., 2003). The Chadwick Center emphasizes that, to assure that each stage of treatment reflects the unique needs of the individual, assessment must be an ongoing process, occurring through in-session evaluation, periodic re-administration of measures and supervision, until it is determined that treatment is no longer needed. This determination may be based on clinical observation, information gathered in therapy and interviews, reduction in symptom levels on assessment measures, and achievement of all treatment goals.

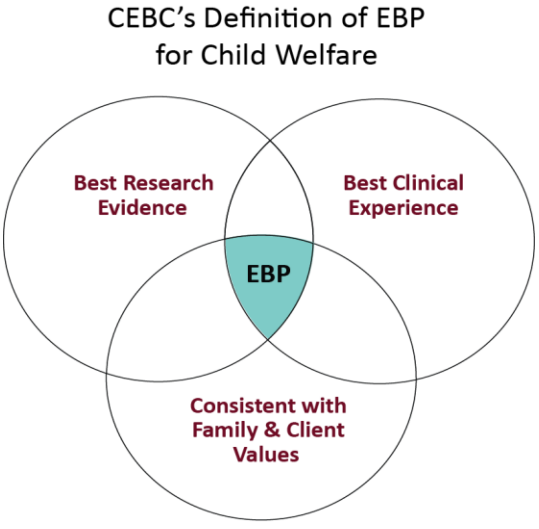
Evidence Based Interventions

Whether or not an individual who experiences a traumatic event develops symptoms of traumatic stress depends on a range of factors. Traumatic experiences may or may not impair a child's brain development, attachment, emotional regulation, behavioral regulation, cognition (learning and school performance), self-concept, and/or social development (DCF, 2013). Due to the unique history of such complex children, it is very difficult to apply a "one size fits all" treatment approach. Evidence-based practice (EBP) is an approach to clinical decision-making in which the practitioner, in consultation with the client (e.g., student and/or parent), uses the best available evidence to choose intervention options that are best suited to current needs. EBP draws upon and integrates information from multiple sources, including empirical evidence derived from systematic research, individual clinical expertise, and informed choice. This gives practitioners the advantage of using strategies that "are based in theory, repeatedly subjected to rigorous scientific evaluation, and demonstrate significant benefit across populations" (NCTSN). An EBP derived from sound, science-based theories incorporate detailed and empirically supported procedures and implementation guidelines, including the target population, criteria for participation, and specific interventions (SAMHSA TIP, 2014).

It is not uncommon for judges to ask about the availability of EBPs when considering treatment providers and specific programs (AOC, 2014). The California Evidence Based Clearinghouse (CEBC) has adopted/adapted the Institute of Medicine's definition of EBPs as noted in the above graphic. It combines best research evidence with best clinical experiences, consistent with values. Various lists of empirically supported treatments and promising practices that appear to meet these criteria are available here in Appendix E.

Classroom and School-Based Strategies

"Skill building and psychoeducation are integral parts of trauma treatment" (Chadwick, 2009, p. 50). Skill building allows children and their families to learn new, more adaptive skills in a safe therapeutic place. Skill building requires teaching and reinforcing behavior management techniques, developing safety plans, teaching safety and coping skills, teaching and enhancing positive behaviors and social skills, teaching relaxation techniques, and improving communication skills. It is important for the child to recognize feelings, to understand the impact of external and internal triggers and stressors, to learn new skills to manage reaction, to have opportunities to practice strategies, and to have opportunities to revise and re-tool the crisis prevention plan after escalation using all debriefing information (Gillece,



2012). It is critical that adults be good role models by being attentive, respectful, honest, and caring. School and classroom environments that are relationally enriched, safe, predictable, and nurturing are important. Breaking the large school environment into smaller pieces (e.g., counseling center, classroom) creates the means for relationship building, thereby creating a trusting connection between the student and the significant adults. This then allows for a sense of safety and security to translate to the larger school environment.

Classroom climate also becomes a critical factor for students who have experienced trauma. It is important for staff members to avoid inconsistency, shaming, blaming, humiliating or embarrassing students; to not use a raised voice, punishments or treats or putdowns, or trivialize a student's feelings/behavior. It is important to not allow bullying or name calling and to follow through on promises. When working with students who have been exposed to trauma, particularly those who still over perceive danger and/or don't feel safe, McVittie (2005) recommends the following strategies be tried to create a stable platform for academic and social-emotional growth.

- Take time to teach routines, post schedules, and practice transitions.
- Pay attention to which parts of transitions are hard for the student and work together to create solutions (nonverbal signals, advance warning etc.).
- Lead the classroom respectfully (kind and firm).
- Establish clear agreements about classroom behavior with students. Teach the students how to follow them by regularly checking in with them about how they are doing and asking them to silently make improvements.
- Warn students of potential "surprises" including fire drills, guests, substitutes, schedule changes, new seating arrangements.
- Connect with students each day in a similar fashion; use small connection rituals such as a hand shake or high five.
- Give the student control where possible (e.g., when changing the seating chart, ask the student if he or she has a place in the classroom that feels best).
- Use whole class activities involving patterns of motion (regular motion/rhythm/music helps reestablish helpful connections in the lower brain).
- Keep your mood relatively stable. (If you are having a bad day, let the students know so they don't think you are mad at them).

The above strategies also work well for students who are not able to self-regulate well, physically or emotionally. In addition, teachers might try the following strategies:

- Regularly teach short self-regulation tools such as deep breaths, 10 second quiet moments for reflection, listening until the chime is silent, BrainGym activities, activities that require awareness of the body in space.
- Teach emotional awareness. This might include feeling faces charts, vocabulary work to distinguish feelings, journaling, regular emotional check-ins using a consistent format.
- Connect with the student. "It seems like you feel...."

Research on *resiliency*, or the ability to adapt in the face of challenges and adversity, emphasizes the importance of children having environmental supports and opportunities. Such supports can come from family, school, and/or the community. Factors that promote resilience in trauma-exposed children can be found on the individual level (e.g., child's cognitive abilities), the family level (e.g., presence of a loving, supportive adult in the child's life), and the community level (e.g., resources available to the child

in the community) (AOC, 2014). Strengthening the presence of multiple protective factors can help buffer children in the face of trauma. Per researchers cited by Hendricks, Katz, and Conradi (2013), protective factors can include:

Individual Characteristics

- Cognitive ability (i.e., thought processes)
- Self-efficacy (i.e., belief in one's ability to succeed in a particular situation)
- Internal locus of control (i.e., a sense of having control over one's life and destiny)
- Temperament
- Social skills

Family Characteristics

- Family connection
- Supportive parent-child interaction
- Social support (i.e., extended family support)

Community Characteristics

- Positive school experiences
- Community resources
- Supportive peers and/or mentors

Although there do not appear to be specific traits predictive of resilience, the following individual characteristics seem to influence resilience: neurobiology, flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and the ability to experience positive emotions (see SAMHSA TIP, 2014). One key element that can encourage resilience is the support of at least one competent, caring adult who can consistently be there to support and care for the child (NCJFCJ, 2010). "The belief that you matter to another human being is one of the most powerful foundations for resilience. Our beliefs about ourselves shape the way we interpret and respond to the world around us. You cannot talk a student out of their beliefs, however beliefs can change based on regular consistent behavior of the people around us" (McVittie, 2005, p. 4).

Forming trusting attachments and relationships is critical for children who have suffered trauma. Any school personnel can use the following approaches to establish a trusting relationship:

- Have quality interactions with the child (fully engaging with and listening to the child);
- Do not make commitments or promises that you may not be able to keep;
- Involve the child in decisions that affect their lives;
- Focus on the child's strengths and resilience.

For students who don't believe they matter, use the following strategies:

- Encouragement
- Have appreciation circles
- Writing post-it notes that are honest
- Teach students to make amends
- Learn about the student's likes/dislikes
- If you have to call home, call after the problem has been fixed
- Support student in creating systems to help (organizing notebooks, homework tracking)
- Help student notice successes
- Teach the class encouragement skills
- Notice strengths
- Not giving up
- Use solutions instead of consequences
- Get to know the student's family
- Communicate regularly with family, sharing successes as well as concerns
- Use teacher tools to elevate student's status with peers
- Empower instead of enable

Sometimes classroom teachers need the support of other team members. In trauma-sensitive schools, all adults:

- Share an understanding of how trauma impacts learning and why a school-wide approach is needed for creating a trauma-sensitive school;
- Support all students to feel safe physically, socially, emotionally and academically.
- Address students' needs in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional well-being;
- Explicitly connect students to the school community, providing them with multiple opportunities to practice newly developing skills;
- Embrace teamwork with a sense of shared responsibility for every student;
- Anticipate and adapt to the ever-changing needs of students and the surrounding community (Cole et al., 2013).

Tap into Cultural Influences

"Culture and trauma have a profound bidirectional influence on each other" (NCTSN). *Culture* has many definitions and influences. It can be broadly be defined as a dynamic pattern of language, beliefs, values, rituals, and customs that characterize specific racial, ethnic, religious, or social groups (National Center for Cultural Competence, 2001). It also refers to beliefs, attitudes, values and standards of behavior that are passed from one generation to the next. Cultural groups can include people identifying with various racial and ethnic groups, age groups, religious affiliations, gender, and/or sexual preference. In addition, "culture can influence how a child and family are impacted by trauma, how they understand the trauma, and how they perceive therapy and relate to the clinician; This is especially true for immigrant families" (Chadwick, 2009, p. 46). Since culture shapes attitudes toward traumatic experiences, it can also influence how children and families respond to – and recover from – trauma exposure (Cohen et al., 2006).

As previously noted, understanding a student's cultural perspective, the family's culture, and level of acculturation is important in the assessment and treatment process. Demonstrating cultural competence is also an important part of the relationship building process, including (1) conveying acceptance, respect, and understanding of the child's culture, and (2) communicating effectively with the child and his or her caretaker based upon sufficient knowledge about the values and experiences of the family's cultural group (Chadwick, 2009). As best practice, a culturally competent clinician engages the child and family from a strengths perspective, tailors treatment approaches to fit the individual and family, and maintains knowledge and respect for diverse cultures. A culturally aware and competent clinician:

- Assures language needs are met;
- Determines and considers the child's values and spiritual needs;
- Evaluates and considers the child's level of acculturation/cultural identity;
- Understands the child's view of therapeutic process;
- Modifies communication style to meet child's needs;
- Assesses differing meanings of therapeutic terms for different cultural groups;
- Understands and considers the child's view of relationships and roles;
- Assesses intergenerational/cultural transmission of trauma; and

- Demonstrates knowledge of diverse cultures and seek to understand the child's experiences (Chadwick, 2009).

On the larger scale, it is important that schools consider the following as they design and implement culturally competent services:

- Have a defined set of values, principles, policies, and structures that enable them to work effectively cross-culturally;
- Value diversity and demonstrate the skills needed to acquire cultural knowledge and adapt to the cultural contexts of the communities they serve;
- Incorporate the above in all aspects of an organization's policies, administration, and practice, while systematically involving consumers and key stakeholders within their communities (NCTSN).

The NCTSN website (www.NCTSN.org) provides a comprehensive annotated bibliography of resources on culture and trauma. Another resource is the *Culture and Trauma Speaker Series* presentations which are archived on the NCTSN Learning Center for Child and Adolescent Trauma (http://learn.nctsn.org). The book entitled *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* identifies 22 trauma-informed treatment interventions, developed and utilized with trauma affected youth populations of various cultural backgrounds. The fact sheet for each intervention describes adaptations for use with specific cultural groups, including the supporting clinical and research evidence.

Employ Various Counseling Strategies

Counseling may be provided for individuals, in a group, and/or with the family. The primary modality to be used is determined by the unique picture of the child and the hypothesis concerning the root cause of the child's distress. For many, a combination best meets the needs of the child and their particular family system (Chadwick, 2009). Among the possible therapeutic options to help maltreated and traumatized children are cognitive-behavioral therapy, individual insight-oriented psychotherapy, family therapy, group therapy, play or art therapy, and pharmacotherapy (Perry, 2004). To help a child re-establish trust and enhance relationship building, it is recommended that clinicians do the following:

- Establish a working relationship with the child (using unconditional positive regard, genuineness, empathic understanding);
- Establish a working relationship with the caretaker (using unconditional positive regard, genuineness, empathic understanding);
- Develop trust, feelings of safety and security;
- Help the child develop sense of control;
- Educate and model appropriate boundaries;
- Address attachment needs and establish relationships that will enhance clinical work;
- Develop cultural competence for all served (Chadwick, 2009).

Whether or not a child is on an individualized education program (IEP), it is important to identify goals to be achieved during the counseling sessions. Progress toward goals can then be used to determine the effectiveness of the intervention and if a higher level of care may be needed. Frequently the goals of trauma-specific treatment include:

- Safe expression of feelings;
- Relief from symptoms and post-traumatic behaviors;

- Recovery of a sense of mastery and control in life;
- Corrections of misunderstanding and self-blame;
- Restoration of a sense of trust in oneself and the future;
- Development of a sense of perspective and distance regarding the trauma;
- Minimizing the scars of the trauma;
- An enhanced sense of safety and security; and
- Providing support and skills to help non-offending caregivers cope effectively with their own emotional distress and optimally respond to the traumatized child (DCF, 2013).

Play-based activities can meet the need of many children with trauma-related problems who need some form of body-oriented therapy to establish or regain a sense of control or self-regulation over their bodies. Research by Cook et al. (2005) and van der Kolk (2006) indicates that most children respond to the 'language of the senses' (e.g., visual, tactile, and auditory perception of tone, rhythm, and pitch), as well as communication via eye contact, face-to-face gaze, facial gestures, touch, physical movement, and rhythm. Limiting stimuli (light, sound, movement, and people) to decrease arousal and sooth the child are also critical to creating a state of regulation. The goal is to help the child match his or her state with a calm adult model. Soothing, calming, pacifying sensory activities (e.g., rhythmic, sequenced motor or exercise activities like yoga and tai chi) that are pleasurable and provided within an intensely relational context are best. For the child to restore their perception of safety and control, it is important to create a sense of consistency, routine, familiarity; to use activities that mirror children's normal developmental paths; and to provide the supports consistently, predictably, in a patterned and repetitive manner.

Kuban (2013) argues for taking a physical approach, believing that traumatized individuals must be taught to use their bodies as resources that can be called upon to reduce the psycho physiological experiences of arousal. Through repetitive body conditioning (e.g., recognizing differences in the body when stressed versus relaxed) traumatized individuals can be taught that, although difficult situations may still be experienced, arousal responses can be managed. Problem solving is more easily engaged when individuals have been able to practice the repetitive processes of moving in and out of stressed to relaxed body states and distinguish between good and bad stress. He concludes that, "to accept oneself as a survivor and thriver, an individual must first discover, repeatedly at a sensory level, the ability to regulate responses to the environment and day-to-day interactions within that environment" (Kuban, 2013, p. 1).

Kuban (2014) relies on brain functioning research (e.g., Perry, 2009; van der Kolk, 2006) to argue that trauma is experienced in the deep affective and survival areas of the brain where there are only sensations, emotionally conditioned memories, and visual images. However, reason, language, and logic needed to make sense of past experiences are upper brain cognitive functions that are difficult to access in trauma. Structured Sensory Interventions for Traumatized Children, Adolescents and Parents (SITCAP) provides the opportunity to safely revisit and rework past trauma, beginning with sensory memories which youth have experienced and stored. The SITCAP process helps youth identify ways their body responds to stress. By learning to recognize how post-traumatic memories can be activated by current events, youth learn to use their body as a resource to regulate their reactions.

If an individual gets "triggered" during the school day, help him or her focus on what is happening in the here and now, use "grounding techniques" to help distinguish between what is happening now versus what happened in the past, offer education about the experience of triggers and flashbacks as a common traumatic stress reaction, and, afterwards, discuss the experience to better understand why the trigger occurred so as to help prevent future similar events (SAMHSA TIP, 2014).

Individual counseling is usually important to individuals who have experienced trauma in that it helps the person address individual problems stemming from the trauma and resolve emotions surrounding the traumatic experience. Several review studies have found that individual therapy alone is effective in helping children and is better than changes that occur naturally over time in the absence of treatment (Chadwick, 2009). Individual sessions may need to address family systems concerns in order to promote the child's understanding of appropriate and healthy relationships, power distribution, physical and emotional boundaries, and roles.

"There is also significant evidence that group therapy combined with individual is helpful for victims of all types of trauma" (see Chadwick, 2009, p. 42). Involvement in group therapy can be a powerful resource for children who have impacted social interactions with family and friends, a sense of isolation, and/or feel different from others. Group counseling can help trauma victims enhance their coping skills and improve their overall outcomes. Socialization and peer confrontation are important considerations in deciding whether or not a child would benefit from group interventions. Furthermore, children with limited developmental and/or social levels of sophistication may not be emotionally ready to process traumatic events in a group situation.

Regardless of the method chosen, research on treatment models for child traumatic stress suggests the following core elements should be identifiable within any proposed treatment plan:

- parent support, conjoint therapy, or parent training;
- building a strong therapeutic relationship,
- providing psychoeducation (i.e., information on psychological principles that guide human behavior) to children and caregivers;
- emotional expression and regulation skills;
- anxiety management and relaxation skills;
- cognitive processing or reframing;
- strategies that allow exposure to traumatic memories and feelings in tolerable doses to that they can be mastered and integrated into the child's experience;
- personal safety training and other important empowerment activities;
- resilience and closure (Conradi & Wilson, 2013).

Work with Parents and Caregivers

Typically trauma affects the entire family so family involvement and support throughout treatment is crucial to the child's progress and overall outcomes (see Chadwick, 2009; Cook et al., 2003). The extent of family therapy will depend on the unique picture of the child. For example, a resilient child may find conjoint sessions adequate but a child from a more dysfunctional family may need to spend time to restructure boundaries, improve communications and address family dynamics. The amount of time spent addressing systemic issues depends largely upon the family's existing dynamics. Some family members are very willing to participate in treatment with their child, whereas other family members want their child to "be fixed," but are unwilling to make changes themselves. It may be difficult for some children to make progress in treatment without complimentary changes being made in the family system.

Across multiple studies, caregiver functioning has been found to be a major predictor of child functioning following a child's exposure to traumatic experiences. In fact, "how a child responds and fares in the aftermath of a traumatic experience depends partly on his/her caregiver's ability to manage his/her own emotions related to the trauma, the caregiver's own trauma history, and the caregiver's

ability to respond to the child and re-establish safety" (Hendricks, 2013c, p. 99). The sooner parents understand themselves, their children, and their responsibilities, the sooner newer and healthier visions for their family can be formed (Chadwick, 2013).

Teaching caregivers parenting skills can give them confidence in their ability to manage their child's behaviors at home. Parenting skills, such as behavioral management, setting boundaries, and positive discipline are often a focus of parent education. It is important to conduct such skill-building activities in a safe and supportive environment. In some instances it may be necessary to see caretakers alone to help them resolve their own issues that may interfere with their ability to be supportive of their child (Deblinger & Heflin, 1996). It is important to provide such sessions in a culturally competent manner. It is also important to know signs of "compassion fatigue", watch for isolation, and recognize if a caregiver's own trauma gets reactivated (Hodas, 2006). Parents will become more effectively engaged in service supports for their child and themselves when professionals:

- Understand that parents' anger, fear, avoidance, and challenging behaviors may reflect reactions to their own past traumatic experiences, not to the person at hand;
- Remember that traumatized parents are not "bad" and that approaching them in a punitive way, blaming them, or judging them will likely worsen the situation rather than motivate the parent to engage;
- Build on parents' strengths and desire to be effective in keeping their children safe and reducing their child's challenging behaviors;
- Help parents understand the impact of past trauma on current functioning and parenting; and ,
- Pay attention to ways trauma can play out during meetings (i.e., conferences, court proceedings, child visits) (NCTSN).

Effective communication can help an individual to restore trust in a caregiver (Konarz, 2013). In children of all ages, it is essential that caregivers attempt to keep a child's daily schedule as close to a routine as possible. Children become easily agitated when they do not know what to expect next. If there is a change in their routine, if at all possible, try to let them know before it happens. Sometimes the parent or caregiver is the first responder in giving a child in crisis first aid. School personnel working with parents and caregivers may want to provide a copy of the following strategies recommended by TLC (2013c):

- Be nurturing and comforting.
- Respond to your child's basic needs.
- Provide him/her with rest, comfort, food, and opportunities to play.
- Talk openly with your child about what happened.
- Reinforce with your child that you will protect him/her.
- Help your child to share his/her feelings in your supportive presence, and acknowledge his/her feelings. Do not tell your child how he/she should or should not feel. Healing takes time - do not hurry your child's reactions along with comments like, "It's time to get over it."
- Understand that physical reactions such as headaches, fatigue, etc. can be normal responses to fear and a child's attempts to avoid thoughts of the crisis.
- Provide labels for the feelings they are experiencing, such as sad, afraid, angry, especially for younger children.
- Encourage your child to let you know when he/she is thinking about the crisis or when new reactions occur.

- Give your child special support by keeping things fairly structured. Adjust for your child's fears, especially at bedtime.
- Help to re-establish a sense of safety for your child. Let your child know where you are going and when you will be back. If you are gone for several hours, call and let hem/her know that you are all right.
- Reassure your child that his/her feelings may not be the same as those of siblings or friends, and that those feelings are normal.
- Be patient with difficulties in concentration, completing school work, etc. It is not unusual for a child's school performance to decline temporarily.
- Recognize that regressive behavior such as nail biting and thumb sucking, as well as acting-out behaviors are normal reactions and should be discussed rather than punished.
- Limit tasks and keep them simple.
- If the crisis involves a death, help your child to recall positive memories of the victim.
- Share your own similar experiences, giving the message that you survived and that he/she can too.
- Help your child to understand that angry, defiant, aggressive behaviors, staying away from home, or taking unnecessary risks are ways to avoid feeling the pain, hurt, and fear that he/she is experiencing.
- If shame is tied to a physical reaction that your child experienced during the crisis (such as wetting his/her pants, vomiting, crying, etc.) assure your child that unlike television portrayals, many people faced with a crisis will lose control over their bodies.
- If your child expresses that he/she is not afraid of anything anymore ("Nothing scares me."', be more protective of your youngster, as he/she many not act safely in a potentially dangerous situation.)
- Help your child to understand the relationship between his/her feelings and the crisis and encourage your youngster to find safe ways to express his/her feelings (i.e. drawing pictures, writing, talking, exercise, etc.).
- If changes in your child's behavior or personality concern you, seek the support of a mental health professional.

Parents can also help themselves and their children in difficult times by focusing on "The Three C's" (TLC, 2013b): Comfort: Share meals and provide more comfort foods than usual. Comfort food makes one feel better when he or she is feeling bad. Most often it is associated with childhood memories – the special food or treat that their mother or grandma gave when they weren't feeling well. Plan family time – game night, exercise, or work on a project together. Enjoy laughter. Reach out to a network of family and friends. Engage in activities that are fun, relaxing and pleasant. Conversation: Offer reassurance. Ask thoughtful questions. Listen carefully. Share beliefs and values. Commitment: Set a good example, be calm, and do not present your child with your own fears. Participate in school and community activities. Help neighbors do chores or small errands. Reach out supportively to friends and family. Be optimistic!

Some children who have severe or chronic traumatic experiences are removed from the home and placed with a kinship caregiver or in a foster home, adoptive home, group home, or residential treatment facility with "substitute care providers". Although such people are required to go through specialized training, it "usually does not include much content related to trauma or how to provide trauma-informed caregiving. Resource parents and group home staff are therefore ill-prepared to

handle the trauma-related reactions and behaviors exhibited by a traumatized child who enters their home" (Hendricks, 2013d, p. 104). Therefore, it is important for educators and other professionals who work with such staff to provide educational training on trauma, trauma triggers, psychological safety, the impact of trauma, parenting skills, and strategies for self-care.

In some instances, educators will work with current or prospective foster or adoptive parents of a child with a known or suspected history of child sexual abuse. Such parents may feel confused, concerned, and unsure so equipping them with information is one of the most useful actions we can do (Child Welfare, 2013). There are several evidence-based programs for adult trauma treatment models (http://nrepp.samhsa.gov) and some that have been found especially useful for treating children who have been sexually abused and their families (http://www.cebc4cw.org/topic/sexual-behavior-problems; http://www.nctsn.org/trauma-types/sexual-abuse).

Military service is another factor to consider in working with children and families. Per NCTSN, most military families contend with a variety of deployment-related stressors, including separation from the parent who is a service member, family reunification, and reintegration. Due to frequent moves, many military children experience disrupted relationships with friends and must repeatedly adapt to new schools and cultivate new community supports. Some children also experience the trauma of losing a parent or having a parent return home with a combat injury or illness. Children most at risk for experiencing trauma due to these circumstances are those that: are very young; have preexisting physical and mental health problems; have parents who serve in the National Guard, are reserve personnel, or have had multiple deployments; do not live close to military communities; live in isolated communities with limited treatment resources; are in single-parent families with the parent deployed; or have had both parents deployed. Professionals who work with and support such families need to become familiar with the risks that can compromise a military child and/or family.

Targeted Interventions

An individual's ability to recover from trauma can be impeded by individual and family factors, the severity of ongoing life stressors, community stress, prior trauma exposure, psychiatric comorbidities, ongoing safety concerns, poverty and racism, as well as caretaker responses to trauma. However, numerous scientific studies support the conclusion that providing supportive, responsive relationships as early in life as possible can prevent or even reverse the damaging effects of toxic stress (see Harvard; Gillece, 2012; Chadwick, 2009). Many caretakers (parents, teachers, family, etc.) must be actively committed to participating in the effort to help people who have experienced trauma to understand, symbolize or verbalize their experiences to others (Perry & Hambrick, 2008). Understanding the child's intellectual, cognitive and social levels of functioning helps to identify developmentally appropriate treatment plans to:

- Improve the likelihood that interventions will be effective. For example, a child with a learning deficit may have difficulty learning new skills or integrating these skills into other areas of his or her life so it is important to involve multiple persons (i.e., the teacher & parental caregiver) to address the desired behavior 24/7.
- Recognize the need to adapt communication strategies to insure the child can comprehend what is stated (i.e., use simple phrases and words for a child that does not understand complex language and/or play therapy for a child in lieu of words).
- Help the student recognize early warning signs during the earliest stages of escalation before a crisis erupts and to identify coping strategies before they are needed.
- Help staff plan ahead and know what to do with each person if a problem arises; to use interventions that reduce risk and trauma to individuals.

Simple strategies that can be used as part of a crisis prevention plan or positive behavioral intervention plan can include the following.

1. To avoid using restraint and seclusion, include talking to the student, leaving him or her alone, and/or distraction tactics in the plan.
2. An adult can give a picture card of different behaviors to the student to circle to help him or her know when angry, scared or upset (e.g., cry, clenched teeth, loud voice, red or hot face, laughing or giggling, being mean or .rude, swearing, racing heart, breathing hard, wringing hands, clenched fists, tantrums, rocking, pacing)
3. Similarly, a card with various pictures or a checklist could be given to the student to identify what makes him or her feel sad, mad, scared or other feelings that could cause him or her to go into crisis (e.g., arguments, being isolated, being touched, too many people, feeling lonely, lack of privacy, darkness, being teased or picked on, feeling pressured, certain times of the year, certain times of the day or night, having a door open, loud noises, people yelling, thunderstorms, not having control, having contact with family).
4. Ask the student to identify early warning signs that others might notice or what might be felt just before losing control (e.g., clenching teeth, wringing hands, bouncing legs, shaking, crying, giggling, heart pounding, singing inappropriately, pacing, eating more, breathing hard, shortness of breath, clenching fists, using a loud voice, rocking, inability to sit still, swearing, restlessness).
5. The team could ask the student (and write down in the plan) what does not help him or her when upset (e.g., being alone, humor, not being listened to, being ignored, having too many people around, being told to stay in a room, having space invaded, using a loud tone of voice, teasing, not being taken seriously).
6. If a person is getting agitated, use HALT = Hungry? Angry? Lonely? Tired?
7. Ask the student about things that help him or her calm down when he or she starts to get upset (e.g., time away from a stressful situation, going for a walk, talking to someone who will listen, lying down, reading, pacing, coloring, hugging a stuffed animal, deep breathing, being left alone, talking to peers, touch, exercising, eating, writing, listening to music, molding clay, calling a special someone).
8. Allow the student to use strategies that help him or her deescalate (e.g., blanket wrap, using a cold face cloth, deep breathing exercises, getting a hug, running cold water on hands, ripping a paper, having hand held, snapping bubble wrap, bouncing a ball, using the gym, screaming into and/or punching a pillow, crying, speaking with therapist, using sensory or comfort room).
9. Frequently remind the student of the agreed upon strategies by posting it in his or her bedroom as well as in a special place in the classroom, reviewing the plan, creating a pocket version laminated card, and/or developing a computer version that can be easily accessed (Gillece, 2012).

Per Cook et al. (2003), *trauma resolution* is often the central goal of treatment as it involves not only making sense of the traumatic event but also helping the child learn to regulate their emotions, working with the family to establish a safe environment, and enhancing the child's resiliency and social supports. *Trauma integration* is the process through which traumatic memories, thoughts, feelings and behaviors related to the trauma are understood, accepted, and integrated within the child's view of himself or herself and the world around him or her. When using this approach, one can help the child:

- Tell the story of the trauma through various mediums
- Integrate the traumatic experience into cognitive schema

- Experience a full range of emotions associated with trauma experience and reminders of the trauma
- Allow for corrective emotional re-working of the trauma
- Reduce emotional charge related to the trauma
- Process grief and loss associated with the trauma
- Identify physical reactions to the traumatic experience and process

Most of this work is best done in phases (Luxenberg, Spinazzola, Hildago, Hunt, & vander Kilk, 2001). Phase One attends to basic needs, including connection to resources, self-care, and identification of support system (e.g., friends, family, community). Self-care can include sleeping 8 hours a night, eating nutritious foods, exercise, practicing good boundaries, and using positive coping mechanisms. The focus is on the regulation of emotion and developing the capacity to self-soothe. It includes education on trauma and the treatment process. Phase Two is all about the processing and grieving of traumatic memories. The primary goal of this phase of treatment is to have the individual acknowledge, experience and normalize the emotions and cognitions associated with the trauma at a pace that is safe and manageable. Phase Three is about reconnection: developing a firm or new sense of self and development of healthy and supportive friendships, intimacy, and spirituality.

"A competent mental health provider who is knowledgeable about trauma and solid trauma assessment and skilled in evidence-based trauma treatment should be given clinical discretion as to what model to employ and how to integrate various models and strategies" (Conradi & Wilson, 2013, p. 84). For instance, the TAP model promotes selecting an intervention based on the specific pathway identified, encouraging decisions based on strong connections between the identified problem and intervention:

- Child Experienced a Traumatic Event ➡ TF-CBT (Trauma-Focused Cognitive-Behavioral Therapy)
- Physical Abuse ➡ AF-CBT (Alternatives for Families: A Cognitive-Behavioral Therapy)
- Traumatic Grief ➡ Losing a parent in death in the early years model
- Domestic Violence ➡ CPP (Child-Parent Psychotherapy)
- Behavior Problems that Supersede Traumas Processing ➡ PCIT (Parent-Child Interaction Therapy)

The National Child Traumatic Stress Network (NCTSN) notes that many existing trauma-focused interventions overlap in their content and approaches. These areas of overlap are termed *"core components."* Mental health providers are encouraged to consider (1) whether and how specific interventions include desired intervention components, (2) how, if included, these components are carried out (e.g., specific skills-acquisition activities, homework, role-play, games), and (3) how well these components "fit" with the specific needs and preferences of the students served. For example, does the intervention emphasize acquiring the appropriate coping skills? If so, are the activities in which skills are acquired appropriate for the developmental level, cultural background, and geography of the population served? Interventions that do not include needed core components may be inappropriate for the population, or may at least require substantial adaptation in order to be considered appropriate.

Appendix E1 connects with *The National Registry of Evidence-Based Programs and Practices* (www.nrepp.samhsa.gov), a searchable database of interventions for the prevention and treatment of mental and substance use disorders. Appendix E2, *Blueprints for Violence Prevention* (http://www.colorado.edu/cspv/blueprints), describes 11 prevention and intervention programs that meet a scientific standard of program effectiveness. These programs have been effective in reducing adolescent violent crime, aggression, delinquency, and substance abuse. The website also provides

information on other programs that are viewed as promising practices. Additional evidence based practices are listed in Appendix E3. Some of those listed therein and/or below have also been recommended by the Department of Children and Family Services (DCF, 2013), The National Child Traumatic Stress Network (Chadwick, 2013), and/or the Administrative Office of the Courts (AOC, 2014):

- Attachment, Self-Regulation, and Competency (ARC) is frequently used with children and youth ages 5 - 17 and focuses on enhancing resilience by building tangible life skills and encouraging a supportive care giving system.
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed to relieve symptoms of posttraumatic stress, anxiety, and depression; focuses on reducing behavior problems and improving school function, grades, and attendance.
- Child and Family Traumatic Stress Intervention (CFTSI) is a brief, 4 to 6 session treatment for children and youth, ages 7 to 18 and their parent or other caregiver, delivered by a trained CFTSI provider that supports children and their families/caregivers exposed to potentially traumatic events. Implemented immediately following a potentially traumatic event or disclosure of physical or sexual abuse, CFTSI enhances communication about the symptoms and responses to the event, and teaches the family the skills to manage the child's reactions.
- Child Parent Psychotherapy (CPP) is an intervention for children from birth through age 5 who have experienced at least one traumatic event and, as a result, are experiencing behavior, attachment, and/or mental health problems including PTSD. The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning. CPP is based on attachment theory and combines developmental, trauma, social learning, psychodynamic and cognitive-behavioral theories.
- Eye Movement Desensitization and Reprocessing Therapy (EMDR) involves recalling traumatic memories while focusing on personal strengths and engaging in distracting behaviors such as lateral eye movements. EMDR is generally conducted as only one part of a multimodal therapy program rather than a stand-alone treatment.
- Parent Child Interaction Therapy (PCIT) is an empirically supported therapy for conduct-disordered children, ages 2 to 7 and their caregivers. It uses a combination of behavioral therapy, play therapy, and parent training to teach more effective discipline techniques and improve the child-parent relationship. PCIT is divided into two stages: relationship development (child-directed interaction) and discipline training (parent-directed interaction) with three distinct assessment periods (pre-treatment, mid-treatment, and post-treatment).
- Prolonged Exposure Therapy for Adolescents (PE-A) is targeted toward adolescents who have experienced trauma such as sexual assault, car accident, violent crimes, etc. It has also been used with children 6-12 years of age who have experienced trauma.
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a short term, family/child focused treatment that is designed to assist children and adolescents (ages 3-18) who are experiencing emotional and behavioral difficulties related to traumatic life events. The goal of the program is to teach children and their parents how to process and manage the distressing thoughts, emotions and behaviors that are related to the traumatic experiences. TF-CBT can be delivered to youth who are at home with their parents, in foster care, and in residential facilities.

Encourage Interagency Coordination

Herein, *"recovery"* is defined as the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Individual, family, cultural and community strengths can facilitate recovery and promote resilience. Social, community and governmental support networks are critical for recovery, particularly when an entire community is affected, as when a natural disaster occurs (Greene & Conrad, 2001). The goal of each child-serving system is to improve outcomes for children and to maintain excellent standards of care. However, each system approaches trauma differently; has different levels of awareness, knowledge and skill about trauma; varies in perceptions about the utility of gathering information about trauma; and differs in their responsibilities for meeting children's needs. Schools and/or primary health care settings are the best source for children to access mental health services (NCTSN).

Some children with trauma experiences demonstrate emotional and behavioral needs that cannot be met with therapy alone and pharmacological interventions are needed. This requires collaborative working relationships with the families and their physicians as well as the local Department of Behavioral Health. A psychotropic medication is one prescribed to help people who are experiencing a mental health disorder (e.g., depression, anxiety, conduct disorder, or attention-deficit hyperactivity disorder). Furthermore, a psychiatric evaluation is typically completed by a psychiatrist prior o prescribing such medication (Rowe & Demaree, 2013). Statistics indicate increased rates of psychotropic use with young children, with a higher use among children in the child welfare system when compared to the general population, especially among older children, boys, those with behavior problems, and children in group homes and residential treatment centers (Rowe & Demaree, 2013). Although there is no medication to treat post-traumatic stress, some medications can be used to reduce some trauma-related symptoms. An evaluation may be warranted when a child or youth:

- presents with complicated, problematic, or unexpected responses to current psychotropic medication;
- experiences significant side effects, inadequate control of their mental health symptoms, or whose signs and symptoms of illness threaten their life and safety;
- presents with complex and atypical signs and symptoms; and,
- presents with severe risk to their safety and the safety of others despite intensive treatment (Rowe & Demaree, 2013).

Research has identified a link between exposure to multiple traumas and academic and behavioral issues in school settings, including an increased likelihood of failing grades, behavioral problems in school, and risking behaviors (i.e., alcohol use, binge drinking, cigarette smoking, and marijuana use) (AOC, 2014). These factors may increase the likelihood that youth will become involved with the juvenile court system. Therefore, it is important that juvenile court judges know about trauma and delinquency. The National Council of Juvenile and Family Court Judges (NCJFCJ, 2010) believe every juvenile court judge should know:

1. A traumatic experience is an event that threatens someone's life, safety, or well-being.
2. Child traumatic stress can lead to Posttraumatic Stress Disorder (PTSD).
3. Trauma impacts a child's development and health throughout his or her life.
4. Complex trauma is associated with risk of delinquency.
5. Traumatic exposure, delinquency, and school failure are related.
6. Trauma assessments can reduce misdiagnosis, promote positive outcomes, and maximize resources.

7. There are mental health treatments that are effective in helping youth who are experiencing child traumatic stress.
8. There is a compelling need for effective family involvement.
9. Youth are resilient.
10. The juvenile justice system needs to be trauma-informed at all levels.

Judicial officers, probation and child welfare workers can play an important role in identifying and assisting youth who have experienced trauma, utilizing trauma-focused screening and assessment tools, and considering trauma factors when making dispositional decisions on treatment and placement options (AOC, 2014). Recommendations include a focus on physical and psychological safety for trauma-exposed children (e.g., ensuring appropriate and stable placements), universal screening for trauma exposure, trauma-focused assessments for youth with known trauma histories, appropriate trauma-focused services and treatment, parent and caregiver engagement, and system coordination between service providers, schools, and the courts (Spinazzola, Habib, Knoverek, Arvidson, Nisenbaum, Wentworth, Hodgdon, Pond, & Kisiel, 2013; Wilson, 2013).

Similarly, the child welfare system recognizes that it must reach out and coordinate with other systems so they too can work with the child and family through a trauma lens. This partnering includes teaming with law enforcement, working with mental health agencies, and coordinating with schools, the courts, and attorneys (Chadwick, 2013). For example, the Department of Children and Family Services (DCF, 2013) has recognized that children and youth who receive their services have typically experienced or been exposed to traumatic events (e.g., physical abuse, sexual abuse, chronic neglect, sudden or violent loss of or separation from loved ones, domestic violence, and/or community violence). As a consequence, many of these children have emotional, behavioral, social and mental health challenges that require special care and treatment. To address these multiple challenges, efforts have been made to have the social welfare workforce be both trauma-aware and trauma-informed. To achieve the goals of safety, permanency and well-being, all activities by the DCF workforce are focused on strengthening the family, promoting resiliency, enhancing physical, emotional, and social well-being including healing trauma wounds, and reducing or eliminating system level activities that may further harm or re-traumatize children and their families (DCF, 2013).

Seeing this, it is clear that no one child-focused agency can function alone. School-based mental health professionals can take on the important role in promoting interagency coordination. They may work with first responders and community organizations that serve families with children. They may reach out to link children and families affected by trauma to community resources. They may research and implement effective evidence-based treatments. Sometimes a community needs to come together in response to a large scale traumatic event. In preparation for such a scenario, school personnel can become active members of a disaster response network and leaders in the training of personnel. For example, the *Psychological First Aid (PFA) Field Operations Guide (Second Edition),* available at www.NCTSN.org, was developed by NCTSN and the National Center for Posttraumatic Stress Disorder (NCPTSD) to address the needs and concerns of children, adolescents, adults, and families during the first hours and days after disasters or large-scale traumatic events. The standardized face-to-face training created for PFA includes a DVD series entitled *Crisis in the Aftermath of Disasters*, to demonstrate evidence based intervention strategies following such an event. When taking on such leadership roles, it is important that staff remember to manage their own stress.

Manage Professional and Personal Stress

This is hard but rewarding work! One has to have the following set of skills to face and overcome the challenges associated with the central elements of trauma-informed practice:

- Gather information about the child's or adolescent's trauma history and its impact on his or her development, behavior, and relationships in order to guide services;
- Utilize a strength-based approach that enhances children's skills to manage reactions, reduce high-risk behaviors, and promote constructive activity;
- Provide support and guidance to the child's family and caregivers;
- Support and promote positive, stable relationships in the child's life;
- Coordinate services with other agencies;
- Explain trauma-specific care to children and their families and motivate them to participate in care; and
- Manage personal and professional stress (NCTSN).

Working with others who have experienced trauma can be gratifying, frustrating and exhausting. It is important to consistently maintain appropriate boundaries, be aware of secondary traumatic stress, know the signs of burnout, and prepare a personal coping plan (Hodas, 2006). Osofsky, Putnam, and Lederman (2008) describe s*econdary traumatic stress (STS)* within the child welfare field. These characteristics can also appear in staff members working for other agencies who also hear about firsthand trauma experiences of others. The symptoms of STS can include:

cynicism, anger or irritability	anxiety, fearfulness	sadness, depression
emotional detachment or numbing	intrusive imagery or thoughts about clients' traumas	nightmares and sleep disturbance
social withdrawal	pessimistic worldview	diminished self-care
increased physical complaints and illness	use of alcohol/drugs to "forget about work"	

Organizational factors can also contribute to secondary traumatization, including high caseload, lack of supervisory and peer support, inadequate resources, excessive workload or paperwork, role conflict, risks to personal safety, lack of job recognition, and personal liability for job-related decisions. High rates of STS can also have a negative impact on organizational functioning due to increased absenteeism, poor quality of work, impaired judgment, decrease compliance with organizational requirements, lack of willingness to accept extra work or assume responsibility, greater staff friction, low motivation, high staff turnover, and lower productivity (Osofsky. et al., 2008).

Hendricks (2013b) describes *vicarious trauma (VT)* as similar to but different from STS. VT refers to internal changes in worldview and perception of self and others due to chronic exposure to traumatic material. Since VT is cumulative, it can affect one's sense of trust, safety, control, esteem and intimacy. Symptoms of VT include:

feeling powerless or inadequate	feeling estranged
feeling "infected" by trauma	difficulty separating work from personal life
feeling hopeless or depressed	fatigue
adopting a pessimistic or cynical outlook on life	decrease interest in self-care and/or pleasurable activities
difficulty with trust	increased absence from work
social withdrawal	

Compassion fatigue is a natural consequence of helping traumatized individuals and is often due to the empathy one feels when working with individuals who have suffered. Symptoms include irritability, apathy, loss of motivation, fatigue, feeling overwhelmed, loss of interest in things you enjoy and intrusive thoughts (especially about work). One must also watch for *burnout*. While symptoms are similar to compassion fatigue, it is very different, in this instance once can lose the ability to empathize. To protect one from these situations, Saakvitne and Pearlman (1998) recommend self-assessment and provide the following effective strategies to maintain self-care.

- Physical Self-Care: eat regularly, eat healthy, exercise, get regular medical care for prevention, get medical care when needed, take time off when needed, get massages, do a physical activity that is fun (e.g., dance, swim, walk, run, play sports, sing), take time to be sexual (with yourself or with a partner), get enough sleep, wear clothes you like, take vacations, take day trips or mini-vacations, make time away from telephones
- Psychological Self-Care: make time for self-reflection, have your own personal psychotherapy, write in a journal, read literature that is unrelated to work, do something at which you are not an expert or in charge, decrease stress in your life, let others know different aspects of you, notice your inner experience (e.g., listen to your thoughts, judgments, beliefs, attitudes, and feelings), engage your intelligence in a new area (e.g., go to a museum, sporting event, theater performance), practice receiving from others, be curious, say "no" to extra responsibilities sometimes
- Emotional Self-Care: spend time with others whose company you enjoy, stay in contact with important people in your life, give yourself affirmations and praise, love yourself, reread favorite books or review favorite movies, identify and seek out comforts (e.g., activities, objects, people, relationships, places), allow yourself to cry, find things that make you laugh, play with children
- Spiritual Self-Care: make time for reflection, spend time with nature, find a spiritual connection or community, be open to inspiration, cherish your optimism and hope, be aware of nonmaterial aspects of life, try at times not to be in charge or the expert, be open to not knowing, identify what is meaningful to you and notice its place in your life, meditate, pray, sing, spend time with children, have experiences of awe, contribute to causes in which you believe
- Workplace or Professional Self-Care: take a break during the workday, take time to chat with co-workers, make quiet time to complete tasks, identify projects or tasks that are exciting and rewarding, set limits with your clients and colleagues, balance your case load so that no one day or part of a day is too much, arrange your work space so it is comfortable and comforting, get regular supervision or consultation, negotiate your needs (salary and benefits), have a peer support group
- Balance: strive for balance within your work-life and work-day; strive for balance among work, family, relationships, play and rest.

The National Child Traumatic Stress Network (NCTSN) recognizes that being immersed in the traumas of others can affect one's worldview and impact what one believes about the world, self, youth and others. Like those they serve, intervention providers can develop an "invisible suitcase" of thoughts and beliefs as a result of experiences. It is important to consider in what ways your work has had a negative influence on what matters to you in life, on the way you see the world, on the way you see yourself or the ways others in your life see you. "Think Trauma" recommends the following coping strategies for before, during and after a trauma or loss reminder or a "hidden" trauma reminder.

1. Reduce Unnecessary Exposure: Limit exposure to reminders and distressing situations in a common sense fashion, especially right after a trauma.

2. Anticipate Exposure: A certain amount of exposure is unavoidable. Plan ahead to give yourself some sense of control and support.
3. Do Calming Exercises: Specific calming activities used before, during and after exposure to reminders or distressing situations can help manage anxiety. Techniques include slow abdominal breathing, progressive muscle relaxation, vigorous exercise, listening to music, singing, rocking, swaddling self in a blanket, or other calming activity of choice.
4. Build Resilience by Staying in Touch and Active: Lead a healthy lifestyle that includes appropriate sleep, eating and exercise routines. It is very important to maintain your relationships and network of support – withdrawing often makes people feel worse – while connecting will help you manage posttraumatic reactions.
5. Distract Yourself Through Positive Activities: Exercise, sports, hobbies, projects, and work are all positive activities.
6. Seek Support: It helps to share your concerns by talking with a trusted friend, family member or staff member before, during and after exposure to a trauma or loss reminder. This can help diminish the intensity of your reaction.
7. Take a Time-Out: Sometimes simply taking yourself out of a stressful situation by quietly leaving, taking a walk, or going to a quiet place can be a means to calm yourself.
8. Journal Writing: Many who have experienced trauma or traumatic loss have found value in keeping a journal. Reflecting back can be calming and help one find meaning as remembrances, thoughts and feelings are written down.

Establishing an Organizational System

Building a trauma-informed system of care requires a paradigm shift. The basic premise for organizing services is transformed from the question "What is wrong with you?" to "What happened to you?" and from a traditional top-down environment to one that is based on collaboration with those who have experienced trauma and their families (NCTIC). No single educator can adequately incorporate trauma sensitivity alone. Usually a small but enthusiastic group of educators learn about the impacts of trauma on learning and then articulate their sense of urgency to others. The key steps for creating a trauma-informed environment include:

- Meeting student needs in a safe, collaborative, and compassionate manner;
- Preventing treatment practices that re-traumatize people with histories of trauma;
- Building on the strengths and resilience of students and their families in the context of their environments and communities; and,
- Endorsing trauma-informed principles within the organization through support, consultation, collaboration, and supervision of staff (SAMHSA TIP, 2014).

Self-Assessment

Five areas considered essential to the adoption and implementation of a child trauma treatment practice are:

1. Organizational readiness to implement evidence-based practices;
2. Organizational readiness to monitor and evaluate clinical processes and outcomes;
3. Clinically competent practices in child trauma treatment;
4. Quality training and supervisory skills; and,

5. Effective child and family engagement (NCTSN).

To get started, a school site or district can complete the Agency Self-Assessment for Trauma-Informed Care. The form, detailed suggestions and a "toolkit" are available on the Trauma Informed Care Website: http://www.traumainformedcareproject.org/. This self-assessment tool covers

1. Supporting Staff Development: training and education, staff supervision, support and self-care;
2. Creating a Safe and Supportive Environment: establishing a safe physical environment, establishing a supportive environment (information sharing, cultural competence, privacy and confidentiality, safety and crisis prevention planning, open and respectful communication, consistency and predictability);
3. Assessing and Planning Services: conducting intake assessments (intake assessment process and follow-up), developing goals and plans, offering services and trauma specific interventions);
4. Involving Consumers: involving current and former consumers; and,
5. Adapting Policies: creating written policies, reviewing policies.

Another tool, an Organizational Capacity and Readiness Assessment is posted on www.NCTSN.org. The NCTSN website has also made available the *Service Systems Briefs Series*, Service *Systems Speaker Series*, papers on *Creating Trauma-Informed Child-Serving Systems*, and archived presentations on creating such systems. The *Child Trauma Toolkit for Educators*, a series of fact sheets and a DVD (available in both English and Spanish). It is designed for teachers and administrators in preschool, elementary, middle and high schools. It is helpful to have a designated point person to collect completed assessments and compile the results.

The American Institutes for Research (AIR) believes that building trauma-informed organizations is a long-term process that requires (1) organizational commitment to changing culture and practice; (2) a framework for organization-wide implementation; and (3) support for organizations throughout the change process. Organizations can use the Trauma-Informed Organizational Capacity Scale (TIC-Scale) to determine their baseline for organization-wide, trauma-informed care; target strategic planning and professional development activities; monitor change over time; and assess whether improvements in organizational trauma-informed care influenced success for service users. This 35-item instrument has been psychometrically validated to gauge the extent to which a human service organization provides trauma-informed care. More information is available at http://www.air.org/resource/framework-builindg-trauma-informed-organizations-and-systems.

Successful Models

Sometimes a school chooses to focus on prevention. *Selective prevention* targets people who are at risk for developing social, psychological, or other conditions as a result of trauma or who are at greater risk for experiencing trauma; *Indicated prevention* targets people who display early signs of trauma-related symptoms (SAMHSA TIP, 2014). Other schools may choose to go beyond in developing a continuum of care. Those seeking to create trauma-informed schools can benefit from a supportive online learning community: traumasensitiveschools.org. In addition, a variety of successful models have been reported by Cole et al. (2013, p. 110):

- The Collaborative Learning for Educational Achievement and Resilience (CLEAR) model for trauma-informed educational practice for Pre K-12 education, using a Response to Intervention (RtI) framework in a structured 2-3 year professional and systems development model. It has three primary objectives: linking social emotional learning and trauma knowledge in classroom practices, integration of community behavioral health partners in schools, and development of policies and practices to support teacher trauma-informed practices. CLEAR employs an adaptation of the Attachment, Self-Regulation, and Competence (ARC) Framework as the

common vocabulary for staff development and decision-making. Community partners provide targeted trauma-specific interventions as educational supports for vulnerable students. For a description of the CLEAR program, see http://extension.wsu.edu/ahec/trauma/Pages/ComplexTrauma.aspx.

- The Compassionate Schools: The Heart of Teaching and Learning is an initiative sited in the Washington State Office of Superintendent of Public Instruction (OSPI). It provides training, guidance, referrals, and technical assistance to schools to create Compassionate Schools that benefit all students who attend but focus on students chronically exposed to stress and trauma in their lives. OSPI has developed a handbook which is a helpful resource. For a description of this program, see http://www.k12.wa.us/compassionateschools.
- UCSF Healthy Environments and Response to Trauma in Schools (HEARTS), a program of Child and Adolescent Services, Psychiatry Department, University of California, San Francisco – San Francisco General Hospital, aims to promote school success for students who have experienced complex trauma by creating school environments that are more trauma-sensitive, safe, and supportive of their needs. The goal is to increase productive instructional time and school engagement by collaborating with San Francisco Unified School District to provide prevention and intervention at many levels of the school community: student, caregiver, school staff, school district, and policy. HEARTS takes a public health approach to addressing trauma in schools, and has found that more safe and supportive school environments benefit not only traumatized children and youth, but also those who work with these students, including school personnel and student peers. For a description of this program, see http://coe.ucsf.edu/coe/spotlight/ucsf_hearts.html.
- A multi-disciplinary work group organized by the Wisconsin Department of Public Instruction (DPI) came together to support schools in their journey to become more aware of the impact that trauma has on learning, behavior and development, and to foster school environments where all students can grow and learn. The goal of the Wisconsin state trauma-sensitive schools initiative is to ensure that children impacted by traumatic experiences can learn and be successful. The effort focuses on helping schools create a culture that prioritizes safety, trust, choice, and collaboration. The work group has developed a “Trauma Tool Kit” that is posted on the DPI website and is available for any school to use. The Tool Kit is comprised of a slide presentation with detailed speaker notes to use in an in-service training, a resource guide for further readings, videos, and a trauma-sensitive school checklist (developed jointly by the Trauma and Learning Policy Initiative and Lesley University), along with other materials. The Wisconsin DPI and its work group partners have sponsored a variety of professional development events to spread the effort. To find these materials, as well as articles exploring how PBIS and RtI can be used in a trauma-sensitive school, see http://sspw.dpi.wi.gov/sspw_mhtrauma.

School leaders should recognize the diverse needs of the child and adolescent populations served when considering the interventions and treatments listed as evidence-based practices. It is important to address the appropriateness of an evidence based practice for a given community and target population, training requirements, feasibility of adoption and implementation, and potential for sustainability. The needs, values, and preferences of a provider's service population should also influence the type of intervention needed. Factors to consider include:

- Prevalence of types of trauma and traumatic bereavement to which the population(s) is exposed;
- Associated types and rates of mental distress and associated behavioral and functional impairment;

- Cultural background(s) of the clientele and the surrounding community;
- Developmental factors, including age, cognitive, and social domains;
- Socioeconomic factors;
- Logistical and other barriers to help-seeking;
- Availability of individual/family/community strength-based resources; and,
- Setting in which services are offered (school, residential, clinic, home).

A key principle in moving forward is engagement. "Staff are more apt to be empowered, invested and satisfied if they are involved in the ongoing development and delivery of trauma-informed services" (SAMHSA TIP, 2014, p. 9). Once leadership becomes fully invested in the belief that trauma sensitivity will provide better educational outcomes for all students, the entire staff can become engaged. Hiring and promotional practices that attract and retain individuals trained in trauma-informed practices becomes an organizational benefit in moving forward. Involving youth and family in the design and delivery of mental health services is another critically important step in making those services responsive, culturally sensitive, and effective (NCTSN). Lists and links to a variety of resources available from NCTSN and other organizations are available on www.NCTSN.org in a special section for youth and families.

Changing the culture of a school is a process that requires the commitment of the staff and leaders and support from policymakers. Furthermore, there is no program that, by itself, can make a school trauma sensitive. For programs and services to be successful, they need to fit a school's culture and foster the growth of all those involved in the learning community. Although each will be individualized, there can be common definitions and a shared vision. For example, Cole et al., (2013) identify the following as critical attributes of a trauma-sensitive school:

- Leadership and staff share an understanding of trauma's impacts on learning and the need for a school-wide approach (approaches infused into the curricula, philosophy, the ways adults relate to children);
- The school supports all students to feel safe physically, socially, emotionally, and academically (structure and limits, safe enough to make mistakes);
- The school addresses students' needs in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional well-being (going beyond surface behaviors, understanding the needs that underlie behavior, maximizing opportunities to learn);
- The school explicitly connects students to the school community and provides multiple opportunities to practice newly developing skills (creating a culture of acceptance and respect, where everyone is seen as having something significant to contribute, and encouraged and supported to do so; deliberate efforts are made to engage parents and caregivers and help them connect to the school community in meaningful ways);
- The school embraces teamwork and staff share responsibility for all student (structures are in place to address struggling student's needs holistically and colleagues join together in this work; partnering with families to share their knowledge of and insight into their children);
- Leadership and staff anticipate and adapt to the ever-changing needs of students (flexibly and proactively adjust to staff and student turnover so the equilibrium is maintained).

While this type of flexible framework allows for individualization at each site, it is important that the following familiar and important school operations are in the base:

- Leadership by school and district administrators to create the infrastructure and culture to promote trauma-sensitive school environments;
- Professional development and skill building for all school staff, including leaders, in areas that enhance the school's capacity to create supportive school environments;
- Access to resources and services, such as mental health, that help students participate fully in the school community and help adults create a schole-school environment that engages all students;
- Academic and nonacademic strategies that enable all children to learn;
- Policies, procedures, and protocols that sustain the critical elements of a trauma-sensitive school;
- Collaboration with families that actively engages them in all aspects of their children's education, helps them feel welcome at school, and understands the important roles they play (Cole et al., 2005).

The original document on helping traumatized children learn was expanded in 2013 to provide specific questions and activities to help guide a school in developing a shared vision, using a flexible framework, and an action plan (see Appendix F). Similarly, SAMSHA (2014) provides specific questions to ask within the following 10 implementation domains involved in such organizational change:

1. Governance and Leadership – a champion; support and investment in implementing and sustaining a trauma-informed approach; identified points of responsibility within the organization; inclusion of peer voice
2. Policy – written policies and protocols establishing a trauma-informed approach; including across community based agencies; becoming "hard-wired" into practices and procedures (beyond training workshops and good intentions)
3. Physical Environment – promoting a sense of safety and collaboration
4. Engagement and Involvement – of people in recovery, trauma survivors, people receiving services, and family members receiving services; include their voice and choice in program design, implementation, service delivery, quality assurance, cultural competence, peer support, workforce development, and evaluation
5. Cross Sector Collaboration – built on shared understandings of trauma, key principles of a trauma-informed approach; understanding how awareness of trauma can help or hinder achievement of the organization's mission
6. Screening, Assessment, Treatment Services – practitioners are trained in and use interventions based on best available evidence; trauma screening and assessment are an essential part of the work; trauma-specific interventions are accepted and available for individuals and families in need of services (in house or via a trusted, effective referral system)
7. Training and Workforce Development –training on trauma and peer support are on-going and incorporated into hiring, supervision, and staff evaluation
8. Progress Monitoring and Quality Assurance – on-going assessment, tracking and monitoring of key principles and effective use of evidence-based trauma specific screening, assessments and treatment
9. Financing – structures include resources for the above listed implementation domains

10. Evaluation – measures and evaluation designs are used to evaluate service or program implementation and effectiveness

Conclusions

Like any initiative, it is important for organizations to see promoting trauma-informed care in schools as relevant, timely, and supportive of other activities or initiatives occurring in the school system. The various types of trauma, especially the timing and frequency of their occurrence, can have significant impacts on a child's development; performance in school; need for academic, behavioral, social and emotional interventions. Early screening, assessment, and appropriate treatment models can clearly make a difference. Personnel do not have to start from scratch as effective tools, strategies, and evidence-based practices are included herein. Linkages with other agencies such as juvenile justice, probation, mental health and social services ensures that we have common goals and coordinated supports to maintain the child in the least restrictive setting. Finally, how to establish such systems within any organizational setting are modeled with on line resources provided. The Riverside County SELPA can also support endeavors to move forward in creating trauma-informed schools via professional development opportunities. For more information, call (951) 490-0375.

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Appendix A: Types of Trauma

Based on National Child Abuse and Neglect Data Systems (NCANDS) Glossary

Although many of the definitions appear in the body of this document, additional definitions for your reference are included below. These definitions will be used across all Network data collection activities whenever possible, and are consistent with external data collection efforts to allow comparability of results.

1. SEXUAL MALTREATMENT/ABUSE

i. **Note:** Sexual maltreatment/abuse refers to acts by an adult or older youth who is playing a caretaker role for the youth (e.g., parent, parent-substitute, babysitter, adult relative, teacher, etc.). Sexual contact/exposure by others (i.e., non- caretakers) should be classified as 'sexual assault/rape'.
ii. Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-in-appropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child
iii. Sexual exploitation of a minor child by an adult for the sexual gratification or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children)
iv. Unwanted or coercive sexual contact or exposure between two or more minor children

2. SEXUAL ASSAULT/RAPE

i. **Note:** Sexual assault/rape should include contact/exposure by perpetrators who are NOT in a caretaking role with the youth (sexual misconduct by caregivers should be recorded as 'sexual maltreatment/abuse'.
ii. Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child
iii. Sexual exploitation of a minor child by an adult for the sexual gratification or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children)
iv. Unwanted or coercive sexual contact or exposure between two or more minor

3. PHYSICAL ABUSE/MALTREATMENT

i. **Note:** Physical maltreatment/abuse refers to acts by an adult or older youth who is playing a caretaker role for the youth (e.g., parent, parent-substitute, babysitter, adult relative, teacher, etc.). Physical pain and/or injury by others (i.e., non- caretakers) should be classified as 'physical assault.'
ii. Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation.) by an adult, another child, or group of children to a minor child with or without use of an object or weapon and including use of severe corporeal punishment
iii. Does not include rough and tumble play or developmentally normative fighting between siblings or peers of similar age and physical capacity (e.g., assault of a physically disabled child by a non-disabled same-aged peer would be included in this category of trauma exposure)

4. PHYSICAL ASSAULT

i. **Note:** Physical assault should include infliction of physical pain/bodily injury by perpetrators who are not in a caretaking role with the youth (such actions by caregivers should be recorded as 'physical maltreatment/abuse').

ii. Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation.) by an adult, another child, or group of children to a minor child with or without use of an object or weapon and including use of severe corporeal punishment
iii. Does not include rough and tumble play or developmentally normative fighting between siblings or peers of similar age and physical capacity (e.g., assault of a physically disabled child by a non-disabled same-aged peer would be included in and physical capacity (e.g., assault this category of trauma exposure)

5. EMOTIONAL ABUSE/PSYCHOLOGICAL MALTREATMENT

i. Acts of commission against a minor child, other than physical or sexual abuse, that caused or could have caused conduct, cognitive, affective or other mental disturbance. These acts include:
    a. Verbal abuse (e.g., insults; debasement; threats of violence)
    b. Emotional abuse (e.g., bullying; terrorizing; coercive control)
    c. Excessive demands on a child's performance (e.g., scholastic; athletic; musical; pageantry) that may lead to negative self-image and disturbed behavior
ii. Acts of omission against a minor child that caused or could have caused conduct, cognitive, affective or other mental disturbance. These include:
    a. Emotional neglect (e.g., shunning; withdrawal of love)
    b. Intentional social deprivation (e.g., isolation; enforced separation from a parent, caregiver or other close family member)

6. NEGLECT

i. Failure by the child victim's caretaker(s) to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so. Includes:
    a. Physical neglect (e.g., deprivation of food, clothing, shelter)
    b. Medical neglect (e.g., failure to provide child victim with access to needed medical or mental health treatments and services; failure to consistently disperse or administer prescribed medications or treatments (e.g., insulin shots))
    c. Educational neglect (e.g., withholding child victim from school; failure to attend to special educational needs; truancy)

7. DOMESTIC VIOLENCE

i. Exposure to emotional abuse, actual/attempted physical or sexual assault, or aggressive control perpetrated between a parent/caretaker and another adult in the child victim's home environment
ii. Exposure to any of the above acts of perpetrated by an adolescent against one or more adults (e.g., parents, grandparent) in the child victim's home environment

8. WAR/TERRORISIM/POLITICAL VIOLENCE INSIDE THE U.S.

i. Exposure to acts of war/terrorism/political violence on U.S. soil (including Puerto Rico). Same as above, only in U.S. Historical examples include attacks of 9-11, Oklahoma bombing, and anthrax deaths.
ii. Includes actions of individuals acting in isolation, e.g. sniper attacks, school shootings if they are considered to be political in nature.

9. WAR/TERRORISIM/POLITICAL VIOLENCE OUTSIDE THE U.S.

i. Exposure to acts of war/terrorism/political violence, including living in a region affected by bombing, shooting, or looting other than in the U.S.

ii. Accidents that are a result of terrorist activity (e.g. bridge collapsing due to intentional damage, hostages who are injured during captivity) outside the U.S.

10. ILLNESS/MEDICAL

i. Having a physical illness or experiencing medical procedures that are extremely painful and/or life-threatening
ii. The event of being told that one has a serious illness
iii. Examples of illnesses include cancer or AIDS. Examples of medical procedures include changing burn dressings or undergoing chemotherapy.
iv. Does NOT include medical injuries that would otherwise be classified under Injury/accident (e.g. a child who is burned in a fire would be designated as experiencing an accident/injury trauma; however, if they then had to undergo repeated, painful dressing changes theyw would also qualify for illness/medical trauma).

11. INJURY/ACCIDENT

i. Injury or accident such as car accident, house fire, serious playground injury, or accidental fall down stairs.
ii. Does NOT include injury or accident caused at the hands of another person who is intending harm of any type (e.g. a child who falls down the stairs after a parent pushes him would be classified under physical maltreatment/assault, even if the parent didn't intend for the push to lead to the fall).
iii. Key concept here is "Unintentional".

12. NATURAL DISASTER

i. Major accident or disaster that is an unintentional result of manmade or natural event, e.g. tornado, nuclear reactor explosion.
ii. Does NOT include disasters that are intentionally caused (e.g. Oklahoma City Bombing, bridge collapsing due to intentional damage), which would be classified as acts of terrorism/political violence.

13. KIDNAPPING

i. Unlawful seizure or detention against the child's will
ii. May include kidnapping by non-custodial parent as well as by stranger.

14. TRAUMATIC LOSS OR BEREAVEMENT

i. Death of a parent, primary caretaker or sibling
ii. Abrupt, unexpected, accidental or premature death or homicide of a close friend, family member, or other close relative iii. Abrupt, unexplained and/or indefinite separation from a parent, primary caretaker, or sibling, due to circumstances beyond the child victim's control (e.g., contentious divorce; parental incarceration; parental hospitalization; foster care placement)

15. FORCED DISPLACEMENT

i. Forced relocation to a new home due to political reasons. Generally includes political asylees or immigrants fleeing political persecution. Refugees or political asylees who were forced to move and were exposed to war may be classified here and also under war/terrorism/ political violence outside US.
ii. Does NOT include immigrants who move voluntarily (e.g. moving due to poverty of home country), or families who are evicted.

iii. Does NOT include homelessness.
iv. The key concept here is “Political”.

16. IMPAIRED CAREGIVER

i. Functional impairment in at least one of child’s primary caregivers that results in deficient performance of the caretaking role (i.e., inability to meet the child’s needs).
ii. Impairment means that caregiver(s) were neither able to provide children with adequate nurturance, guidance, and support nor attend to their basic developmental needs due to their own mental illness, substance abuse, criminal activity or chronic overexposure to severe life stressors (e.g., extreme poverty, community violence).
iii. Impairment may be due to various causes (e.g., medical illness, mental illness, substance use/abuse, exposure to severance life stressors (e.g., extreme poverty, community violence)).
iv. If impairment results in additional trauma (e.g., neglect, emotional abuse/psychological maltreatment), BOTH ‘impaired caregiver’ and the more specific type of trauma should be reported.

17. EXTREME PERSONAL/INTERPERSONAL VIOLENCE (NOT REPORTED ELSEWHERE)

i. Includes extreme violence by or between individuals that has not been reported elsewhere (hence, if the child witnessed domestic violence, this should be recorded as “domestic violence” and NOT repeated here).
ii. Intended to include exposure to homicide, suicide and other similar extreme events.

18. COMMUNITY VIOLENCE (NOT REPORTED ELSEWHERE)

i. This category is intended to capture episodic or pervasive violence in the youth’s community that have not been captured in other categories.
ii. Include extreme violence in the community (i.e., neighborhood violence).
iii. Exposure to gang-related violence should be recorded here (though specific incidents of gang-related violence (e.g., homicide, assaults) should also be recorded under those more specific headings.

19. SCHOOL VIOLENCE

i. This category is intended to capture violence that occurs in the school setting and that has not been reported in other categories.
ii. It includes, but is not limited to, school shootings, bullying, interpersonal violence among classmates, classmate suicide.

20. OTHER TRAUMA

i. Any other type of trauma that is not captured by this list. Please describe.
ii. **VICARIOUS:** Experienced or realized through imaginative or sympathetic participation in the experience of another (e.g., siblings of child maltreated)

Appendix B: Key Terms Used Herein

Acculturation Process: refers to the process in which members of one cultural group adopt the beliefs and behaviors or another group. Although acculturation is usually in the direction of the newly immigrated group adopting habits and language patterns of the mainstream group, acculturation can be reciprocal – that is, the mainstream group also adopts patterns of the newly immigrated group. Acculturation level may vary among family members.

Acute Trauma: a one-time traumatic event (e.g., an auto accident, a violent event in the community, a natural disaster, a sudden loss of someone, an assault).

Affect Dysregulation: often identified as the primary concern when a child has difficulty identifying, coping, and managing feelings in a healthy, productive, and appropriate manner.

Assessment-Based Treatment (ABT): refers to an integrated plan of prioritized interventions, based on the diagnosis and psychosocial assessment of the client, to address mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries, and social problems. Integrating ABT into all phases of the clinical and/or educational process includes developing a comprehensive understanding of the student, identifying high-risks, establishing treatment goals, selecting appropriate treatment interventions, monitoring and re-evaluating the student's functioning throughout the course of therapy.

Attachment: can be defined as (a) a special enduring form of "emotional" relationships with a specific person; (b) involves soothing, comfort and pleasure; (c) loss or threat of loss of the specific person evokes distress; and (d) the child finds security and safety in context of this relationship.

Bonding: the process of forming an attachment.

Child Sexual Abuse: The National Child Traumatic Stress Network (NCTSN) defines child sexual abuse as "…any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer. Sexual abuse can include both touching and non-touching behaviors. Touching behaviors may involve touching of the vagina, penis, breasts or buttocks, oral-genital contact, or sexual intercourse. Non-touching behaviors can include voyeurism (trying to look at a child's naked body), exhibitionism, or exposing the child to pornography. Abusers often do not use physical force but may use play, deception, threats, or other forms of coercion to engage children and maintain their silence. Abusers frequently employ persuasive and manipulative tactics to keep the child engaged. These tactics—referred to as 'grooming'—may include buying gifts or arranging special activities, which can further confuse the victim."

Child Traumatic Stress: the physical and emotional response a child has to events that pose a threat to the child or someone important to them. As a consequence of experiencing stress, the child may be unable to cope, have feelings of terror and powerlessness, and experience physiological arousal they cannot control.

Chronic Trauma: occurs when children experience multiple traumatic events; can have a cumulative effect.

Clinical Pathway: a patient-focused tool, which describes the timeframe and sequencing of routine, predictable multidisciplinary interventions and expected patient outcomes, for a group of patients with similar needs. Clinical pathways are used to describe and implement clinical standards, in support of quality and efficiency in patient care.

Complex Trauma: The experience of multiple simultaneous or sequential traumatic events, primarily occurring within the caregiving relationship and home environment, and typically including emotional abuse, neglect, sexual abuse, physical abuse, and witnessing domestic violence. Traumatic exposure

is usually chronic and begins early in childhood. It can have a profound impact on a child's development and ability to function normally.

Culture: has many definitions and influences: a common heritage or set of beliefs, norms, and values; the shared, and largely learned, attributes of a group of people; a system of shared meanings; a dynamic pattern of language, beliefs, values, rituals, and customs that characterize specific racial, ethnic, religious, or social groups. It also refers to beliefs, attitudes, values and standards of behavior that are passed from one generation to the next. Cultural groups can include people identifying with various racial and ethnic groups, age groups, religious affiliations, gender, and/or sexual preference.

Cultural Competence: the recognition of cultures and the development of a set of skills, knowledge, and policies to deliver effective treatments to children and youth from a variety of cultures. In the relationship building process, cultural competence includes (1) conveying acceptance, respect, and understanding of the child's culture, and (2) communicating effectively with the child and his or her caretaker based upon sufficient knowledge about the values and experiences of the family's cultural group. Also defined as a set of behaviors, attitudes, and policies that enable a system, agency, or group of professionals to work in cross-cultural situations.

Cultural Identity: the culture with which someone identifies and to which he or she looks for standards of behavior.

Dissociation: is a common symptom in traumatic stress reactions. It is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity that helps distance the experience from the individual

Early Warning Signs: a signal of distress that is a physical precursor and/or manifestation of upset (e.g., restlessness, agitation, pacing, shortness of breath, sweating).

Emotional Regulation: the ability to maintain a well-regulated emotional state to cope with everyday stress. It is the ability to differentiate between emotions and body sensations. Emotional regulation doesn't just happen; it must be taught, learned and practiced.

Ethnicity: a common heritage shared by a particular group, including similar history, language, rituals, and preferences.

Evidence-Based Practices: Evidence-based practice (EBP) is an approach to clinical decision-making in which the practitioner, in consultation with the client (e.g., student and/or parent), uses the best available evidence to choose intervention options that are best suited to current needs. EBP draws upon and integrates information from multiple sources, including empirical evidence derived from systematic research, individual clinical expertise, and informed choice. An EBP derived from sound, science-based theories incorporates detailed and empirically supported procedures and implementation guidelines.

Flashback: re-experiencing a previous traumatic experience as if it were actually happening in the moment.

Neglect: the absence of essential physical or emotional care, soothing and restorative experiences from significant others, particularly in children.

Post-Traumatic Stress Disorder (PTSD): a mental health condition that is trigger by a terrifying event. This is a psychiatric condition characterized by specific symptoms that include:

- Re-experiencing the event through nightmares, flashbacks (which may include auditory hallucinations), or other symptoms for more than a month after the original experience;
- Avoidance and fear including not thinking about the event or having memory lapses, or new fears such as separation, being alone, or darkness;

- Increased arousal such as nightmares, difficulty falling asleep or staying asleep, decreased attention or concentration, hyperactivity, irritability and mood changes, increased aggression, or hyper vigilance and easily startled; and
- Decreased responsiveness, numbing, and regression such as less interest in play or normal activities, social withdrawal, or peer difficulties.

Race: a social (not biological) category used to classify people into groups according to a set of characteristics that are socially significant. The concept of race is especially potent when certain social groups are separated, treated as inferior or superior, and given differential access to power and other valued resources.

Racism and Discrimination: umbrella terms referring to beliefs, attitudes, and practices that denigrate individuals or groups because of phenotypic characteristics (e.g., skin color and facial features) or ethnic group affiliation.

"Recovery": A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Resilience: the ability of an individual, system or organization to meet challenges, to bounce back, rise above, and do well despite adversity. Resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events.

Resiliency: the ability to adapt in the face of challenges and adversity; associated with stress that is predictable and moderate as compared with stress that is unpredictable and severe that leads to vulnerability.

Re-traumatization: the occurrence of traumatic stress reactions and symptoms after exposure to multiple events or re-experiencing traumatic stress as a result of a current situation that in some way takes the person back to the prior traumatic experience. This can be a significant issue for some trauma survivors.

Secondary Trauma: sometimes used interchangeably with compassion fatigue or vicarious trauma; trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences; can occur among any professionals who provide services to those who have experienced trauma.

Self-Harm: any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Often used in an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and "damaged".

Stigma: a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illness.

Stress: a commonly used term with mixed definitions of what it means. For purposes herein, stress is defined as any challenge or condition which forces one's regulating physiological and neurological systems to move outside of their normal dynamic activity. Stress occurs when homeostasis is disrupted.

Trauma: There are many definitions of trauma. The one adopted herein is "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful of life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being".

Trauma-Informed: *Trauma Informed Care* is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played

in their lives. *A Trauma Informed System* is one in which all components of a given services have been reconsidered and evaluated in light of a basic understanding of the role that violence plays in the lives of people seeking mental health services. *Trauma Informed Services* are not specifically designed to treat symptoms or syndromes related to abuse or other trauma but they are informed about and sensitive to trauma related issues present in others.

Trauma Integration: is the process through which traumatic memories, thoughts, feelings and behaviors related to the trauma are understood, accepted, and integrated within the child's view of himself or herself and the world around him or her.

Trauma Resolution: often the central goal of treatment as it involves not only making sense of the traumatic event but also helping the child learn to regulate their emotions, working with the family to establish a safe environment, and enhancing the child's resiliency and social supports.

Trauma Wheel: a therapeutic guide, which delineates the required areas of child trauma treatment, including psychoeducation and skill building; addressing maladaptive cognitions; affect regulation; trauma integration; and system dynamics. Each of the key components is grounded in theory and requires awareness of the child's developmental, relational, and cultural dynamics. The developmental functioning of the child and the therapeutic relationship are also important components of the Trauma Wheel.

Traumatic Event: one that overwhelms the organism, dramatically and negatively disrupting homeostasis – throwing the person off balance. This can create a persistent set of compensatory responses which create a new, but less functionally flexible state of equilibrium. Traumatic events are sudden, unexpected, and extreme; usually involve physical harm or perceived life threat; and are experienced as outside of one's control.

Traumatic Stress: an extreme form of stress.

Trigger: something that sets off an action, process, or series of events (such as fear, panic, upset, agitation) that causes the person to re-experience intense and disturbing feelings that are tied to the original trauma. It is sometimes referred to as a "threat cue" (e.g., anniversary of event, bedtime, yelling, people too close).

Type I Trauma: a single traumatic event, such as an earthquake or a single rape episode is considered Type I.

Type II Trauma: refers to more severe repeated, prolonged trauma, such as extensive child abuse. Individuals with Type II trauma are more likely to have PTSD symptoms and often keep the abuse secret, resulting in fewer support systems and the use of less effective coping mechanisms.

Unique Client Picture: Through the use of standardized assessment, a thorough clinical interview, and behavioral observations, the clinician integrates information from several critical areas including: the child's trauma history, presenting symptomatology, relevant contextual history, and developmental history. From this, a complete picture of the client is formed prior to identifying treatment needs and setting goals.

Appendix C: Examples of Some Standardized Measurement Options

C1: Based Upon Domain and Reporter

Areas of Concern	**Informants**			
	Child	**Caretaker**	**Clinician**	**Other**
Trauma History	*UCLA PTSD Index*	*UCLA PTSD Index*	Interview	
Trauma Symptoms	*UCLA PTSD Index* *TSCC* *TSI*	*UCLA PTSD Index* *TSCYC CDC* *CSBI*	Interview Observation	
General Symptoms	*YSR CDI* *BAIC BASC*	*CBCL BASC*	Interview Observation	*TRF BASC*
Relevant Contextual History	Family Dynamics: *FAM-III* *FRI FACES* Peers: *YSR*	Family Dynamics: *FAM-III* *FRI FACES* Parenting: *PSI* Peers: *CBCL*	Interview Observation	
Developmental History/Intellectual Functioning	*WISC-IV, K-BIT* *Stanford Binet*	*ITSEA BITSEA*	*Denver II* *BSID-II* *Observation*	

Measure Abbreviations and Names:

BSID-II *= Bayley Scales of Infant Development, Second Edition;* ***BAIC*** *= Beck Anxiety Inventory for Children;* ***BASC*** *= Behavior Assessment System for Children;* ***BITSEA*** *= Brief Infant-Toddler Social and Emotional Assessment;* ***CBCL*** *= Child Behavior Checklist;* ***CDI =*** *Children's Depression Inventory;* ***CDC*** *= Child Dissociative Checklist;* ***CES-D*** *= Center for Epidemiological Studies on Depression;* ***CSBI*** *= Child Sexual Behavior Inventory;* ***Denver II*** *= Denver Developmental Screening Test II;* ***ITSEA*** *= Infant-Toddler Social and Emotional Assessment;* ***FACES-II or III*** *= Family Adaptability and Cohesion Evaluations Scale ;* ***FAM-III*** *= Family Assessment Measure;* ***FRI*** *= Family Relationship Index;* ***K-BIT*** *= Kauffman Brief Intelligence Test;* ***PSI*** *= Parenting Stress Inventory;* ***Stanford Binet*** *= Stanford Binet Intelligence Scales, Fifth Edition;* ***TRF*** *= Teacher Report Form;* ***TSCC*** *= Trauma Symptom Checklist for Children;* ***TSCYC*** *= Trauma Symptom Checklist for Young Children;* ***TSI*** *= Trauma Symptom Inventory;* ***UCLA PTSD Index*** *= UCLS PTSD Reaction Index for DSM-IV;* ***YSR*** *= Youth Self Report;* ***WISC-IV*** *= Wechsler Intelligence Scale for Children, IV*

C2: Based Upon Problems/Symptoms

Clinician checks each problem/symptom/disorder currently displayed by this child.

	Child has/exhibits this problem?	**Assessment Pathway** (Required)	**Optional Measures** (Assessment tools)
1. Acute stress disorder:	$_0$ No $_1$ Probable $_2$ Definite		***STAIC***
2. PTSD:	$_0$ No $_1$ Probable $_2$ Definite		***STAIC, CDC***
3. Traumatic/complicated grief:	$_0$ No $_1$ Probable $_2$ Definite		***CDI***
4. Dissociation:	$_0$ No $_1$ Probable $_2$ Definite		***CDC***
5. Somatization:	$_0$ No $_1$ Probable $_2$ Definite		
6. Generalized anxiety:	$_0$ No $_1$ Probable $_2$ Definite		***STAIC***
7. Separation disorder:	$_0$ No $_1$ Probable $_2$ Definite		***STAIC, PSI, FAM-III***
8. Panic disorder:	$_0$ No $_1$ Probable $_2$ Definite		***STAIC***
9. Phobic disorder:	$_0$ No $_1$ Probable $_2$ Definite		***STAIC***
10. Obsessive Compulsive Disorder (OCD):	$_0$ No $_1$ Probable $_2$ Definite		***STAIC***
11. Depression:	$_0$ No $_1$ Probable $_2$ Definite		***CDI***
12. Attachment, family, parenting or systems problems:	$_0$ No $_1$ Probable $_2$ Definite	***PSI, FAM-III*** **or** ***TSI*** **– see pathway**	
13. Sexual behavioral problems:	$_0$ No $_1$ Probable $_2$ Definite	***CSBI***	
14. Oppositional Defiant Disorder (ODD):	$_0$ No $_1$ Probable $_2$ Definite		***TRF, YSR***
15. Conduct disorder:	$_0$ No $_1$ Probable $_2$ Definite		***TRF, YSR***
16. General behavioral problems:	$_0$ No $_1$ Probable $_2$ Definite		***TRF, YSR***
17. ADHD:	$_0$ No $_1$ Probable $_2$ Definite		***TRF, YSR***
18. Suicidality:	$_0$ No $_1$ Probable $_2$ Definite	**In-depth risk assessment**	
19. Substance abuse:	$_0$ No $_1$ Probable $_2$ Definite	**In-depth risk assessment**	
20. Sleep disorder:	$_0$ No $_1$ Probable $_2$ Definite	***AUDIT /DAST/*** **Substance Use Screener**	
21. Homicidality:	$_0$ No $_1$ Probable $_2$ Definite		
22. Eating Disorders:	$_0$ No $_1$ Probable $_2$ Definite		
23. Adjustment Disorder	$_0$ No $_1$ Probable $_2$ Definite		

C3: Other Assessment Tools

Assessments for Trauma and Child Abuse

- Trauma Symptom Checklist for Children™ (TSCC™)
- Trauma Symptom Checklist for Young Children™ (TSCYC™)
- Checklist for Child Abuse Evaluation (CCAE)
- Child Sexual Behavior Inventory™ (CSBI™)
- House-Tree-Person and Draw-A-Person (HTP/DAP)

Assessments of Depression

- Reynolds Child Depression Scale™ 2nd Ed. & Short Form (RCDS™-2 & RCDS™-2SF)
- Reynolds Adolescent Depression Scale™ 2nd Ed. & Short Form (RADS-2™ & RADS-2SF™)
- Clinical Assessment of Depression™ (CAD™)
- Adolescent Psychopathology Scale™ & Short Form (APS™ & APS-SF™)
- Personality Assessment Inventory – Adolescent (PAI-A)
- Reynold's Depression Screening Inventory™ (RDSI™)

Assessments of Anxiety & Irritability

- Adolescent Psychopathology Scale™ (APS)™
- Personality Assessment Inventory – Adolescent (PAI-A)
- Clinical Assessment of Behavior™ (CAB)™

Assessments of Behavioral Disturbance

- Emotional Disturbance Decision Tree™ (EDDT™)
- Eyberg Child Behavior Inventory™ (ECBI™)
- Sutter-Eyberg Student Behavior Inventory-Revised™ (SESBI-R™)
- Clinical Assessment of Behavior™ (CAB™)
- Pediatric Behavior Rating Scale™ (PBRS™)
- Personality Assessment Inventory – Adolescent (PAI-A)
- Revised Behavior Problem Checklist – PAR Edition (RBPC)
- Children's Aggression Scale™ (CAS)
- Reynold's Adolescent Adjustment Screening Inventory™ (RAASI™)

Assessments of Interpersonal Relationships

- Parenting Stress Index™, 4th Ed. (PSI™-4)
- Stress Index for Parents of Adolescents™ (SIPA™)
- Clinical Assessment of Interpersonal Relationships™ (CAIR™)

Risk Assessments

- Psychosocial Evaluation & Threat Risk Assessment™ (PETRA™)
- Structured Assessment of Violence Risk in Youth™ (SAVRY™)
- Suicidal Ideation Questionnaire (SIQ)
- Adolescent & Child Urgent Threat Evaluation™ (ACUTE™)
- Firestone Assessment of Violent Thoughts™ – Adolescent (FAVT™-A)

Appendix D: Forty Developmental Assets

EXTERNAL ASSETS

SUPPORT

1. Family Support: Family life provides high levels of love and support.
2. Positive Family Communication: Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. Other Adult Relationships: Young person receives support from three or more nonparent adults.
4. Caring Neighborhood: Young person experiences caring neighbors.
5. Caring School Climate: School provides a caring, encouraging environment.
6. Parent Involvement in Schooling: Parent(s) are actively involved in helping the child succeed in school.

EMPOWERMENT

7. Community Values Youth: Young person perceives that adults in the community value youth.
8. Youth as Resources: Young people are given useful roles in the community.
9. Service to Others: Young person serves in the community one hour or more per week.
10. Safety: Young person feels safe at home, school, and in the neighborhood.

BOUNDARIES AND EXPECTATIONS

11. Family Boundaries: Family has clear rules and consequences and monitors the young person's whereabouts.
12. School Boundaries: School provides clear rules and consequences.
13. Neighborhood Boundaries: Neighbors take responsibility for monitoring young people's behavior.
14. Adult Role Models: Parent(s) and other adults model positive, responsible behavior.
15. Positive Peer Influence: Young person's best friends model responsible behavior.
16. High Expectations: Both parent(s) and teachers encourage the young person to do well.

CONSTRUCTIVE USE OF TIME

17. Creative Activities: Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
18. Youth Programs: Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.
19. Religious Community: Young person spends one hour or more per week in activities in a religious institution.
20. Time at Home: Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS

COMMITMENT TO LEARNING

21. Achievement Motivation: Young person is motivated to do well in school.
22. School Engagement: Young person is actively engaged in learning.
23. Homework: Young person reports doing at least one hour of homework every school day.
24. Bonding to School: Young person cares about her or his school.
25. Reading for Pleasure: Young person reads for pleasure three or more hours per week.

POSITIVE VALUES

26. Caring: Young Person places high value on helping other people.
27. Equality and Social Justice: Young person places high value on promoting equality and reducing hunger and poverty.
28. Integrity: Young person acts on convictions and stands up for her or his beliefs.
29. Honesty: Young person "tells the truth even when it is not easy."
30. Responsibility: Young person accepts and takes personal responsibility.
31. Restraint: Young person believes it is important not to be sexually active or to use alcohol or other drugs.

SOCIAL COMPETENCIES

32. Planning and Decision Making: Young person knows how to plan ahead and make choices.
33. Interpersonal Competence: Young person has empathy, sensitivity, and friendship skills.
34. Cultural Competence: Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. Resistance Skills: Young person can resist negative peer pressure and dangerous situations.
36. Peaceful Conflict Resolution: Young person seeks to resolve conflict nonviolently.

POSITIVE IDENTITY

37. Personal Power: Young person feels he or she has control over "things that happen to me."
38. Self-Esteem: Young person reports having a high self-esteem.
39. Sense of Purpose: Young person reports that "my life has a purpose."
40. Positive View of Personal Future: Young person is optimistic about her or his personal future.

Appendix E: Evidence Based Interventions

E1: The "Top 14 Trauma-Informed Care Online Resources"

Retrieved from Trauma Informed Resource Guide (2013)

- **ACEs Too High News Article** In addressing problematic student behavior at Lincoln High School in Walla Walla, WA, principal Jim Sporleder recognized that in many cases, punishing misbehavior was akin to piling on even more trauma for his troubled students. So he adopted a supportive, person-centered approach that helps kids learn to recognize their reactions and control their behavior. As a result, Lincoln High School has seen a significant drop in suspensions, expulsions, and written referrals.
- **CDC's Adverse Childhood Experiences (ACE) Study** This landmark study measures 10 types of childhood traumas such as emotional and physical neglect and witnessing a parent being abused. It has found that the more trauma a person experiences as a child, the more likely he is to experience adverse health and mental health effects later in life.
- **Child Trauma Academy** The Child Trauma Academy strives to improve the lives of high-risk children through service and education. Their site offers free online learning modules.
- **Creating Trauma-Sensitive Schools to Improve Learning: A Response to Intervention (RTI) Model** This site offers resources to help schools become more trauma-sensitive. Frequently asked questions are answered and a PowerPoint presentation with detailed speaker notes can be used in building in-services.
- **National Council for Community Behavioral Healthcare** This organization features an infographic designed to help you provide educated, empathic care. The poster outlines the roots, symptoms, and prevalence of trauma and provides useful coping strategies.
- **National Association of State Mental Health Program Directors** This site offers valuable information about CMHS's (Center for Mental Health Services) National Center for Trauma-Informed Care. It offers tools such as publications, reports, and webinars.
- **National Child Traumatic Stress Network** The National Child Traumatic Stress Network aims to improve access to care, treatment, and services for traumatized children and teens. Its site offers a wealth of information geared toward children, including numerous webinars.
- **Resiliencetrumpsaces.org/providersin.cfm** This Children's Resilience Initiative (CRI) website is interactive and packed with useful resources for parents, care providers, and communities to help kids cope with trauma. Mastering a skill, building a sense of belonging, and feeling a part of a larger purpose are the top three resilience building blocks outlined by the CRI. The site offers games and tools to help kids build resilience.
- **Safe Start Center** Among a variety of tools for preventing and reducing traumatic events for kids, the Safe Start Center offers two toolkits packed with infographics about children's exposure to violence and tips that can help you help kids deal with trauma at home and at school.
- **SAMHSA's National Center for Trauma-Informed Care (NCTIC)** The Substance Abuse and Mental Health Services Administration's (SAMHSA's) NCTIC provides training for staff, consumers, and others to facilitate person-centered, trauma-informed care in a range of service systems.
- **SAMHSA—Recovery Support** SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. The site offers resources such as publications, grants, and webinars.
- **SAMHSA's Webinars: Advancing Seclusion-Free, Restraint-Free Trauma-Informed Care** These six informative webinars highlight professionals who have been instrumental in implementing trauma-informed care within their organizations. Challenges and successes are discussed.
- **Trauma Center at Justice Resource Institute** The Trauma Center is a program of Justice Resource Institute, a nonprofit organization that offers hope to children and adults who are at risk of not receiving effective services essential to their safety, progress, or survival. The center offers education, research, events, publications, and other resources.
- **Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)—A Web-Based Learning Course** TF-CBT is a child and parent psychotherapy approach for kids who have behavioral difficulties that result from trauma. Children and parents learn new skills to manage and resolve distressing thoughts, feelings, and behaviors that result from traumatic life events.

E2: Specific Interventions for Targeted Populations

Retrieved from www.NCTSN.org Click on each intervention to download a detailed fact sheet that provides a description of the intervention as well as where to obtain additional information. List is in alphabetical order.

Name of Intervention	Targeted Populations	Modality	Culture-Specific Fact Sheet
Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP) (2012) (PDF)	8-21; both males and females; for youth experiencing a wide range of traumas	individual	Yes
Alternatives for Families - A Cognitive Behavioral Therapy (AF-CBT) (2012) (PDF)	School-age children; for youth experiencing a wide range of traumas	individual, family	Yes
Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP) (2012) (PDF)	0-18; both males and females; for children who have experienced a wide range of traumas	individual, family, systems	Yes
Attachment and Biobehavioral Catch-up (ABC) (2012) (PDF)	Birth – 24 months; both males and females; for low-income families who have experienced neglect, abuse, domestic violence, placement instability	individual, family	No
Attachment, Self-Regulation, and Competence (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth (2012) (PDF)	2-21; both males and females; for children, caregivers, and systems that have experienced a wide range of traumas	individual, family, systems	Yes
Child Adult Relationship Enhancement (CARE) (2008) (PDF)	Children of all ages and their caregivers; both males and females	family, systems	Yes
Child and Family Traumatic Stress Intervention (CFTSI) (2012) (PDF)	7-18; both males and females; for parents and children who may have complex trauma histories	individual, family, systems	No
Child Development-Community Policing Program (2007) (PDF)	0-18+; both males and females; for children and families in the aftermath of crime and violence.	individual, family, systems	No
Child-Parent Psychotherapy (CPP) (2012) (PDF)	0-6; both males and females; for youth who have experienced a wide range of traumas and parents with chronic trauma	individual, family, systems	Yes
Cognitive Behavioral Intervention for Trauma in Schools (CBITS) (2012) (PDF)	10-15; both males and females; for children who have experienced a wide range of traumas	individual, family, systems	Yes
Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse (CPC-CBT) (2015) (PDF)	4-17; both male and female; for families with a history of physical abuse and inappropriate physical discipline/coercive parenting strategies	individual, group, family	Yes

Combined TF-CBT and SSRI Treatment (2007) (PDF)	10-18; females	individual, family	No
COPE - Community Outreach Program - Esperanza (2007) (PDF)	4-18; both males and females; for traumatized children who are presenting with behavior or social-emotional problems	individual, family	No
Culturally Modified Trauma-Focused Treatment (CM-TFT) (2008) (PDF)	4-18; both males and females; Latino/Hispanic; for youth who have experienced a wide range of traumas	individual, family	Yes
Family Advocate Program (2005) (PDF)	18-70; both males and females; for youth who present with anxiety, depression, PTSD symptoms, and/or traumatic loss	family	No
Forensically-Sensitive Therapy (2005) (PDF)	4-17; predominantly female; for youth presenting problems ranging from anxiety and depression to risk-taking behaviors and functional impairment. Program is designed for a mental health clinic.	individual, family	No
Group Treatment for Children Affected by Domestic Violence (2007) (PDF)	5-no upper limit; both males and females; for children and their non-offending parents who have been exposed to Domestic Violence	group, family, systems	No
Honoring Children, Making Relatives (2007) (PDF)	3-7; both males and females; for American Indian and Alaska Native children	individual, family	No
Honoring Children, Mending the Circle (2007) (PDF)	3-18; both males and females; for American Indian and Alaska Native children	individual	No
Honoring Children, Respectful Ways (2007) (PDF)	3-12; both males and females; for American Indian and Alaska Native children	individual	No
Integrative Treatment of Complex Trauma (ITCT-C, ITCT-A) (2008) (PDF)	2-21; both males and females; for Hispanic-American, African-American, Caucasian, Asian-American; for youth who may have complex trauma histories	individual, family, systems	Yes
International Family Adult and Child Enhancement Services (IFACES) (2012) (PDF)	6-12; both males and females; for refugee and immigrant children who have experienced trauma as a result of war or displacement	individual	Yes
Parent-Child Interaction Therapy (PCIT) (2008) (PDF)	2-12; both males and females	individual, family, systems	Yes
Psychological First Aid (PFA) (2012) (PDF)	0-120; both males and females; for individuals immediately following disasters, terrorism, and other emergencies	individual	Yes
Real Life Heroes (RLH) (2012) (PDF)	6-12, plus adolescents (13-19) with delays in social, emotional or cognitive functioning; both males and females; for children who have experienced a wide	individual, family, systems	Yes

	range of traumas		
Risk Reduction through Family Therapy (RRTF) (2015) (PDF)	13-18, both males and females; for adolescents and family; primary trauma type is childhood sexual abuse/sexual assault	family	No
Safe Harbor Program (2007) (PDF)	6-21; both males and females; provided in schools for children and adolescents exposed to trauma and violence who may present with a range of problems and symptoms	individual, group, family, systems	No
Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART) (2012) (PDF)	3-11; both males and females; to date the model has been effectively used with primarily African-American children; majority of families are low income	individual, family, systems	No
Sanctuary Model (2008) (PDF)	4-no upper limit; both males and females; evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community to help people heal from trauma	systems	Yes
Sanctuary Model Plus (IRIS Project) (2005) (PDF)	Children and adolescents placed in residential treatment centers and their families	group, systems	No
Skills for Psychological Recovery (SPR) (2012) (PDF)	5-120; both males and females	individual, family	Yes
Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST) (2005) (PDF)	12-21; for females who have experienced sexual/physical abuse and a range of additional traumas, including community violence, domestic violence, and sexual assault	individual, group	No
Southeast Asian Teen Village (2005) (PDF)	adolescents; females, Southeast Asian (mostly Hmong)	group	No
Streetwork Project (2007) (PDF)	13-23; both males and females; harm reduction program good with a wide variety of ethnic/racial groups, religious group, and the LGBTQ community	individual, group, systems	No
Strengthening Family Coping Resources (SFCR) (2008) (PDF)	0-no upper limit; both males and females; for families experiencing economic hardship	family	No
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) (2012) (PDF)	12-21; both males and females; for adolescents with Complex Trauma, e.g. adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g. community violence, sexual assault).	group	Yes

Trauma Adapted Family Connections (TA-FC) (2012) (PDF)	0-18; both males and females; who reside in the household; families experiencing complex development trauma, at risk of neglect	individual, family, group	No
Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET) (2012) (PDF)	10-18+; both males and females; for children and caregivers experiencing traumatic stress; very frequently with single parents or with families whose children have limited contact with biological parents (e.g., foster kids, residential placements), and diversity of religious affiliations	individual, group, family, systems	Yes
Trauma and Grief Component Therapy for Adolescents (TGCT-A) (2015) (PDF)	12-20; both males and females; for trauma-exposed or traumatically bereaved older children and adolescents	individual, group, family, systems	Yes
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (2012) (PDF)	3-21; both males and females; for children with Posttraumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers	individual, family	Yes
Trauma-Focused Coping in Schools (TFC) (AKA: Multimodality Trauma Treatment Trauma-Focused Coping-MMTT) (2012) (PDF)	6-18; both males and females; for children exposed to single incident trauma and targets posttraumatic stress disorder (PTSD) and collateral symptoms of depression, anxiety, anger, and external locus of control	individual, group	Yes
Trauma-Informed Organizational Self-Assessment (2008) (PDF)	6-19; both males and females; for children who have experienced a wide range of traumas	individual, family, systems	Yes
Trauma Systems Therapy (TST) (2008) (PDF)	6-19; both males and females; for youth who have experienced a wide range of traumas	systems	Yes

Appendix F: Sample Questions and Activities to Consider When Implementing a Trauma-Informed Approach

From SAMSHA (2014) Helping Traumatized Children Learn:
Creating and Advocating for Trauma-Sensitive Schools

1. Why do we feel an urgency to become a trauma-sensitive school?
   Activities:
   a. Shared learning and a sense of urgency
   b. Growing a coalition
   c. Engaging leadership
   d. Establishing a steering committee
   e. Reaching out to the district

2. How do we know we are ready to create a trauma-sensitive action plan?
   Activities:
   a. Engaging the whole staff in shared learning (via professional development)
   b. Surveying the staff (reactions, ideas, challenges/barriers to overcome)
   c. Identifying staff's trauma-sensitive priorities for action (includes vision questions)
   d. Assessing staff's readiness to become a trauma-sensitive school

3. What actions will address staff priorities and help us become a trauma-sensitive school?
   Activities:
   a. Identifying trauma-sensitive action steps to address staff's priorities (start with most pressing, achievable in short-term, leading in desired direction; brainstorm)
   b. Developing a school-wide Action Plan (includes Flexible Framework questions connected back to vision questions)
   c. Planning for assessment (kinds of data used to track progress, observations and anecdotes – including how and when it will be collected)

4. How do we know we are becoming a trauma-sensitive school?
   Activities:
   a. Evaluating outcomes of the Action Plan (ongoing, dynamic, observable, qualitative and quantitative)
   b. Assessing progress toward whole school trauma sensitivity (degree of accomplishing goals of Action Plan; expanded Flexible Framework and Vision questions available)
   c. Sustaining the school-wide trauma-sensitive community (continued learning, expecting the unexpected, a spiraling process