

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

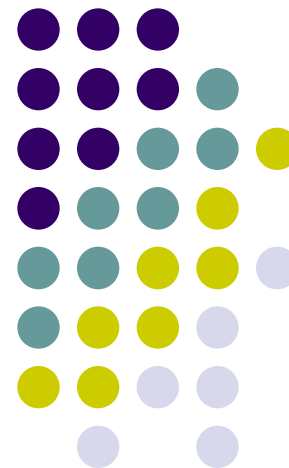
Texas Association of School Psychologists

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President – National Association of School Psychologists

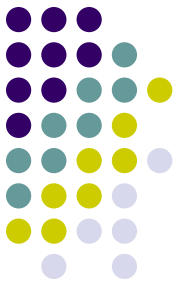
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Objectives



- From participation in this workshop participants will...
 1. increase their understanding of the impact of traumatic events on children and adolescents
 2. become familiar with specific trauma exposure and PTSD symptoms
 3. differentiate between PTSD and other disorders.
 4. understand the school psychologist's role in the identification and assessment of PTSD.
 5. be able to identify strategies designed to prevent, mitigate, and respond to PTSD.



Seminar Outline

- Characteristics of PTSD
 - *Prevalence & Impact*
 - *DSM-5*
 - Developmental Variations
 - Manifestations at School
- Causes of PTSD
- Identification/Assessment of PTSD
- Preventing/Mitigating PTSD
- Responding to PTSD



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

Kai Erickson

In the Wake of a Flood, 1979

Trauma Exposure



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

ACE Study reported over 50% of adults had experienced at least one form of childhood adversity

(www.traumasensitiveschools.org)

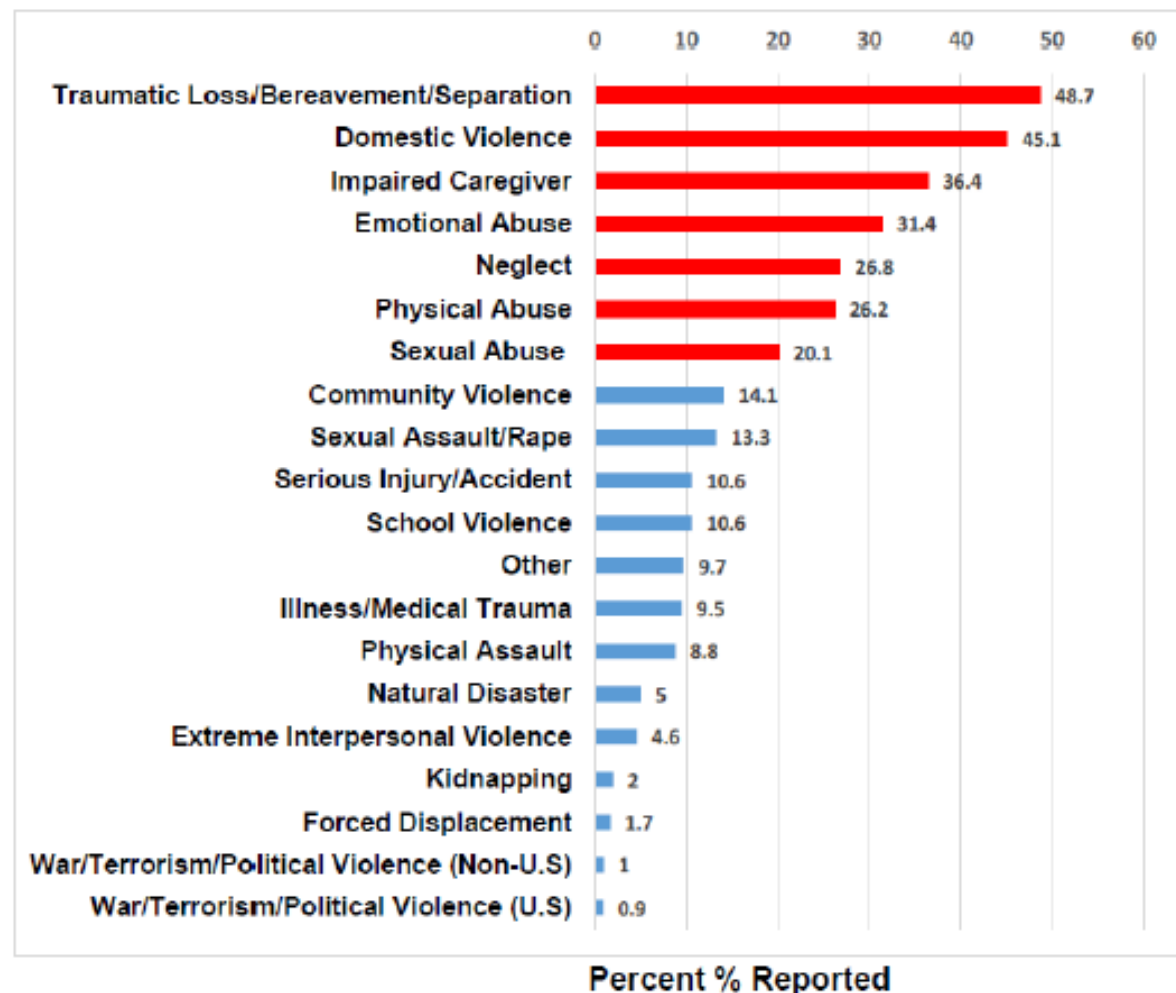
Prevalence



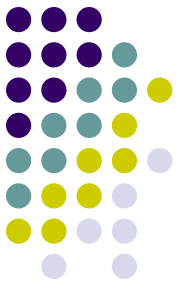
- Prevalence among children and adolescents
 - General Population
 - Experienced Traumatic Event - 2/3 of children by age 16
 - Trauma Exposure - approximately 25%
 - PTSD - 6 to 10%
 - Urban Populations
 - Trauma Exposure - as high as 80%
 - PTSD - as high as 30%
- Frequency
- Similarities with adult PTSD
- Differences from adult PTSD

National Child Traumatic Stress Network Rates of Childhood Trauma and Adversity

- The original ACES (in red) are among the most commonly reported traumas in studies that look at additional traumas.
- Over 40% of the children and adolescents served by the NCTSN (N = 10,991) experienced 4 or more different types of trauma and adversity.



Exposure to traumatic stressor



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

Range of Possible Traumatic Stress Reactions



Not Psychopathological (Common)

Initial Crisis Reactions
Acute Stress Disorder
Post-Traumatic Stress Disorder

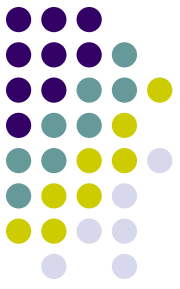
Psychopathological (Uncommon)

Impact of Trauma



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

Impact of Trauma



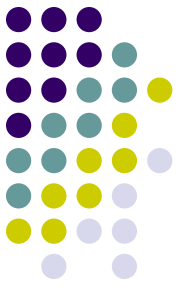
Adverse Childhood Experiences (ACES):

- ACE's Test: 4 or more trauma's → 1200% greater chance committing suicide and 7x's more likely to become alcoholics
- Higher rates:
 - drop out
 - suspension and expulsion rates
 - lower academic achievement
- As adults, increased risk health and mental health problems
 - e.g. heart disease, diabetes, liver disease, and obesity , substance abuse, depression, and suicide)

Trauma exposure:

- Lead to lasting changes in brain structure
 - e.g., reduced overall size and underdeveloped cortex and function (e.g., irritability, excitability, and impulsivity).
- Overproduction of the hormones adrenaline and cortisol
 - overproduction can impede normal development, cognition, memory, and learning.
 - suspend the higher-order skills needed for learning, getting along with others, and succeeding at school.

Impact of Trauma



- **Academics/Cognitive**

- organization
- comprehension
- memory
- ability to produce work
- engagement in learning
- attention/difficulties concentrating
- grasping of cause-and-effect relationships
- language
- lower GPA
- lower academic achievement test scores
- Classroom adjustment difficulties

- **Behavioral**

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

- **Social and Personal**

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



Saigh et al. (1997), Saltzman et al. (2001),
www.traumasensitiveschools.org
Perfect, Turley, Carlson, Yohanna, & Satin Gilles (2016)



Positive Impacts of Trauma

- Short-Term Positives

- ❑ Brings community together
- ❑ Brings attention to individual and community needs
- ❑ Activates resources

- Long-Term Positives

- ❑ Build coping skills
- ❑ Implementation of prevention programs
- ❑ Increase in monies to enhance physical safety and psychological safety

Mental Health Consequences

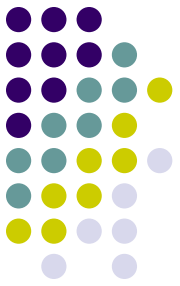


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Mental Illness

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

Need for Mental Health Supports



Approximately 1 in 3 students report being bullied each year

- Bullying and harassment is associated with increased depression and anxiety for bullies, victims, and bystanders

Approximately 2.2 million adolescents aged 12 to 17 reported a major depressive episode in the past year

Nearly 6 out 10 of these adolescents did not receive any treatment

Overall, 1 in 5 of children and adolescents in the U.S. experience signs and symptoms of a mental health problem and 5% experience “extreme functional impairment”





Role School MH Professional

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

Lawsuit: Compton Unified School District, CA (2015)



- Filed on behalf of 5 students and 3 teachers
- Complaint: didn't accommodate students and teachers exposed to trauma (direct exposure or secondary exposure/compassion fatigue)
- Requested injunctive relief:
 - Immediate implementation of school-wide trauma training
 - Restorative practices, conflict resolution skills training, intensive intervention services, employment of appropriately trained MH professionals to provide these services
- Invoked Section 504
- Judge denied preliminary injunction but allowed lawsuit to move forward

Every Student Succeeds Act (ESSA)



- Many provisions support trauma-informed care approach
 - Title IV funds – 20% allocated to be used for school climate initiatives, including trauma-informed approach
- Student Support and Academic Enrichment Grants
 - SSAE- Section 4108
- Professional Development
 - Sections 2012 & 2103
- Addressing family instability and trauma among Native American families
 - Section 6304



DSM 5, CHARACTERISTICS, CAUSES, & CONSEQUENCES

DSM 5: Trauma and Stressor Related Disorders



**Reactive
Attachment
Disorder**

**Disinhibited
Social
Engagement
Disorder**

**Posttraumatic
Stress Disorder**

**Acute Stress
Disorder**

**Adjustment
Disorders**

Characteristics of PTSD



DSM-5

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

*****does not include exposure via electronic media*****



Characteristics of PTSD

DSM-5

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



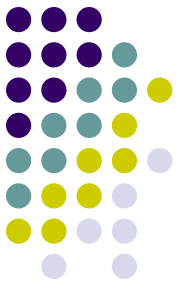
Characteristics of PTSD

DSM-5

- **Intrusion Symptoms**

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

Characteristics of PTSD

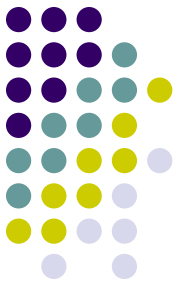


DSM-5

- **Avoidance Symptoms**

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

Characteristics of PTSD



DSM-5

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

Characteristics of PTSD



DSM-5

- **Increased Arousal Symptoms**

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

Characteristics of PTSD



DSM-5

- PTSD may be specified as
 - Acute
 - Chronic
 - Delayed onset



Characteristics of PTSD

Developmental Variations

- Preschoolers
 - Reactions not as clearly connected to the crisis event as observed among older students
 - Reactions tend to be expressed nonverbally
 - Given equal levels of distress and impairment, may not display as many PTSD symptoms as older children
 - **Temporary loss of recently achieved developmental milestones.**
 - Trauma related play

Posttraumatic Stress Disorder for Children 6 & Younger



A. The child (≤ 6 years old) exposure to actual/threatened death, serious injury, or sexual violation, in one or more of the following ways:

1. Direct exposure
2. Witnessing (does not include exposure via electronic media)
3. Learning that the event(s) occurred (to close relative/close friend)

B. Intrusion Symptoms associated w/ traumatic event (began after the event), evidenced by 1+ of the following:

Recurrent, involuntary, intrusive distressing memories

Note: spontaneous/intrusive memories don't necessarily appear distressing, may be expressed as play reenactment

Recurrent distressing dreams

Note: may not be possible to connect content to the event

Dissociative reactions wherein the child feels/acts as if the event(s) were recurring

Note: reactions occur on a continuum w/most extreme being complete loss of awareness of surroundings

Intense/prolonged psychological distress with exposure to internal/external cues that symbolize/resemble the event

Marked physiological reactions to reminders

Posttraumatic Stress Disorder for Children 6 & Younger



C. One (or more) from below:

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

Posttraumatic Stress Disorder for Children 6 & Younger



D. Alterations in arousal/reactivity associated w/ event (began or worsened after the event), as evidenced by 2+ of the following:

- Irritable/angry/aggressive behavior (e.g., extreme temper tantrums)
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance (e.g., difficulty falling or staying asleep, or restless sleep)

E. Duration of disturbance is more than one month

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

Specifier: with dissociative symptoms: Depersonalization or Derealization

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

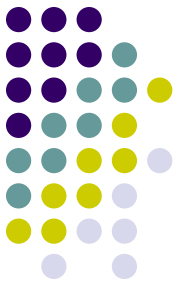
Characteristics of PTSD



Developmental Variations

- Alternative Criteria for Diagnosing Infants and Young Children
 - A. Confirmation of exposure is **not required** within the alternate criteria. Preverbal children cannot report on their reaction at the time of the traumatic event, and an adult may not have been present to observe this

Characteristics of PTSD



Developmental Variations

- Alternative Criteria for Diagnosing Infants and Young Children

- B. In the very young, recurrences and intrusive recollections of events need not be distressing.
- C. Markedly diminished interest in participation in significant activities observed as a constriction of play behavior.

Feeling of detachment/estrangement is mainly evidenced as social withdrawal.

Additional Symptom for Group C

- 1) *Loss of a previously acquired developmental skill, such as toileting or speech.*

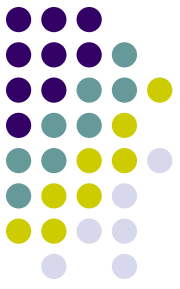
Characteristics of PTSD



Developmental Variations

- Alternative Criteria for Diagnosing Infants and Young Children
 - D. The alternate criteria require only ONE (or more) of Group D symptoms.
 - E. **New Cluster:** At least one (or more) of the following:
 - 1) New separation anxiety.
 - 2) New onset of aggression.
 - 3) New fears without obvious links to the trauma, such as fear of going to the bathroom alone or fear of the dark.

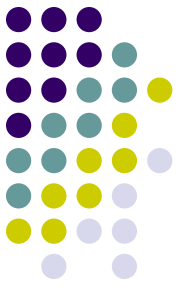
Characteristics of PTSD



Developmental Variations

- School-age children
 - Reactions tend to be more directly connected to crisis event.
 - Event specific fears may be displayed.
 - Reactions are often expressed behaviorally.
 - Feelings associated with the traumatic stress are often expressed via physical symptoms.
 - Trauma related play (becomes more complex and elaborate).
 - Repetitive verbal descriptions of the event.
 - **Problems paying attention.**

Characteristics of PTSD



Developmental Variations

- Preadolescents and adolescents
 - More adult like reactions
 - Sense of foreshortened future
 - Oppositional/aggressive behaviors to regain a sense of control
 - School avoidance
 - Self-injurious behavior and thinking
 - Revenge fantasies
 - Substance abuse
 - **Learning problems**

Cultural Considerations



- Interpretation of events
- Role of religion
- Role of extended family
- Different interpretations of mental health symptoms
- Cultural norms around expression of grief
- Willingness to disclose/cultural norms around expression of emotions



Differential Considerations

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

DSM 5 Changes

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

Acute Stress Disorder



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

DSM 5 Changes



	Changes from DSM-IV-TR to DSM-5	Rationale for Changes	Consequences of Changes	Implications for School Psychologists
Acute Stress Disorder	<ul style="list-style-type: none"> • Must be explicit if experienced directly. Witnessed or experienced indirectly • Minimized emphasis on dissociative disorders 	<ul style="list-style-type: none"> • Better describe the cognitive, emotional, behavioral, and functional implications of PTSD • Gives more specific examples to clarify and also make more culturally appropriate 	<ul style="list-style-type: none"> • Provided better examples for each of the criteria to clarify 	<ul style="list-style-type: none"> • Understand the differences between ASD and PTSD (ASD only within the first month of event & more focus on dissociative symptoms) • Need to be well informed of proven therapies to help if a referral is needed • Does ASD develop into PTSD?



Adjustment Disorders

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

DSM 5 Changes



Adjustment Disorders

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

Characteristics of PTSD



DSM-5

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

Characteristics of PTSD



DSM-5

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

Consequences of PTSD



- **Conditions Co-morbid with Child PTSD**

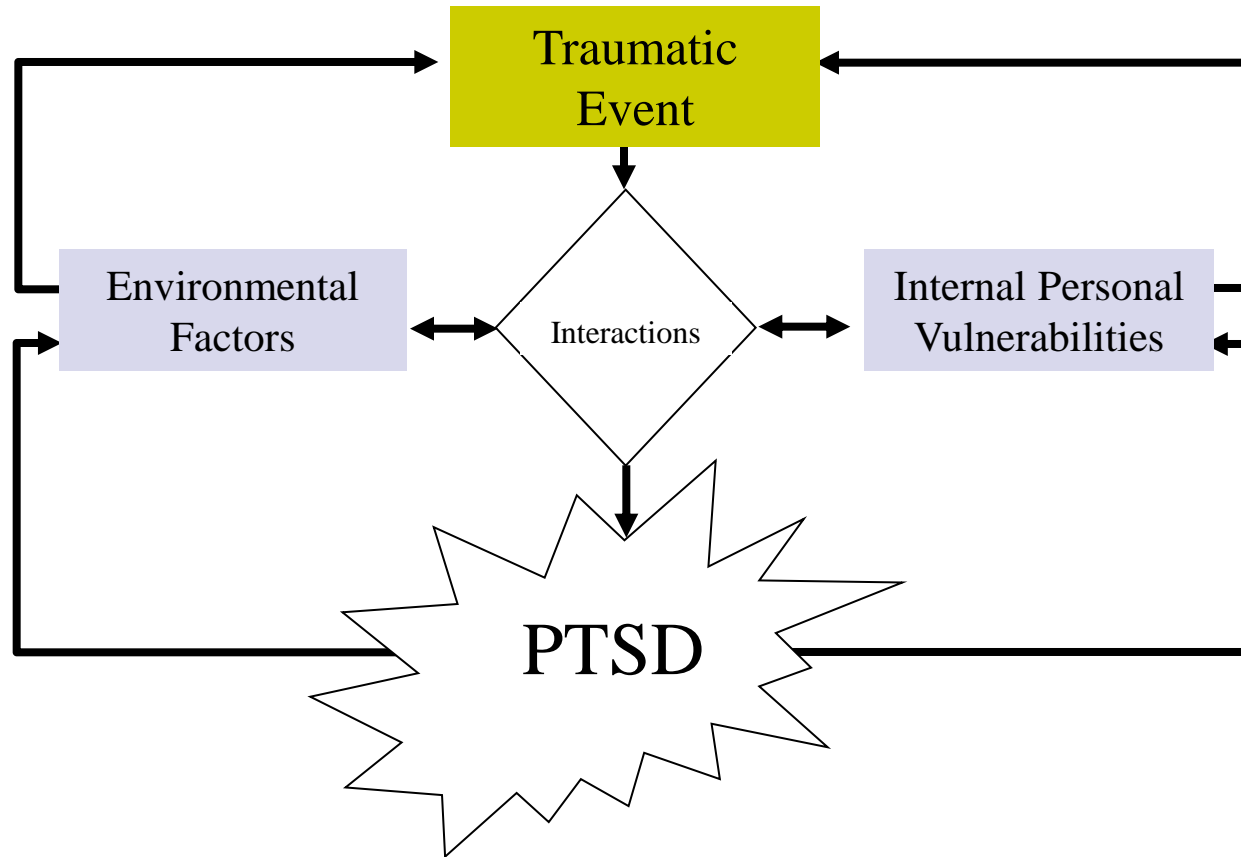
- AD/HD
- Depression
- Obsessive/Compulsive Disorder
- Oppositional/Defiant Disorder
- Anxiety Disorder
- Conduct Disorder



Seminar Outline

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- Causes of PTSD
- Identification/Assessment of PTSD
- Preventing/Mitigating PTSD
- Responding to PTSD

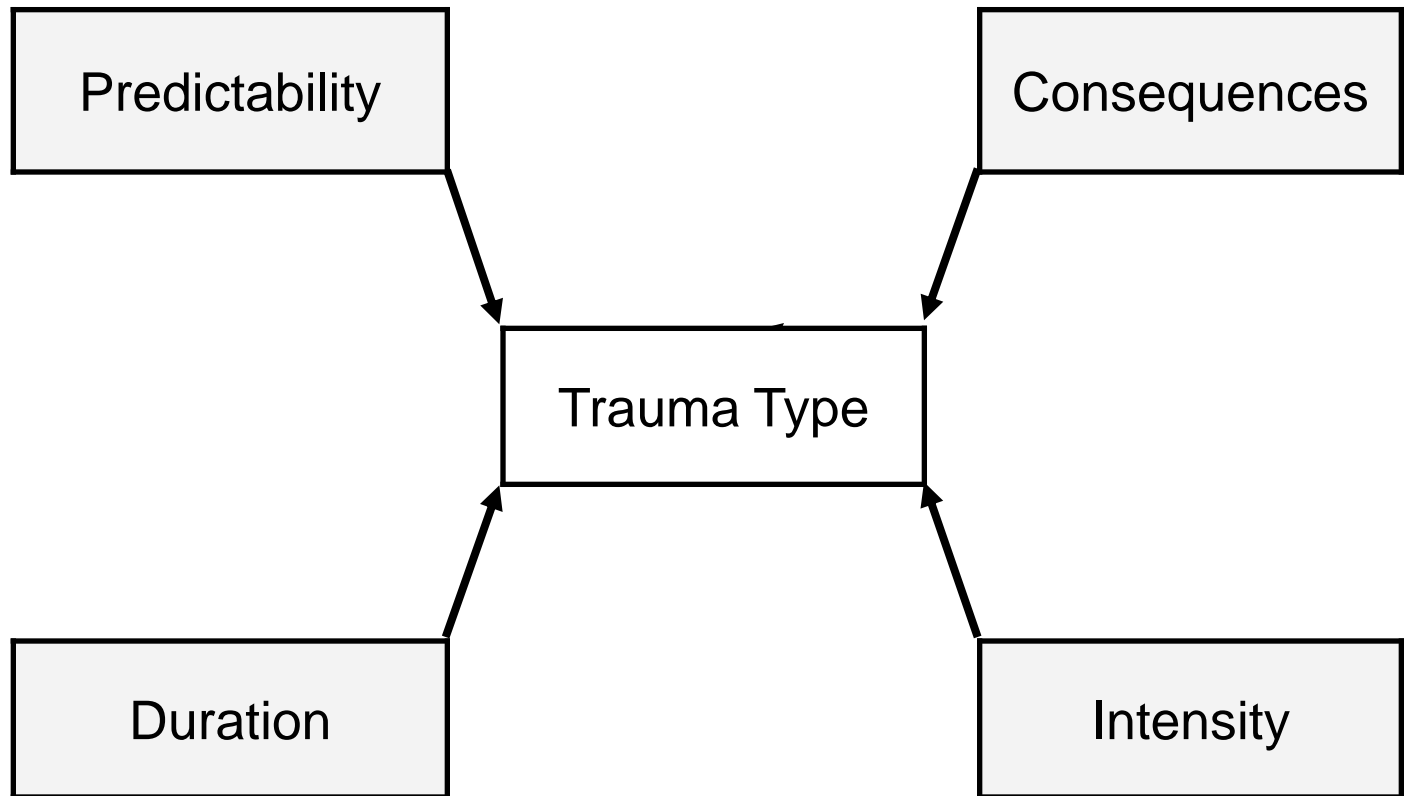
Causes of PTSD



Causes of PTSD



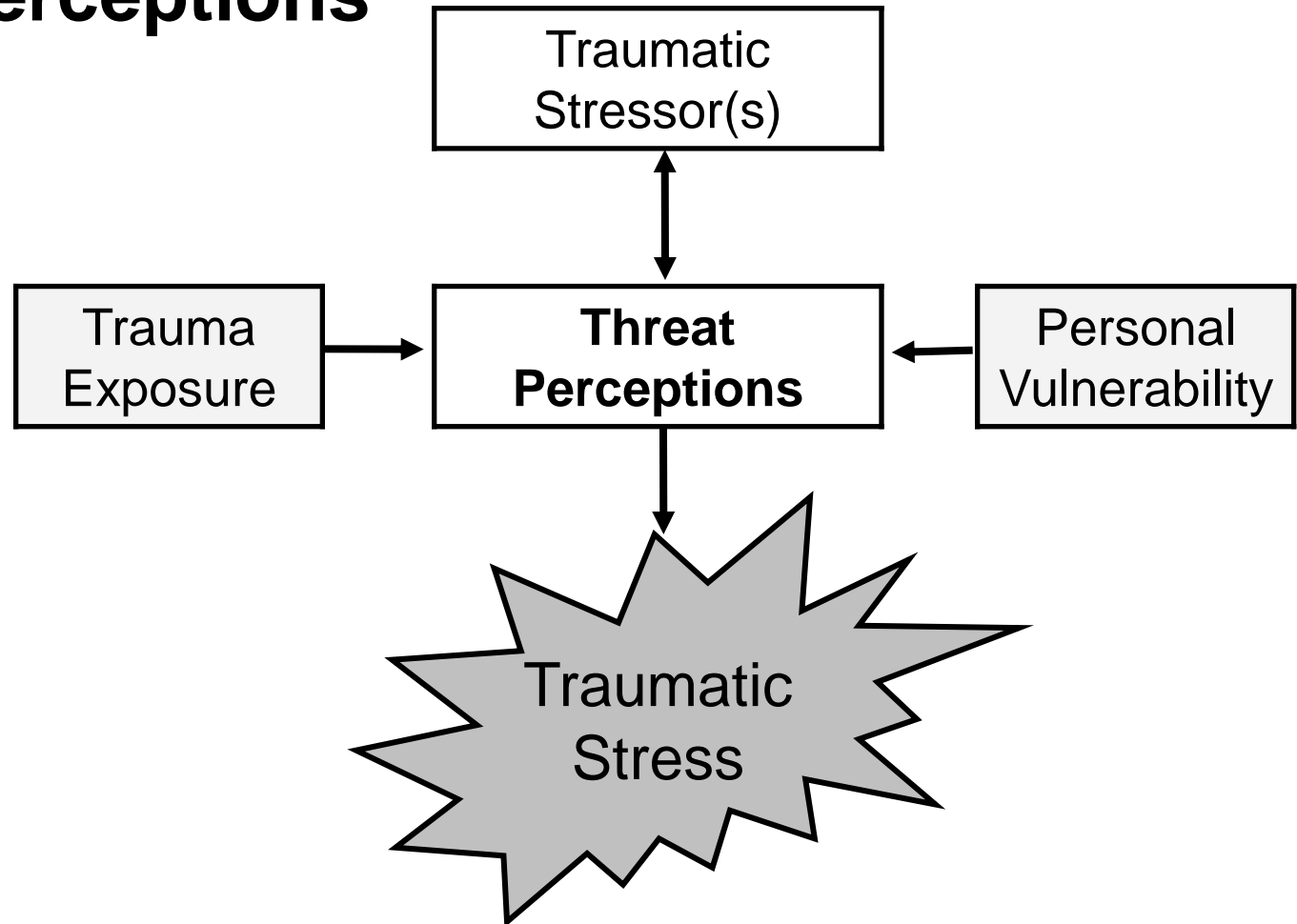
Traumatic Stressor



Causes of PTSD



Threat Perceptions





Causes of PTSD

Threat Perceptions

- Personal Vulnerabilities

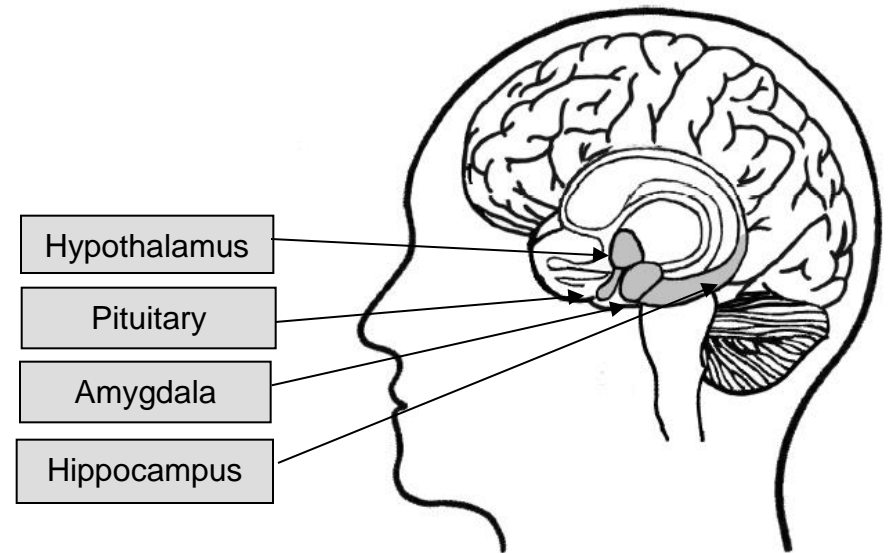
- Internal Personal Factors

- Psychological

- Initial Reactions
- Mental Illness
- Developmental Level
- Coping Strategies
- Locus of Control
- Self-Esteem

- **Genetic**

- Neurobiological



Causes of PTSD



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

Consequences of PTSD



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

Consequences of PTSD



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

Consequences of PTSD



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

Consequences of PTSD



- PTSD & LD

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



Seminar Outline

- Characteristics of PTSD
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Initial Assessment of PTSD



Crisis Event Type*

- a) Human Caused (vs. Natural)
- b) Intentional (vs. Accidental)
- c) Fatalities

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

Initial Assessment of PTSD

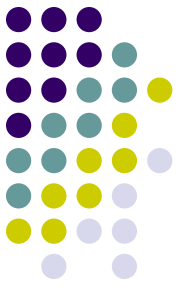


Crisis Exposure*

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

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

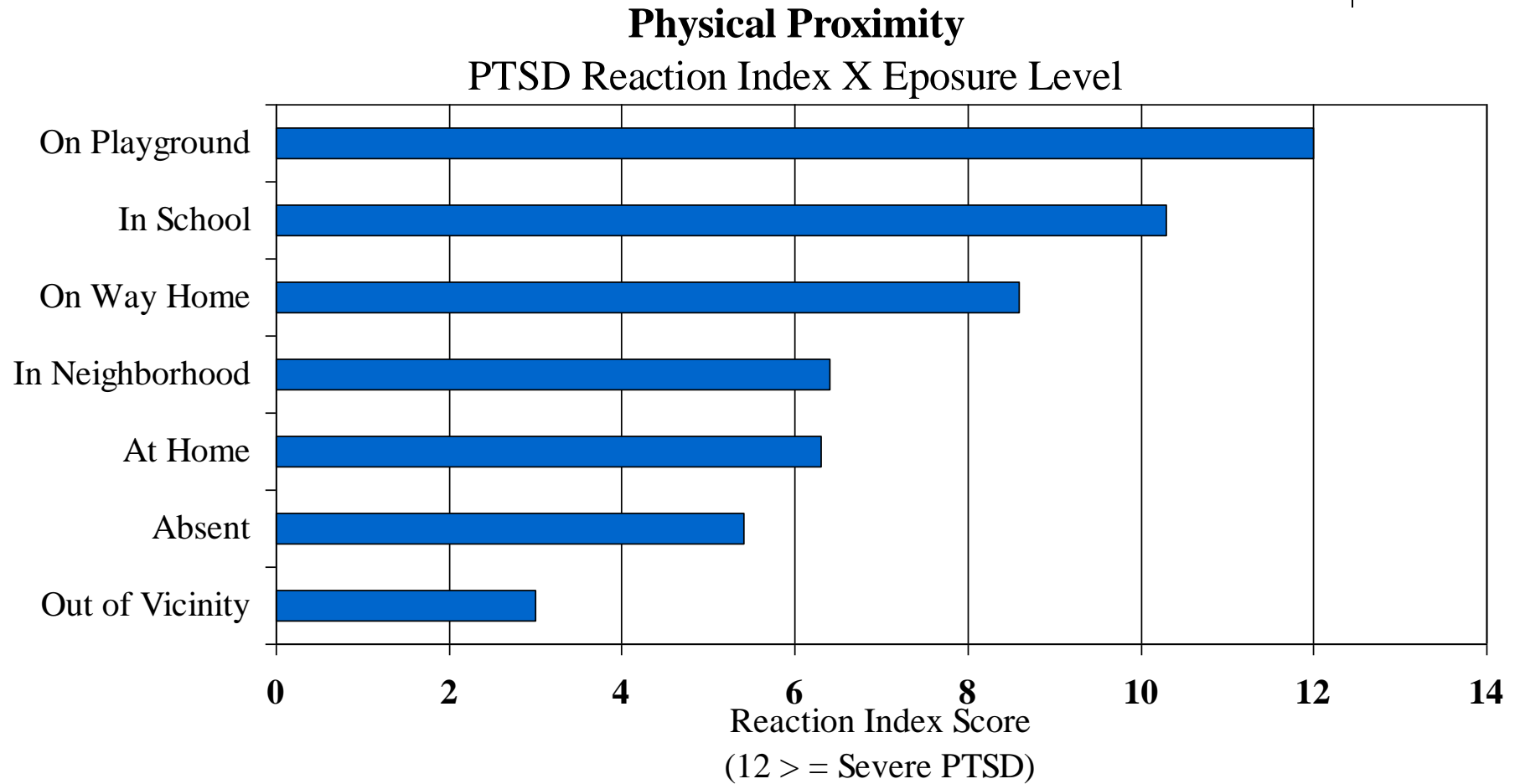
Initial Assessment of PTSD



Physical Proximity

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

Initial Assessment of PTSD



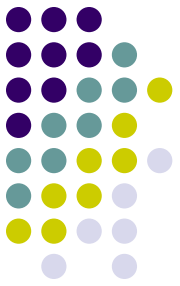
Initial Assessment of PTSD



Emotional Proximity

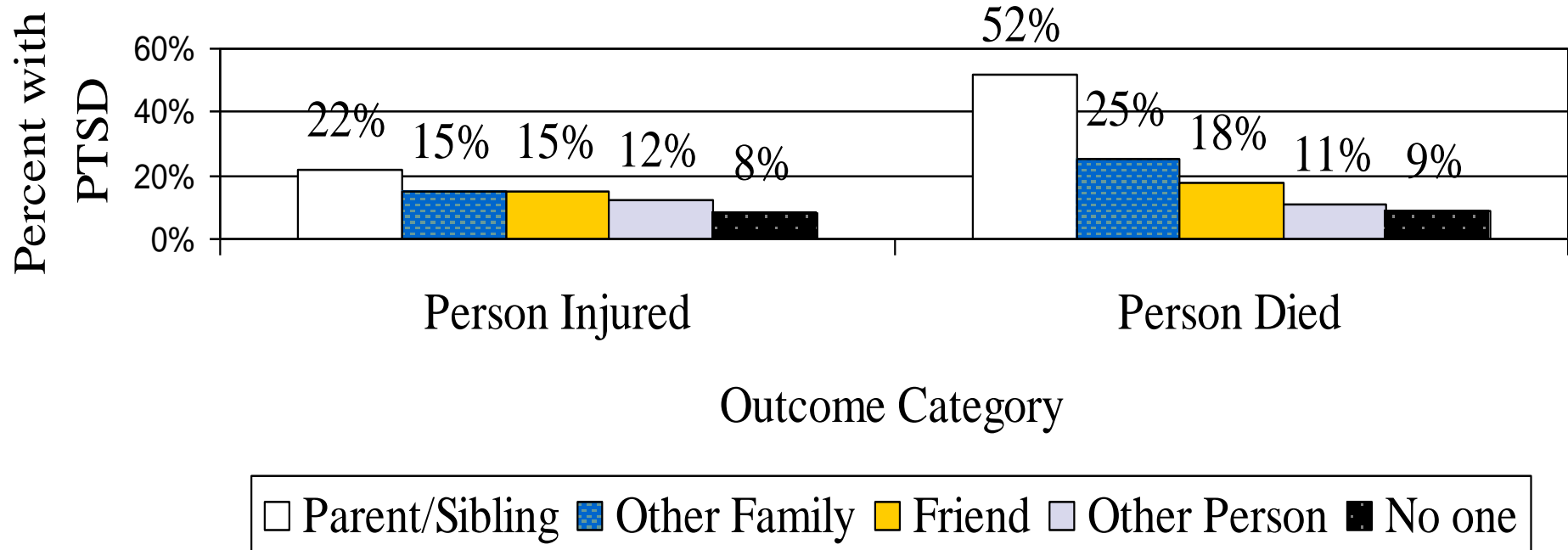
- Individuals who have/had close relationships with crisis victims should be made crisis intervention treatment priorities.
- May include having a friend who knew someone killed or injured.

Initial Assessment of PTSD

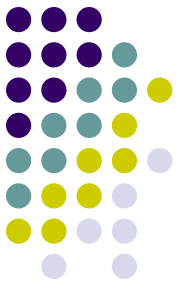


Emotional Proximity

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



Initial Assessment of PTSD



Media/Social Media Exposure

- Children perception's of threat and vulnerability
 - Everyday exposure to news
 - World threats
- Hype vs. facts
- Role of depression and anxiety
- Vicarious Traumatization
- Contagion

Initial Assessment of PTSD



Personal Vulnerabilities*

- Internal vulnerability factors
- External vulnerability factors

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

Initial Assessment of PTSD



Internal Vulnerability Factors

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

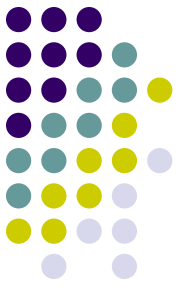
Initial Assessment of PTSD



External Vulnerability Factors

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

Initial Assessment of PTSD



Threat Perceptions*

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

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

Initial Assessment of PTSD



Crisis Reactions*

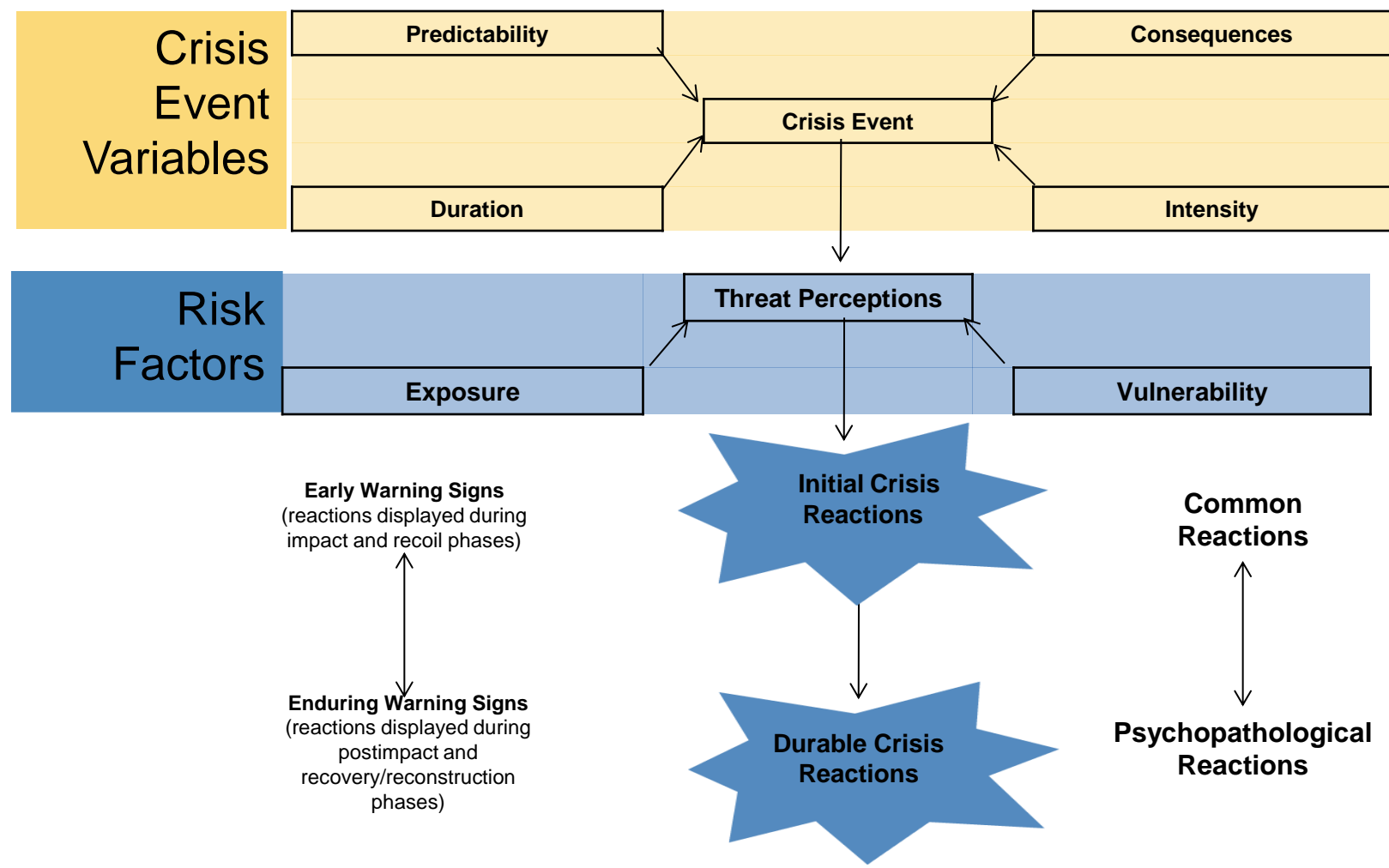
Severe acute stress reactions predict PTSD.
Reactions suggesting the need for an immediate mental health referral

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

*Warning signs that provide concrete indication of psychological trauma



Initial Assessment Trauma Exposure



Initial Assessment of PTSD



Multi-Method & Multi-Source

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

Initial Assessment of PTSD



Primary Evaluation of Psychological Trauma

- Takes place immediately after the crisis

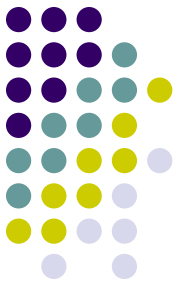
Secondary Evaluation of Psychological Trauma

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

Tertiary Evaluation of Psychological Trauma

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

Identification/Assessment of PTSD



Warning Signs

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

Identification/Assessment of PTSD



Warning Signs: Preschoolers

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

Identification/Assessment of PTSD



Warning Signs: School-aged

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

Identification/Assessment of PTSD



Warning Signs: Adolescents

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

Identification/Assessment of PTSD



Assessment and Evaluation

● Screening

- Trauma Symptom Checklist for Young Children
- Trauma Symptom Checklist of Children
- Child PTSD Symptoms Scale
- Parent Report of Posttraumatic Symptoms
- Child/Adolescent Report of Posttraumatic Symptoms
- Children's Reactions to Traumatic Events Scale
- Children's PTSD Inventory
- Pediatric Emotional Distress Scale
- UCLA PTSD Reaction Index of DSM-IV
- <http://safesupportivelearning.ed.gov/topic-research/school-climate-measurement/school-climate-survey-compendium>

Identification/Assessment of PTSD



Assessment and Evaluation

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

Identification/Assessment of PTSD



Assessment and Evaluation

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

Identification/Assessment of PTSD



Assessment and Evaluation

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

Identification/Assessment of PTSD



Assessment and Evaluation

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

Identification/Assessment of PTSD



Assessment and Evaluation

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

Identification/Assessment of PTSD



Assessment and Evaluation

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

Identification/Assessment of PTSD



Assessment and Evaluation

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

Identification/Assessment of PTSD



Assessment and Evaluation

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



Seminar Outline

- Characteristics of PTSD
 - *DSM-5*
 - Developmental Variations
 - Manifestations at School
- Causes of PTSD
- Identification/Assessment of PTSD
- Preventing/Mitigating PTSD
- Responding to PTSD

A Framework for Safe and Successful Schools



<http://www.nasponline.org/resources/framework-safe-and-successful-schools.aspx>

A Framework for School-Wide Bullying Prevention and Safety



National Association of School Psychologists

Helping children achieve their best.
In school. At home. In Life.



http://www.nasponline.org/resources/Bullying/Bullying_Brief_12.pdf

Preventing/Mitigating PTSD



Strengthen Resiliency

● Internal Resiliency

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



Preventing/Mitigating PTSD



Strengthen Resiliency

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



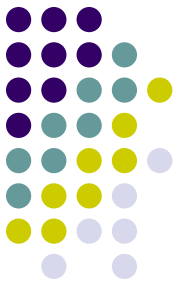
Preventing/Mitigating PTSD



Ensure Objective/Psychological Safety

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





Preventing/Mitigating PTSD

Minimize Trauma Exposure

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



Preventing/Mitigating PTSD



Shape Traumatic Event Perceptions

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

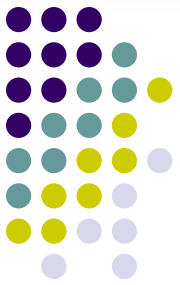


Mitigating: Creating Trauma Informed Schools



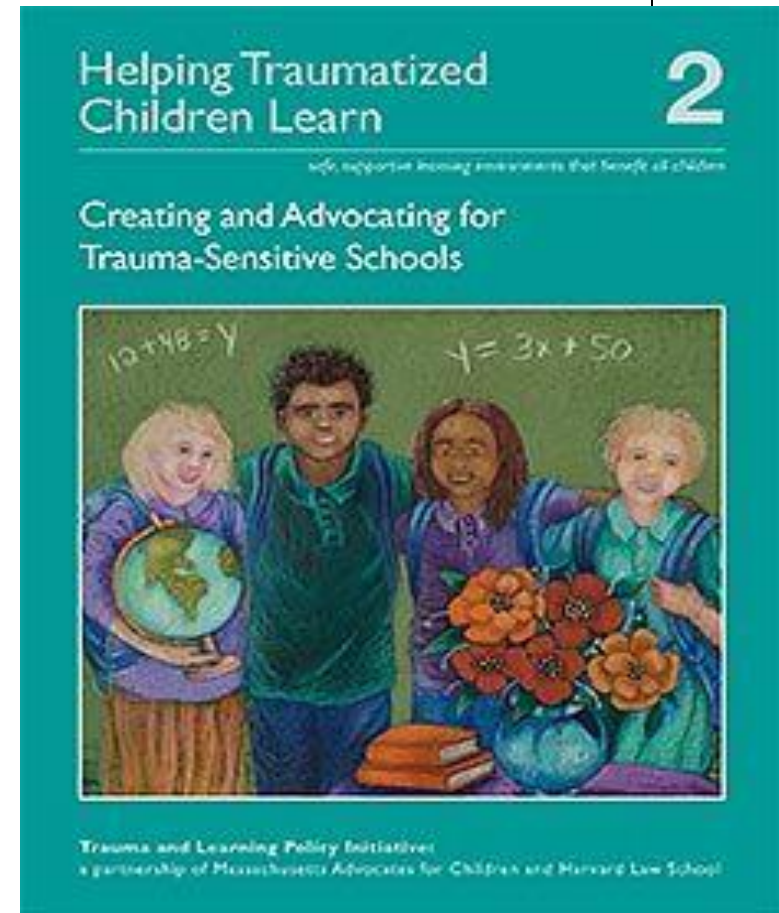
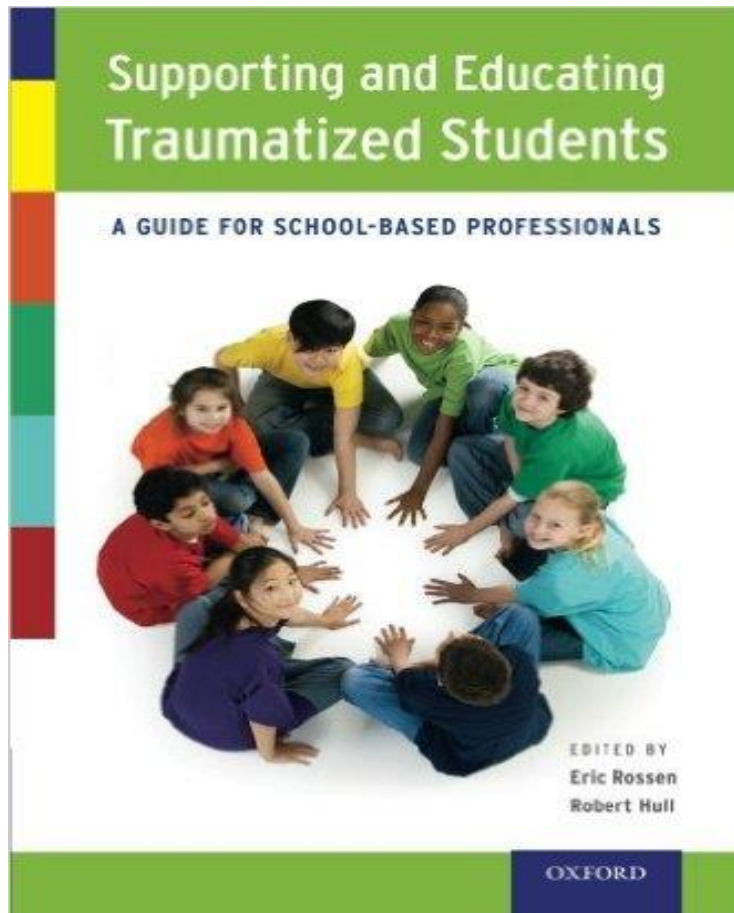
1. A shared understanding among all staff
2. The school supports all children to feel safe physically, socially, emotionally, and academically.
3. The school addresses students needs in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional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

Trauma Informed School



1. A shared understanding among all staff
2. The school supports all children to feel safe physically, socially, emotionally, and academically.
3. The school addresses students needs in holistic ways, taking into account their relationships, self-regulation, academic competence, and physical and emotional well-being.
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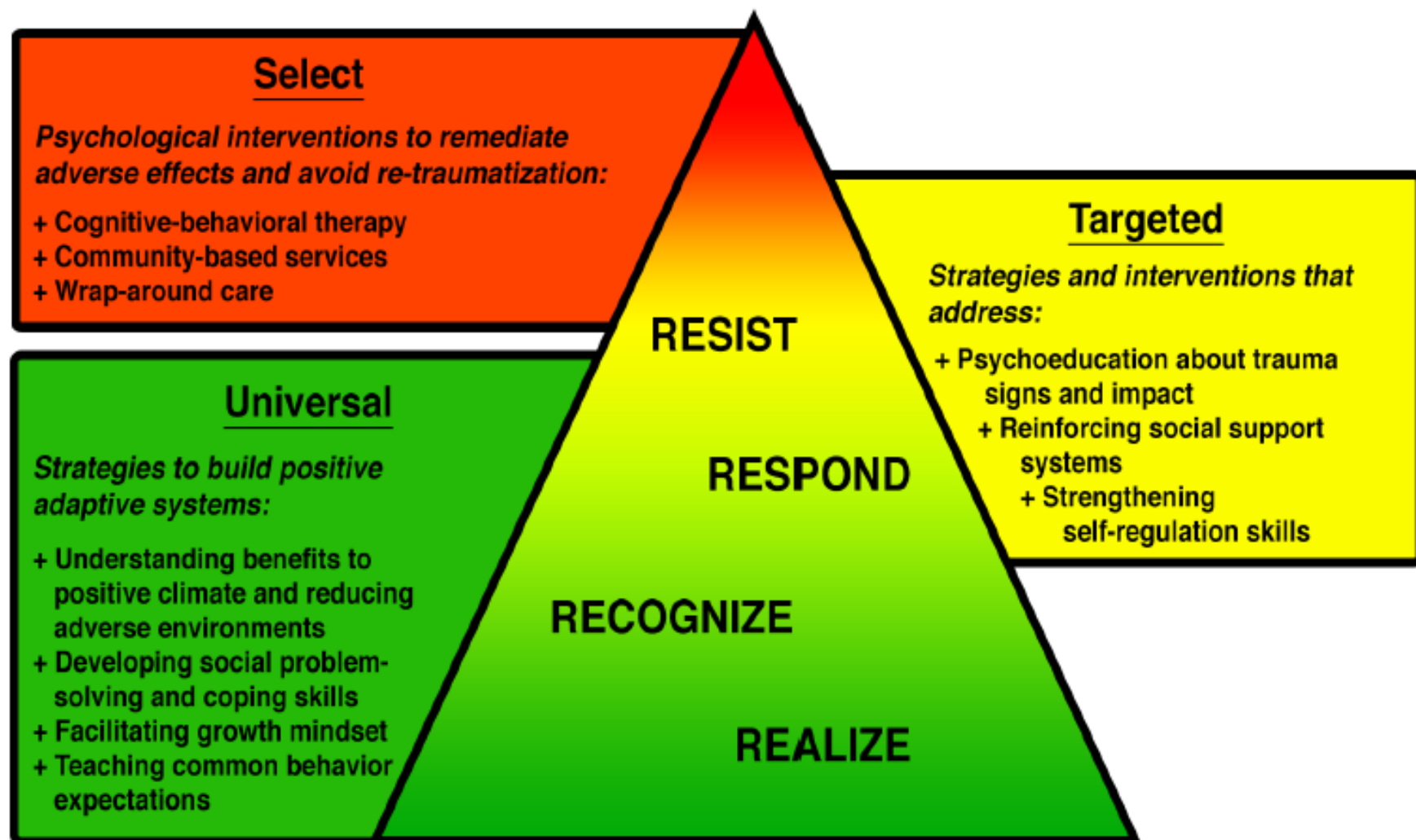
Creating Trauma Informed Schools



Approx \$57 – order online

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

Creating Trauma-Informed Schools



Creating Capacity for Trauma-Informed School Schools

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

Screenings



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

School-Based Interventions



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



Seminar Outline

- Characteristics of PTSD
 - *DSM-5*
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- Identification/Assessment of PTSD
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- Responding to PTSD

School-Based Interventions



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

Levels of School Crisis Interventions



Tier 3
Psycho-
therapy

Tier 2
Individual Crisis Intervention
Classroom-Based Crisis
Intervention
Student Psychoeducational
Groups

Tier 1
Caregiver Trainings
Classroom Meetings
Informational Bulletins, Flyers, and Handouts
Reestablishing of Social Support Systems
Evaluation of Psychological Trauma
Ensured Perceptions of Security & Safety
Reaffirmation of Physical Health

PREPaRE WS2 teaches
participants how to conduct Tier 1
& Tier 2 interventions; discusses
Tier 3

School-Based Interventions



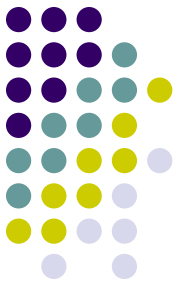
- Maintain academic and behavioral standards
- Discourage avoidance
- Encourage sharing
- Help students cope with triggers
- Empower
- Increase sense of worth (unconditional positive regard)
- Improve sense of control and autonomy
- Effective discipline practices

School-Based Interventions



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

School-Based Academic Interventions



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

School-Based Academic Interventions



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

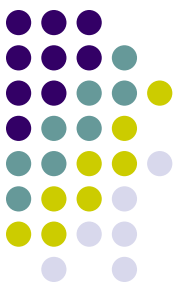
School-Based Academic Interventions



Executive Functioning (cont.)

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

School-Based Academic Interventions



Executive Functioning (cont.)

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

School-Based Academic Interventions



Executive Functioning (cont.)

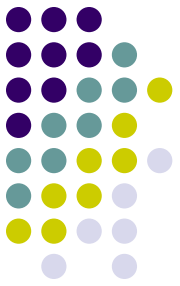
- Monitoring = ability to check for accuracy
 1. Model, teach, and practice use of monitoring routines
 2. Prompt student if they fail to self-cue
 3. Provide opportunities for guided practice

School-Based Interventions



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

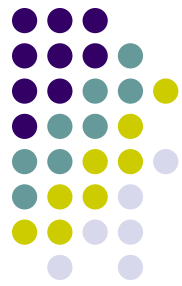
Psychological Interventions for PTSD



Group Approaches

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

C-BITS: Cognitive Behavioral Interventions for Trauma in Schools



- CBITS teaches six cognitive-behavioral techniques:
 - Education about reactions to trauma
 - Relaxation training
 - Cognitive therapy
 - Real life exposure
 - Stress or trauma exposure
 - Social problem-solving
- Includes two parent education sessions and one teacher education.
- Average = 10 sessions
- Reduces symptoms of PTSD depression, behavior prob

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

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

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

Behavioral Regulation: *Zones of Regulation*



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

<http://www.zonesofregulation.com>

THE
ZONES OF
REGULATION®

A CURRICULUM DESIGNED
TO FOSTER SELF-REGULATION AND
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Written and Created by
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Foreword and Selected Lessons by
Michelle Garcia Winner



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<http://kimochiseducation.tumblr.com/curriculum>



he Fourth R ... c and RELATIONSHIPS



THE KIMOCHIS™ EDUCATOR'S TOOL KIT

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

THE KIMOCHIS® MIXED BAG OF FEELINGS

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



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Cloud's Best Worst Day Ever

Bug Makes a Splash!

Cat's Not So Perfect Sandcastle

Kimochis



CLOUD is a bit moody and unpredictable.



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



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



HUGGTOPUS is friendly, affectionate and sometimes too silly.



LOVEY DOVE is nurturing and patient, but can get overly worried.

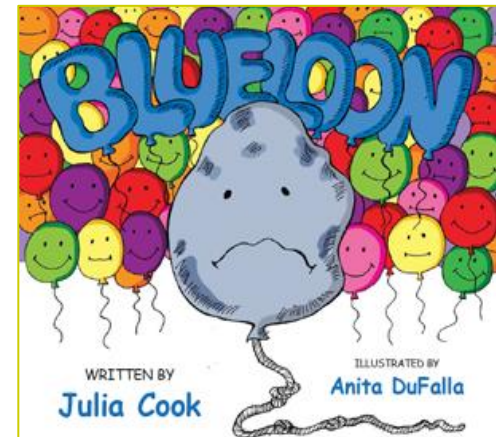
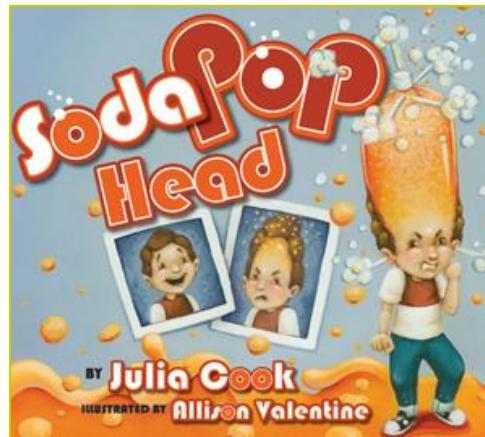
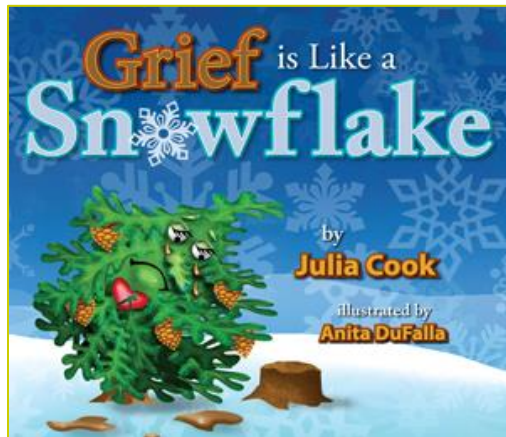
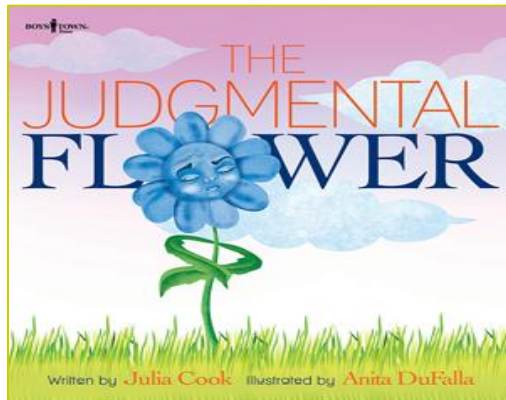


BELLA ROSE is sensitive and sweet and closes up like a bud when her feelings get hurt.



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

Bibliotherapy



<http://www.juliacookonline.com/books/>

Another good source: Dawn Huebner <http://www.dawnhuebnerphd.com/Books.aspx>

Intensive School and Community Supports



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

Systems of Care



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

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

Wraparound Services



10 Essential Elements of Wraparound Services:

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

Responding to PTSD



Psychotherapeutic Interventions

- Empirically Supported **Cognitive-Behavioral Approaches**
 1. Exposure Therapy
 2. Cognitive Restructuring
 3. Stress Inoculation Training
 4. Anxiety Management Training
 5. Trauma Focused CBT

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

Carr (2004), Dyregrov & Yule (2006), Feeny et al. (2004), Nickerson et al. (2009), NIMH (2007)

Responding to PTSD



Other Approaches

- Eye Movement Desensitization and Reprocessing (EMDR)
 - Uses elements of cognitive behavioral and psychodynamic treatments
 - Employs an Eight-Phase treatment approach
 - Principals of dual stimulation set this treatment apart: tactile, sound, or eye movement components
 - More efficient (less total treatment time)
 - Reduces trauma related symptoms
 - Comparable to other Cognitive Behavioral Therapies
 - Suggested to be more effective than Prolonged Exposure
 - *Limited research with children*
 - *No school-based research*
 - *Referral to a trained professional is required*
- Narrative Exposure Therapy
- Art Therapy

Responding to PTSD



Psychotherapeutic Interventions

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Responding to PTSD

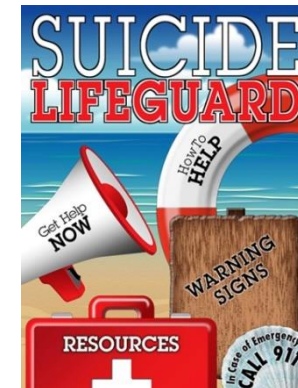
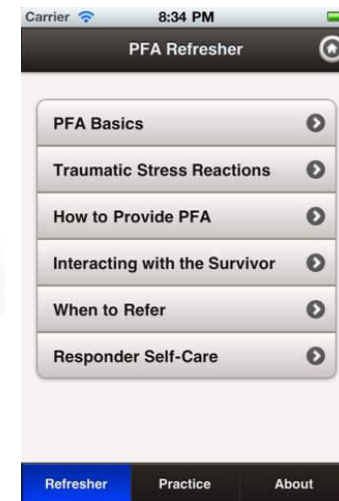
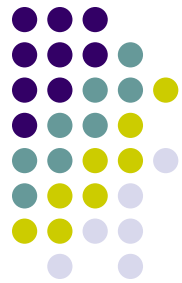
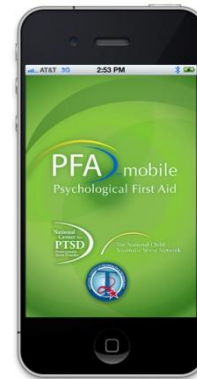


Psychotherapeutic Interventions

- Medication
 - Limited research
 - Imipramine
 - “Without more and better studies documenting good effects and absence of serious side-effects, we urge clinicians to exercise extreme caution in using psycho-pharmacological agents for children, especially as CBT-methods are available to reduce posttraumatic symptoms and PTSD”

Dyregrov & Yule (2006, p. 181)

Apps



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

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

Online Resources



- National Association of School Psychologists
 - <https://www.nasponline.org/resources-and-publications/resources/school-safety-and-crisis>
- Coalition to Support Grieving Students
 - <https://grievingstudents.org/>
- National Center for Traumatic Stress Network
 - <http://www.nctsn.org/>
- Sesame Street – Toolkits
 - Grief, Resilience, Military, Emergency Prep, After an Emergency, etc.
 - <http://www.sesamestreet.org/toolkits>

NASP Online: Trauma Resources

- Podcasts:
 - *Trauma 101: Preparing Your School for Trauma-Informed Service Delivery*
 - *NASP Dialogues: Helping Schools Support Grieving Students*
 - *Supporting and Educating Traumatized Children*
 - *After a Suicide: Guidelines for Schools*
 - *School Psychology Review: Highlights - CBITS in Schools*
- Online Learning Center:
 - *Suicide Risk Assessment*

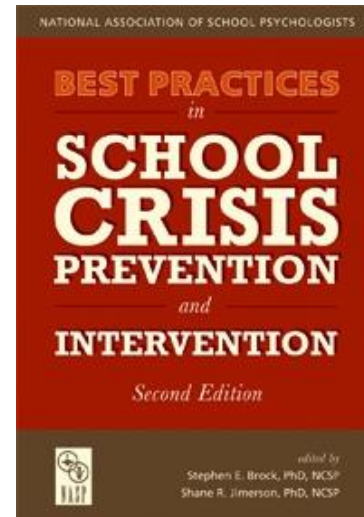
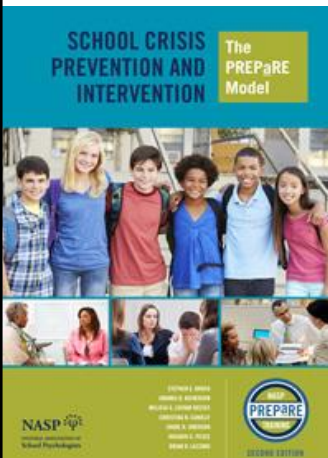
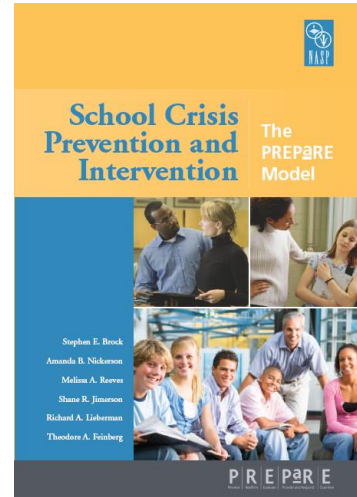
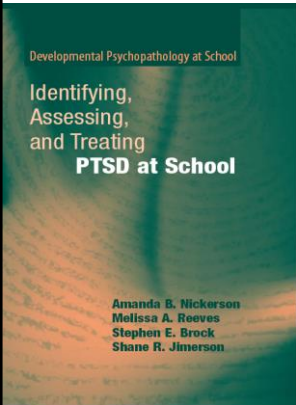
Trauma Resources

Nickerson, A. B., Reeves, M. A., Brock, S. E., & Jimerson, S. R. (2009). *Assessing, identifying, and treating posttraumatic stress disorder at school*. New York: Springer.

Brock, S. E., Nickerson, A. B., Reeves, M. A., Jimerson, S. R., Lieberman, R., & Feinberg, T. (2009). *School crisis prevention and intervention: The PREPaRE model*. Bethesda, MD: NASP.

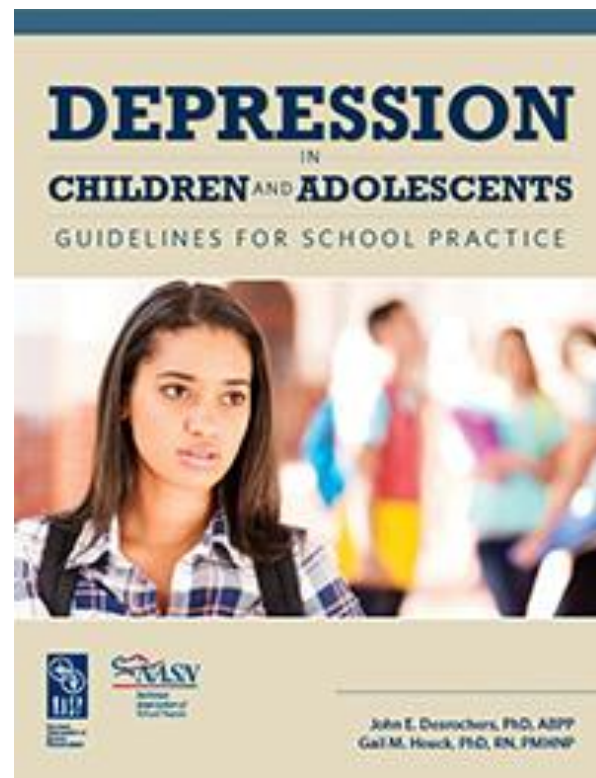
Brock, S. E., Nickerson, A. B., Louvar Reeves, M. A., Conolly, S., Jimerson, S., Pesce, R., & Lazarro, B. (2016). *School crisis prevention and intervention: The PREPaRE model (2nd Ed.)*. Bethesda, MD: National Association of School Psychologists.

Brock, S.E. & Jimerson, S. (2012). *Best Practices in School Crisis Prevention & Intervention (2nd Ed.)*. Bethesda, MD: NASP.



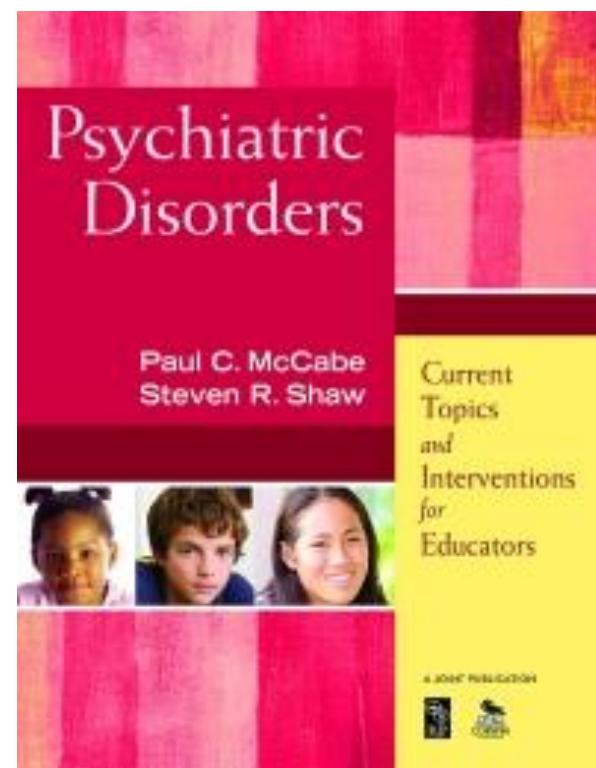
NASP Publication: Depression in Children and Adolescents

- Action steps tailored to your school environment
- Directions for incorporating mental services into a Response to Intervention (RTI) framework
- Concrete descriptions of specific assessment tools and interventions
- Tips for improving school team and school-community collaboration
- How-to guidance linking prevention and intervention efforts
- Brief, easy-to-read theory and research
- Extensive recommended resources



NASP Publication: Psychiatric Disorders

- Written for school psychologists, counselors, administrators, and teachers
- Neuropsychiatric conditions that commonly affect children, including Tourette syndrome, bipolar/mood disorders, and anxiety disorders
- Psychopharmacology and side effects
- Dietary control and supplemental treatments
- Featuring case studies, strategies for educators, discussion questions, glossaries, and handouts,



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