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

Texas Association of School Psychologists
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With contributions from Dr. Stephen Brock

Objectives

- From participation in this workshop participants will...
  1. increase their understanding of the impact of traumatic events on children and adolescents
  2. become familiar with specific trauma exposure and PTSD symptoms
  3. 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

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

Buka et al., 2001; Costello et al., 2003; Dynegy & Vux, 2006; Swedo et al., 2004; APA (2013); NCTSN (2016)
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.

- 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

Period, Turkey, Carlson, Tiihonen, & Satin Gilles (2010)
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

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

Mental Health Consequences

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

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

Need for Mental Health Supports

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

Role School MH Professional

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

Cook-Cattone (2004)


- 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 ones physical integrity.

"does not include exposure via electronic media"

APA (2013)

Characteristics of PTSD

DSM-5

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

APA (2013)

Characteristics of PTSD

DSM-5

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

APA (2013)

Characteristics of PTSD

DSM-5

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

APA (2013)
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

- 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

**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

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

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

  Problems paying attention.


Characteristics of PTSD

Developmental Variations

● Preadolescents and adolescents
  A. More adult like reactions
  B. Sense of foreshortened future
  C. Oppositional/aggressive behaviors to regain a sense of control
  D. School avoidance
  E. Self-injurious behavior and thinking
  F. Revenge fantasies
  G. Substance abuse
  H. 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

DSM 5 Changes

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
<th>Implications for School Psychologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>Better description of cognitive, emotional, behavioral, and functional implications of PTSD</td>
<td>Still no clear definition of a traumatic event - may use adult criteria for elementary and secondary age students</td>
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<tr>
<td></td>
<td>Focus more on reaction to trauma rather than uncovering temperamental vulnerability to stress</td>
<td>Can provide validation for reactions to adversity/trauma</td>
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<td></td>
<td>Maintain boundary with normality is blurred</td>
<td>Has led to school-based intervention that help minimize PTSD symptomology</td>
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<tr>
<td></td>
<td>More heterogeneity so research is challenging</td>
<td>For preschoolers – has allowed for more age and developmentally sensitive diagnostic criteria</td>
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</tbody>
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Acute Stress Disorder

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

Adjustment Disorders

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

Other causes of flashbacks

Perceptual distortions come from substance use, head injury, Bipolar or Depressive Disorder, or Psychotic Disorder

Malingerers

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

Characteristics of PTSD

DSM-5

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

APA (2013)

Characteristics of PTSD

DSM-5

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

APA (2013)

Consequences of PTSD

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

APA (2013)

Seminar Outline

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  - Preventing/Mitigating PTSD
  - Responding to PTSD

Causes of PTSD

Nickerson et al., (2009)
Causes of PTSD

- Traumatic Stressor
  - Predictability
  - Consequences
  - Trauma Type
    - Duration
    - Intensity

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

Threat Perceptions

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

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

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)

Nickerson et al., (2009)
**Consequences of PTSD**

- Emotional and behavioral consequences depend 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**

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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.

**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**

**Physical Proximity**

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

**Reaction Index Score**

(12 \( \geq \) Severe PTSD)

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**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.

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**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.

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**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

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**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
**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

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

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

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**Crisis Reaction**
Severe acute stress reactions predict PTSD.
- 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*

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**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."

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**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


Identification/Assessment of PTSD

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

Pfohl et al. (2002)

Identification/Assessment of PTSD

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

Pfohl et al. (2002)

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

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

Identification/Assessment of PTSD

Assessment and Evaluation
● Diagnosis
   • Background Information
     • www.csus.edu/indiv/b/brocks/Courses/EDS%20243/student_materials.htm
   • Interviews
     • Students
     • Caregivers

Nickerson et al. (2009)
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
  - Self-Report Measures
    - Impact of Events Scale
    - Child Post-Traumatic Stress Disorder Inventory
    - Child PTSD Symptoms Scale
    - Social Support Scale for Children and Adolescents
    - KidCope
  - Support and Coping
    - Social Support Scale for Children and Adolescents
    - KidCope

- 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

- Differential Diagnosis from disorders not associated with trauma exposure.
  - ADHD
  - Oppositional Defiant Disorder
  - Borderline Personality Disorder

- 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

- 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

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?

- 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?

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

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Dr. Melissa Reeves

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)

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.
4. The school explicitly connects students to the school community and provides multiple opportunities to practice newly developing skills
5. The school embraces teamwork and staff share responsibility for all students.
6. Leadership and staff anticipate and adapt to the ever-changing needs of students.

Creating Trauma Informed Schools

Approx $57 – order online

Free download: http://traumasensitiveschools.org/tlpi-publications/
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 systemwide 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

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

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

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

Reeves (2008)

Levels of School Crisis Interventions

Type 1
- Caregiver, Classrooms
- Electronic Meetings
- Informational Bulletins, Home, and Household
- Implementing of Social Support Systems
- Teachers, Staff, and Students
- Financial Perceptions of Security & Safety
- Reaffirmation of Physical Health

Type 2
- Individual Crisis Intervention
- Classroom-Based Crisis Intervention
- Student Psychosocial Groups

Type 3
- Tier II General to School Wide, Community, & More

PREPARE 2011 - NASP
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

Nickerson et al. (2009)

School-Based Interventions

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

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

School-Based Academic Interventions

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

School-Based Academic Interventions

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

Reeves (2008)

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/

**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.

**Kimochis:**

http://kimochiseducation.tumblr.com/curriculum

http://www.zonesofregulation.com


Einholt et al. (2005) 111

Jaycox, et al 2010

Jaycox, et al 2010
**Intensive School and Community Supports**

- Intensive School Interventions
  - Individual Counseling
  - Functional Behavioral Assessment
  - Special Education Consideration
  - Individualized Behavior Plan
  - More restrictive environment

- Intensive Community Interventions
  - Long Term Therapy
  - Family Counseling
  - Involvement with Social Services
  - Community Mentoring

**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 to 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
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
  - More efficient (less total treatment time)
  - Reduces trauma related symptoms
  - Comparable to other Cognitive Behavioral Therapies
  - Suggested to be more effective than Prolonged Exposure

- Narrative Exposure Therapy
- Art Therapy

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)

Psychotherapeutic Interventions
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Eshtholt et al. (2005)

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
- 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
Dr. Melissa Reeves

Trauma Resources


References


## References


