Welcome! Take the SP Traumatic Stress Training survey

https://tinyurl.com/y7pl63t8

Trauma-Informed Assessment and Intervention

Julia Englund Strait, PhD
Texas Association of School Psychologists (TASP) Summer Institute
June 22, 2018 Texarkana, AR
TASP SHORT SESSION DESCRIPTION:
In a recent pilot survey, 82% of school psychologists reported having worked with students who experienced potentially traumatic event(s) in the past year. Unfortunately, many current models of acute crisis management and prevention do not adequately address the needs of students with complex trauma histories. School psychologists can play a vital role in addressing students’ traumatic stress and helping other educators understand how it impacts development, learning, and behavior. You will learn how traumatic stress impacts children’s cognitive, academic, social, emotional, and behavioral functioning; review evidence-based interventions; and use a research-based framework to understand and recommend appropriate interventions for children affected by complex trauma.

Grade Levels: PreK-12
Audience: Beginner to Advanced
NASP Practice Domains: 2, 4

Road map

• How this training came about
• Background
  • Trauma concepts and definitions
• Impact
• Changing the narrative
  • Available interventions
• The ARC model
  • Conceptualization and assessment
  • Interventions and strategies
How this training came about...

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226 - In the past calendar year, I have worked with or consulted with teachers/caregivers regarding a student who expe...
I would rate my **education and training** in trauma-related service delivery (e.g., direct assessment and intervention) as...

![Bar chart with 50% Minimal (I have some exposure) and 17% Adequate]

- None (I have little or no information about this topic)
- Minimal (I have some exposure)
- Adequate
- Expert level (I consider this a mastery/specialty area of mine)

n = 105 total responses to this question
What would you need to provide trauma-informed care in your school setting?
Background: Trauma Concepts and Definitions

No consensus on definition/terms
Defining “TRAUMA”: SAMHSA

3 parts:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

Trauma Reactions – SAMHSA’s 3 “E”s

Event → Experience → Effect(s)
Note: Crisis vs. trauma

Crisis
- Event exposure (potentially traumatic)
- Acute (short-lived) → immediate task is to recover and return to normalcy
- Narrow (does not cover range of possibly traumatic events/experiences)

Event: ACEs
- Adverse
- Childhood
- Experiences
ACEs increase health risks

According to the Kaiser Permanente study, the greater your childhood adversity score, the higher your risk of health problems later in life.

**Behavior**
- Lack of physical activity
- Smoking
- Alcohol use
- Drug use
- Missed work

**Physical & Mental Health**
- Severe obesity
- Diabetes
- Depression
- Suicide attempts
- STDs
- Heart disease
- Cancer
- Stroke
- COPD
- Broken bones

Source: Centers for Disease Control and Prevention

More info on the ACEs study: [https://www.cdc.gov/violenceprevention/acestudy/about.html](https://www.cdc.gov/violenceprevention/acestudy/about.html)


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**Cumulative ACES & Mental Health**

![Cumulative ACES & Mental Health](chart.png)

1. Data from the National Comorbidity Survey-Replication Sample (NCS-R).

CANarratives.org
ACEs increase health risks

**Early death:**
- 6+ ACES – 20 years earlier than 0
- 3-5 ACES – about 6 years earlier
- 2 ACES – about 3 years earlier

More info on the ACES study:  https://www.cdc.gov/violenceprevention/acestudy/about.html

The ACES are Among Many Childhood Traumas and Adversities Measured by the National Child Traumatic Stress Network N=10,991

- 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 experienced 4 or more different types of trauma and adversity.

Our focus: Child Maltreatment

Child Maltreatment

• One of the most impactful:
  • 20 percent to 63 percent in survivors of child maltreatment develop full-blown PTSD
  • as many as 80% of young adults who had been abused met DSM criteria for at least one psychiatric disorder at age 21 (depression, anxiety, eating disorders, suicide attempts, etc.)

• Associated with a developmental cascade of effects
  • Disrupted relationships
  • Disrupted development


How the ACES Work

Adverse Childhood Experiences
- Abuse and Neglect (e.g., psychological, physical, sexual)
- Household Dysfunction (e.g., domestic violence, substance abuse, mental illness)

Impact on Child Development
- Neurobiologic Effects (e.g., brain abnormalities, stress hormone dysregulation)
- Psychosocial Effects (e.g., poor attachment, poor socialization, poor self-esteem)
- Health Risk Behaviors (e.g., smoking, obesity, substance abuse, promiscuity)

Long-Term Consequences

Disease and Disability
- Major Depression, Suicide, PTSD
- Drug and Alcohol Abuse
- Heart Disease
- Cancer
- Chronic Lung Disease
- Sexually Transmitted Diseases
- Intergenerational transmission of abuse

Social Problems
- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- High utilization of health and social services
- Shortened Lifespan

Rates of Maltreatment by Age¹

- Most maltreatment happens to younger children.
- Maltreatment has greater negative effects at younger ages.

Prevalence

• **1 in 4** children suffer abuse or neglect (lifetime).
  - 1 in 7 in the past year
• CPS estimate: 702,000 **confirmed** child victims of abuse and neglect in 2014.

https://www.cdc.gov/violenceprevention/childmaltreatment/consequences.html
“Complex trauma”

- Event exposure and Experience
  - Early ("developing" years, esp. first 3-5 years)
  - Chronic (vs. acute, single-incident trauma)
  - Caregiving system
- Effects: Developmental cascade
  - Attachment/relationships (trust; internal working models)
  - Ability to self-regulate (poor models, co-regulation; biological systems)
  - Pervasive across domains of competency

AKA developmental trauma, complex dev. trauma, interpersonal trauma, chronic maltreatment, etc.

Impact
Traumatic stress impacts learning, development, and behavior.

How? Dysregulation in the Stress Response

Types of stress responses

- **Positive**: A normal and essential part of healthy development
  - Examples: getting a vaccine, first day of school

- **Tolerable**: Response to a more severe stressor, limited in duration
  - Examples: loss of a loved one, a broken bone

- **Toxic**: Experiencing strong, frequent, and/or prolonged adversity
  - Examples: physical or emotional abuse, exposure to violence
How?

Stuck “on” or “off”

How?

1. Experience grows the brain...
   - Lack of experience $\rightarrow$ lack of growth

2. AND... Traumatic stress destroys it.
MALTREATMENT IS ASSOCIATED WITH...

Abnormal levels of cortisol and adrenaline
- Emotional/behavioral reactivity, arousal, stress regulation

MALTREATMENT IS ASSOCIATED WITH...

Overactive/larger amygdala
- Novelty processing (reactivity to new things/changes), threat assessment, memory and recognition for emotional events, stress regulation

Abnormal levels of cortisol and adrenaline
- Emotional/behavioral reactivity, arousal, stress regulation

MALTREATMENT IS ASSOCIATED WITH...

**Decreased Hippocampal Volume**
- Learning and memory
- “Wikipedia of the brain”


MALTREATMENT IS ASSOCIATED WITH...

**Decreased Prefrontal Cortex (PFC)**
- Executive functioning, attention, decision-making, abstract thought, language, behavior/emotion regulation, etc

MALTREATMENT IS ASSOCIATED WITH...

Decreased...
- connections
- overall electrical activity
- overall brain volume
- speed and efficiency of communication across brain areas

Cognitive Endophenotypes (scores)

- Lower overall IQ
- Slower Processing Speed
- Weaker mental flexibility
- Poorer verbal ability, comprehension
- Poorer response inhibition
- Poorer working memory

Sources:
Meta-analysis of school-related outcomes
(506 studies; 1990-2015)

Cognitive
- FSIQ
- Memory (visual, verbal, WM)
- Language/verbal skills
- Attention

Academic
- Engagement
- State standardized tests
- Reading, math scores
- Grades
- Retained
- Absences
- Sped*

Social, Emotional, Behavioral
- Psychiatric disorders
- Externalizing (aggression, hyperactivity, impulsivity, oppositional, conduct)
- Internalizing (depression, anxiety, withdrawal)
- Peer relations
- Prosocial behaviors
- Discipline referrals
- Suspensions

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- Prosocial behaviors
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- Suspensions

Common moderators: alcohol exposure, PTS symptom severity and type (dissociation and arousal)


Changing the Narrative: Available interventions
Science...shows that providing stable, responsive environments for children in the earliest years of life can prevent or reverse these conditions, with lifelong consequences for learning, behavior, and health.

Center on the Developing Child at Harvard University

Changing the narrative

How terrible! It’s so sad. It’s a shame. *Changes channel*

This is awful. I wonder why no one is working to solve this! *SMH at educators, parents, and the government*

This is a big problem, but there are solutions out there. *Gets off couch and does some Googling*
Spoiler alert: The tools to do this are already out there!

Tier I: Trauma Sensitive Schools

- 6 attributes: [https://traumasensitiveschools.org/trauma-and-learning/the-solution-trauma-sensitive-schools/](https://traumasensitiveschools.org/trauma-and-learning/the-solution-trauma-sensitive-schools/)
Tier I:  https://traumaawareschools.org/
Caveat

“Not all things that sound good are effective.”

—Christopher Greeley, MD, MS, FAAP (TCH & Baylor College of Medicine)
Tier II: Evidence Based Intervention Programs

Evidence Ratings
• Trauma- and Stress-Related Disorders and Symptoms
• Depression and Depressive Symptoms
• Non-Specific Mental Health Disorders and Symptoms

Evidence Based Intervention Programs

- [http://nctsn.org/sites/default/files/assets/pdfs/ITCT_general.pdf](http://nctsn.org/sites/default/files/assets/pdfs/ITCT_general.pdf) - An NCTSN Empirically Supported Treatment/Promising Practice
Tier III: Evidence Based Intervention Programs

Evidence Based Intervention Programs
(Selected) NCTSN Core Intervention Components

- **Motivational interviewing** *(to engage clients)*
- **Psychoeducation** about trauma reminders and loss reminders *(to strengthen coping skills)*, and about posttraumatic stress reactions and grief reactions *(to strengthen coping skills)*
- Teaching **emotional regulation** skills *(to strengthen coping skills)*
- Maintaining adaptive **routines** *(to promote positive adjustment at home and at school)*
- Parenting skills and **behavior management** *(to improve parent-child relationships and to improve child behavior)*
- Teaching **safety** skills *(to promote safety)*
- **Advocacy** on behalf of the client *(to improve client support and functioning at school, in the juvenile justice system, and so forth)*

Source: NCTSN [http://nctsn.org/training-guidelines]

But, but, but…

- What if I don’t have the time/$/support/role to implement manualized intervention protocols in my school?
- What if my school isn’t “trauma-informed” yet?
- How can I do this in a way that is…
  - Flexible…
  - But still evidence-informed *(i.e., effective and not harmful)*?
Break 😊

The ARC Model
ARC Theoretical/empirical basis

• Attachment theory
• Empirical literature:
  • child development
  • traumatic stress impact
  • factors promoting resilience

Building a nest around the child
Building a nest around the child

Attachment, Regulation, & Competency (ARC) Model

http://arcframework.org/what-is-arc/
Skills and competencies shown to be negatively impacted by traumatic stress and caregiver disruptions...

which, when addressed, predict resilient outcomes

http://arcframework.org/what-is-arc/
ARC Evidence Base

Depression and anxiety

Internalizing and externalizing behaviors

Caregiver stress

Use of restraints


ARC: Evidence Base

• National Child Traumatic Stress Network (NCTSN) “Promising Practice”

• California Evidence-Based Clearinghouse for Child Welfare (CBEC) not enough evidence yet to rate (2016)

RCT currently underway (outpatient therapy)

http://www.traumacenter.org/research/ARC_Randomized_Controlled_study.php
ARC Pros and Cons

- **Flexible*/adaptable (not manualized, not $$$)
- Specifically for complex trauma
- Translatable to a range of systems (including schools)

**Cons:**
- A longer-term treatment framework.
- Evidence base for full-scale implementation, and applications to schools, still emerging.

Adapted from: NCTSN ARC Factsheet http://nctsn.org/sites/default/files/assets/pdfs/arc_general.pdf

ARC Resources

- [http://arcframework.org/](http://arcframework.org/)
  - *specific school providers forum*
ARC framework applied in schools

1. Integrate ARC **concepts** into understanding of child’s needs (assessment)

2. Apply ARC **strategies** to working with child, teachers, and families (intervention)

Source: [http://arcframework.org/what-is-a-provider/what-are-arc-informed-agencies/](http://arcframework.org/what-is-a-provider/what-are-arc-informed-agencies/)

ARC-guided case conceptualization and assessment
What would your school do with this child?

**Demographics**

- Age 12
- White
- Male but identifies as female
- From rural Southern town

**Learning**

- Ds and Fs across all subjects
- Identified SLD in Reading but recent testing shows math difficulties, as well
- Statewide standardized test scores “Below Basic” in math and reading, “Proficient” in SS and Sci

**Behavior**

- 19 discipline referrals since he transferred here in Oct (it’s now Jan.) – 8 warnings, 5 ISS, 6 OSS
- Disruptive in class (mostly ADHD-related symptoms, e.g., talking, pacing, fidgeting)
- Female students complain he makes sexual comments toward them
- Recently caught with a male student’s penis in his mouth in the bathroom at school

Common response

- PTSD. Family problem. *(Not my job.)*
- Conduct problem. *(Discipline or FBA/BIP as usual.)*
- Academic problem. *(RTI or Sped referral as usual.)*
- Child with complex history, needs, and strengths. *(Does some digging.)*
- *Not my job.*
Sam: A little more information...

- Sam’s biological father dressed him as a girl and repeatedly raped and molested him until age 6.
- Sam entered state custody after his father was arrested for sexual abuse charges and was adopted at age 7.
- At age 8 his adoptive family relinquished custody to the state due to Sam’s problematic sexual and acting out behaviors.
- In the past 4 years, Sam has been in 9 different foster homes, 3 residential treatment centers (for 6-18 months at a time), and 2 inpatient psychiatric care facilities.

Changing the Narrative

PTSD. Family problem.  
*Not my job.*

Conduct problem.  
*Discipline or FBA/BIP as usual.*

Academic problem.  
*RTI or Sped referral as usual.*

Child with complex history, needs, and strengths.  
*Does some digging.*
What would your school do with this child?

**Demographics**
- Andre
- Age 7
- Black
- Male
- Resides in large urban area

**Learning**
- Has significant speech and language delays
- Is "forgetful," and has difficulty following directions, dressing himself, brushing his teeth independently, etc.
- Last year’s state test scores all “Below Basic”
- GAL has requested the school conduct an evaluation, but behavior/expulsions have delayed this.

**Behavior**
- Previous diagnoses of ADHD, ODD, and Mood Disorder NOS
- Disruptive at school — walks out of class, runs down hallways, knocks over desks, hides under furniture, threatens others
- Expelled from at least 2 previous schools and recently expelled from home school for kicking a teacher in the abdomen
- At alternative school, hit and kicked two teachers and punched another child; when teacher tried to intervene, attempted to choke teacher

Common response

- Conduct problem.  
  *Discipline or FBA/BIP as usual.*
- Academic problem.  
  *RTI or Sped referral as usual.*
- PTSD. Family problem.  
  *Not my job.*
- Child with complex history, needs, and strengths.  
  *Does some digging.*

*Not my job.*
ANDRE: A little more information...

- Andre and his 4-year-old brother entered custody several months ago due to allegations of environmental neglect, lack of supervision, and physical abuse. Teachers at a previous school had seen bruises and scratches in various stages of healing on his back. CPS investigation revealed additional bruises, welts, and large scars all over his body. It was discovered that his mother had been beating him with an extension cord and other household implements for several years.

- Andre’s mother, who is low-functioning and has depression, has a long history of domestic violence with three different boyfriends (all putative fathers of Andre/his siblings). Before entering custody, he reportedly witnessed one boyfriend pour liquor over his mother and attempt to stab her and set her on fire.

- Visits recently resumed with Andre’s parents. When his mother is present, he stays in the corner and “shuts down” when asked questions.

- Andre’s mother has reportedly told him he doesn’t have to go to school or learn to read. Prior to entering foster care last year, it is unclear whether he was ever in formal school.

- Several of the aggression incidents at Andre’s various schools occurred during reading classes (i.e., when he was asked to read aloud). During the last incident, a principal threatened to use corporal punishment with Andre and he “exploded.”

Changing the Narrative

PTSD. Family problem.
*Not my job.*

Conduct problem.
*Discipline or FBA/BIP as usual.*

Academic problem.
*RTI or Sped referral as usual.*

Child with complex history, needs, and strengths.
*Does some digging.*
What would your school do with this child?

**Demographics**
- Louisa
- Age 5
- Bi-racial
- Female
- Resides in large urban area

**Learning**
- Speech articulation difficulties and limited verbal communication skills (i.e., one-word sentences)
- Delayed developmental milestones (walking, etc.)
- **Delayed early academic skills**, despite instruction in a full-day special education PreK classroom

**Behavior**
- Frequently in time-out at school for inattention, noncompliance, and aggression toward other children
- Last week, hit another student and cursed at a bus driver

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**Common response**

- **Behavior** (*Discipline or FBA/BIP as usual.*)
- **Academic problem.** (*RTI or Sped referral as usual.*)
- **PTSD. Family problem.** (*Not my job.*)
- **Child with complex history, needs, and strengths.** (*Does some digging.*

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*Not my job.*
Louisa: A little more information...

- Louisa has a history of severe environmental neglect, nutritional and medical neglect, and drug exposure.
- At age 5, this is Louisa’s second time in state custody (foster care). During this episode, she and her 3- and 4-year-old siblings have moved through 4 foster homes and 2 relative caregiver placements in less than 2 years. The 3 siblings are now separated into two different foster homes.
- Louisa’s mother has diagnoses of Depression, Borderline Intellectual Functioning, and Mood Disorder NOS and her father tested positive for THV and pain pills (no prescription) when the children entered custody. Neither parent is employed, and they have lived with various friends and relatives over the past 10+ years.
- Their 90-day Trial Home Visit (THV) with their biological parents is scheduled to begin in the next month, and the children have recently begun visiting with their parents. The parents’ attendance has been inconsistent, and there were reports from one visit that the father hit and cursed at one of the children during a visit. (The children’s other 7 siblings have already had their THVs and been returned to the mother and father.)

Question #1.

What is this child’s history?
History “digging”

- Record review
  - Beyond grades, referrals, standardized test scores
  - Who do they live with? For how long? Any moves (school or home address changes)?
  - Seek out additional providers and get records (with appropriate ROI)
    - Counselors, therapists, medical providers (medication)
    - In foster system? (school should have letter on file)
    - Contact case worker
- Interviews (teacher, caregiver, child)
  - Informal first
  - If necessary, screen for trauma exposure
  - If exposure already known, consider assessing traumatic stress symptoms

Exposure

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NSLIJHS TRAUMA HISTORY CHECKLIST AND INTERVIEW

Date: ___________  Interviewer: ___________  Eval #: ___________

"Sometimes things happen to people that are extremely upsetting, things like being in a life-threatening situation. I'd like to ask if any of those kinds of things have happened to you or anyone in your life. You don't need to give me a lot of details."

Place "Y" or "N" before each item. Write notes to the right and list the most significant trauma at the bottom of this sheet. Provide details only for A1 items as defined by the DSM IV criteria for PTSD. Include information regarding age of onset and duration of trauma. It is not necessary to include details about items endorsed if they were not traumatic. Include information that others may consider to be traumatic, even if the adolescent does not view it as such.

Please describe any significant DETAILS for each A1 Trauma:

1. Have you ever been in a major natural disaster, like a hurricane, earthquake, or flood?
2. Have you ever been directly affected by a terrorist attack, like 9/11?
3. Have you or anyone in your family been involved in or affected by a war?
4. Have you ever been in a fire?
5. Have you ever been in a serious car accident?
6. Have there ever been a time when you were seriously hurt or injured?
7. Have you ever been in the hospital or undergone treatment for any serious or life-threatening illness or injury?
8. Have your parents or siblings ever been in the hospital or undergone treatment?

INCLUDE DETAILS HERE:

(exclude age of onset & duration)
```

• Available here: http://www.mc.vanderbilt.edu/coe/tfcbt/workbook/Assessment/NSLIJHS%20Trauma%20History%20Checklist%20and%20Interview.pdf
Question #2.

• If exposure is known (or highly suspected)...

Is this child experiencing **symptoms** that could be related to traumatic stress?

Symptoms

Available here:

Symptoms

(TSCYC) Trauma Symptom Checklist for Young Children

Also available: TSCC for ages 8-16 years

https://www.parinc.com/Products/Pkey/461

Traumatized students are often focused on survival, which hampers their ability to learn, socialize, and develop the skills needed to thrive.

Question #2.

- If exposure is known (or highly suspected)...
- And child is experiencing symptoms (even if no “PTSD”)...

How might this child’s *history* (exposure) and *symptoms contribute* to the observed academic, social, emotional, and/or behavioral difficulties?

Can you reframe the child’s difficulties?
Can you reframe the child’s difficulties?

Known or suspected trauma history

- Re-experiencing
- Arousal
- Negative alterations in cognition, mood
- Avoidance

• "Impaired ability to build or maintain satisfactory interpersonal relationships with peers and teachers"
• "Deficits in developing, maintaining, and understanding relationships"
• "Deficits in social-emotional reciprocity"
• Poor boundaries
• Attention-seeking (or withdrawn)
Assessment: **Attachment problems**

"...given
(a) the current definition of RAD,
(b) the relatively low prevalence of the condition in **even severely neglected children**, and
(c) the finding that RAD has not been documented in **any** children after a period of time living in a normative caregiving environment,..."
Even in Eastern European orphanages ("grossly pathogenic care"), only 4.6% showed inhibited, 31.8% disinhibited "RAD" criteria (Gleason et al., 2011).

Assessment: Attachment problems

“...the safest conclusion is that RAD is an unlikely clinical presentation that will rarely, if ever, be encountered by most mental health professionals.”

Allen, B. (2016). A RADical idea: A call to eliminate "attachment disorder" and "attachment therapy" from the clinical lexicon. Evidence-Based Practice in Child and Adolescent Mental Health, 1(1), 60-71. (quotes from p. 64)

Assessment: Attachment problems

“Even in the unlikely circumstance that a child does present with RAD, the diagnostic nature of the DSM raises the concern that the condition will be viewed in a ‘disorder-within-the-child’ manner”

“describing a child as displaying an attachment disorder, including RAD, unfortunately focuses clinical attention on the child and not the system”

Allen, B. (2016). A RADical idea: A call to eliminate "attachment disorder" and "attachment therapy" from the clinical lexicon. Evidence-Based Practice in Child and Adolescent Mental Health, 1(1), 60-71. (quotes from p. 64)
Assessment: Attachment problems

**Applied Behavior Analysis (ABA)**

- Social skills instruction and practice
- Modifies self-regulation and promotes relationships and behaviors at school, expectation of gradual progress

**Attachment Difficulties**

- (MCD = 12% of those treated with ASD)
- Difficulties with social interactions: Differences in emotional tone
- Difficulties with communication: Differences in language style
- Difficulties with language: Differences in emotional tone
- Difficulties in behavior: Differences in emotional tone

**Structured observations during social interactions with familiar and unfamiliar caregivers:**

- Evaluate quality and consistency of social interactions, attention-seeking, checking-in, and comfort-seeking behaviors; reactions to others' coming and going

**Child PTSD Symptom Scale (CPSS), UCLA PSTD Index**

- Teacher Relationship Problems Questionnaire (RPQ) [Q]
- Cognitive, language, and adaptive measures

**R**

- Mental health, medical, DFPS
- History of trauma exposure (onset, duration, frequency); course of symptoms and behaviors; timeline of child's life; family tree/geneogram

**I**

- Parent or caregiver—NSLIH Trauma History Checklist and Interview
- Developmental history (age at symptom onset?); screen for trauma exposure; current living situation, relationships, culture of the home/family

**O**

- Structured observations during social interactions with familiar and unfamiliar teachers and/or caregivers; unstructured time with other children
- Evaluation of quality and consistency of social interactions, attention-seeking, checking-in, and comfort-seeking behaviors; reactions to others' coming and going

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Sources: DSM-5; National Center for PTSD; NICHD; Davidson et al., 2015; RIDE; Perls et al., 2016; Warren, Staffe, & Wagner, 2001
Can you reframe the child’s difficulties?

- “Acts as if driven by a motor”
- “easily distracted by extraneous stimuli”
- “often fidgets” or “leaves seat when remaining seated is expected”
- “Inappropriate types of behavior or feelings under normal circumstances”
- “resistance to environmental change or change in daily routines”
- “hyper- or hypo-reactivity to sensory input”

Assessment: Self-Regulation problems

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Sources: DSM-5; National Center for PTSD; NCTSN; Davidson et al., 2015; Ribeirão Preto et al., 2016; Weisenstein, Staffo, & Briggs, 2001
Assessment: Self-Regulation problems

<table>
<thead>
<tr>
<th>R</th>
<th>Mental health, medical, DFPS</th>
<th>History of trauma exposure (onset, duration, frequency); course of symptoms and behaviors; timeline of child’s life; family tree/genogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Parent or caregiver—NSLUH5 Trauma History Checklist and Interview</td>
<td>Developmental history (age at symptom onset?); screen for trauma exposure Ask about content and context of inattention; ask about emotions, avoidance, and changes in feelings and behaviors over time</td>
</tr>
<tr>
<td>O</td>
<td>Multiple settings and days/times, esp. during unstructured times</td>
<td>Evaluate setting events, possible antecedents or “triggers”</td>
</tr>
<tr>
<td>T</td>
<td>Child PTSD Symptom Scale (CPSS), UCLA PTSD Index</td>
<td>Exposure to possibly traumatic events</td>
</tr>
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<td></td>
<td>Trauma Symptom Checklist for Children (TSCC or TSCYC)</td>
<td>PTS symptoms, dissociation, sexual concerns</td>
</tr>
</tbody>
</table>

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Sources: DSM-5; National Center for PTSD; Davidson et al., 2015; ROBB; Poffert et al., 2016; Weiss, Stoffelbach, & Traupel, 2000

Can you reframe the child’s difficulties?

- “delays in physical, cognitive, communicative, social emotional, and/or adaptive development”
- “Deficits in...reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, and learning from experience”
- “Disorder in one of more...basic psychological processes”
- “imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations”
- Executive function deficits
Assessment: Competency

• This is the stuff you already know how to do!
  • Developmental domains
  • Adaptive skills (ABAS, Vineland)
  • Achievement (grades, work samples, state tests, WJ, KTEA, etc.)
  • Social skills (SSIS, observations)
  • Executive skills e.g., inhibition, planning, goal setting, making choices, problem solving, flexibility, self-monitoring, etc. (ESQ, BRIEF, CEFI, etc.)
  • Strengths (records, interviews, inventories/questionnaires)

Assessment: Competency

VIA Classification of Character Strengths

Free survey at: https://www.viacharacter.org/survey/account/register
Assessment

ARC-informed interventions and strategies
Interventions and strategies: Attachment

Psychoeducation about trauma’s impact, child’s history

• Help teachers understand:
  
  Behavior is the language of trauma

http://www.nctsn.org/resources/audiences/school-personnel/trauma-toolkit
Build teacher’s awareness of their own emotional reactions to child behaviors

Help teacher with attunement

- AKA antecedent awareness 😊
  - “Tuning in” to the child’s cues (needs, subtle signals)
  - Anticipating student’s needs and possible triggers
Help teachers build relationships with (even difficult) students

Teacher/staff buddy or mentor

Source: http://arcframework.org/
Routines and rituals – Consistency, Predictability

**Morning Meeting Structure**

1. Youth put up bookbags, listen to morning announcements and sit in circle
2. Staff put out felt color blocks, and youth choose color based on mood meter. If any youth on RED, follow Youth on RED Process
3. Teacher gives general greeting and guides youth in check-ins, making reflective/morning statements for each youth
4. Address Weekly Theme based on SEL Curriculum Define, Identify, Practice

Developed by Jen Ancord, LCSW, CHEC Counseling Center, Atlantic, IA
Based on Attachment, Repetition and Competency (ARC) – Blasek & Weidleigh, 2010 Weidleigh & Blasek, 2006

Predictability, Structure
Consistent (effective) response

What to do when a youth is “on Red”?

Our goal is to help youth to “reset” and move out of the red zone with as little intervention and time spent out of the classroom and disruption as possible. Please follow the steps below when responding to a youth “on red.” Start with first step of intervention and only move to second step if the prior intervention was not effective in helping youth to calm down, their system enough to return to the classroom activities.

1) Paraprofessional Intervention
2) Calm Down Corner
3) Send youth to talk to staff member with strong relationship
4) Visit Counselor or Social Worker
5) SST Visit/Consultation
6) Opportunity Room

Developed by Jen Alexander, LCSW, DARE Counseling Center, Atlanta, GA. Based on Attachment, Regulation and Competency (ARC) — Krasnoleva & Krasnoleva, 2012; Krasnoleva & Blattler, 2015.

Train (and support) **all** teachers and staff

- Trauma’s impact on learning, behavior
- Recognizing signs
- Consistent and **effective response**
- **Self-care!**
Built-in time for relationship building

Strong family-school communication and collaboration
Interventions and strategies: Self-Regulation

Traumatic stress symptoms

Competency

Attachment

Regulation

“Affect” and granularity

Regulating arousal
Include coping skills for high arousal + high negativity

Help teachers cue and reinforce appropriate responses
Individual counseling

**Cognitive Behavioral approaches**

- Psychoeducation (e.g., about the stress response)
- Stress management, relaxation, and coping skills
- Caregiver involvement

http://www.nctsn.org/sites/default/files/assets/pdfs/effective_treatments_youth_trauma.pdf

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CBT techniques

[Stress loop diagram]
CBT techniques

Relaxation, stress management skills
– In the moment:
Relaxation, stress management skills – regular practices ("flossing")

Interventions and strategies: Competency
This is the stuff you already know how to do!

• Targeted interventions for skills deficits...
  • Developmental domains
  • Adaptive skills
  • Achievement (reading, math, writing – SLD)
• Teach (and cue and reinforce)...  
  • Social skills (SEL, groups) – including safety, problem solving, conflict mgmt  
  • Executive skills (coaching, individual, classwide)
• Identify and use strengths, interests
  • Extracurricular activities

Teach social skills
Teach social skills

Teach executive skills
Teach executive skills
Identify and use strengths, interests

Interventions and strategies

Traumatic stress symptoms
Competency
Attachment
Regulation

Cognitive Behavioral Intervention for Trauma in Schools
Bounce Back
Support for Students Exposed to Trauma
Interventions and strategies

TF-CBT

- Psychoeducation and Parenting
  - Psychoeducation about childhood trauma and PTSD
  - Parenting component, including parent management skills

- Relaxation
  - Relaxation skills individualized to the child and parent

- Affect Modulation
  - Affective modulation skills adapted to the child, family, and culture

- Cognitive Coping
  - Connecting thoughts, feelings, and behaviors related to the trauma

- Trauma Narrative
  - Assisting the child in sharing a verbal, written, or artistic narrative about the trauma and related experiences
  - Including cognitive and affective processing of the trauma experiences

- Novus Exposure
  - Mastery of trauma reminders

- Conjoint Parent-Child Sessions
  - Practice skills and enhance trauma-related discussions

- Enhancing Safety and Development
  - Enhancing future personal safety and optimal developmental trajectory by providing safety planning and social skills training
TF-CBT

- Trauma integration
- Making meaning
- Identity development ("self")

Interventions and strategies

- Traumatic stress symptoms
- Competency
- Attachment
- Regulation

I am...
Move from “What’s wrong with you” to...

What happened to you?

Thank you! straitj@uhcl.edu