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

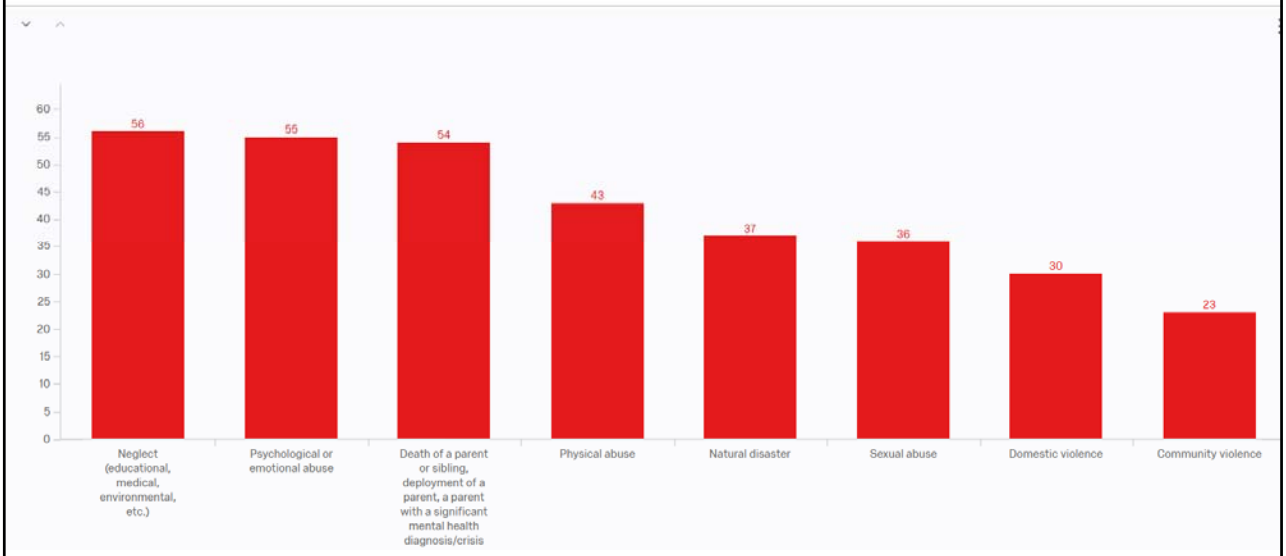
Road map

- 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

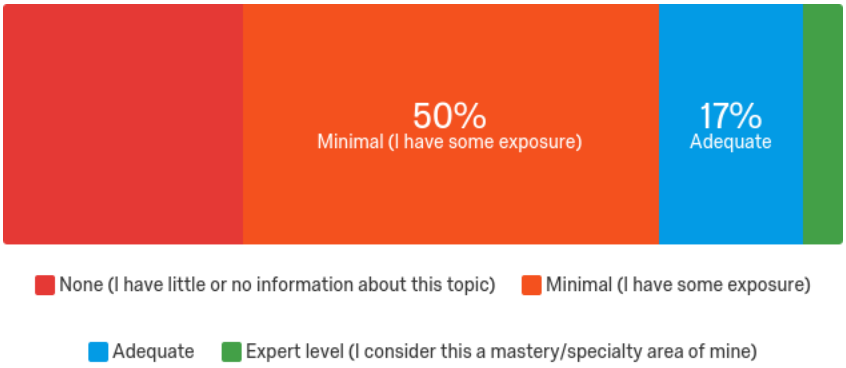
How this training came about…

Q26 - In the past calendar year, I have worked with or consulted with teachers/caregivers regarding a student who expe...

Page Options

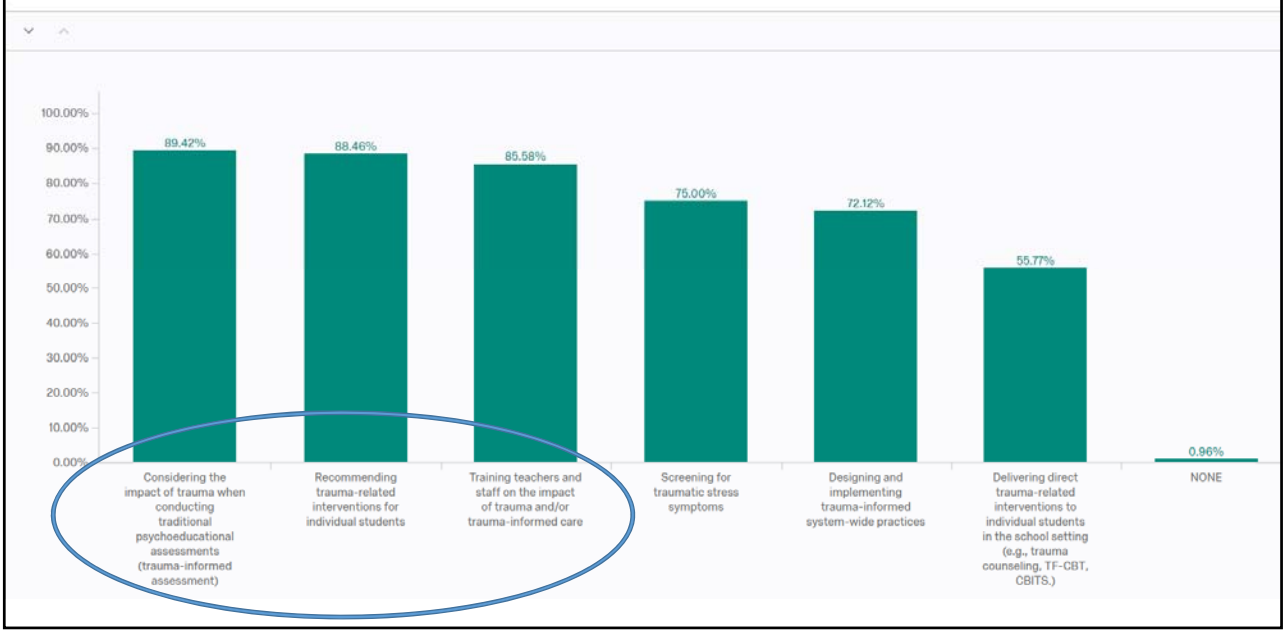


I would rate my **education and training** in trauma-related service delivery (e.g, direct assessment and intervention) as...



n = 105 total responses to this question

Q32 - I believe that school psychologists should be involved in the following activities related to trauma-informed care:

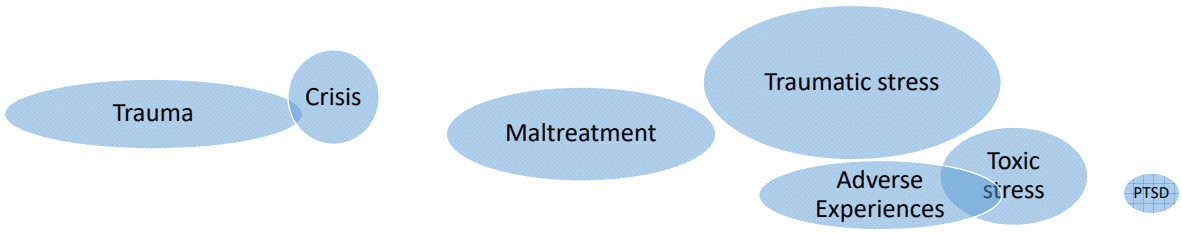


What would you need to provide trauma-informed care in your school setting?

What would you need to provide trauma-informed care in your school setting?

Background: Trauma Concepts and Definitions

No consensus on definition/terms



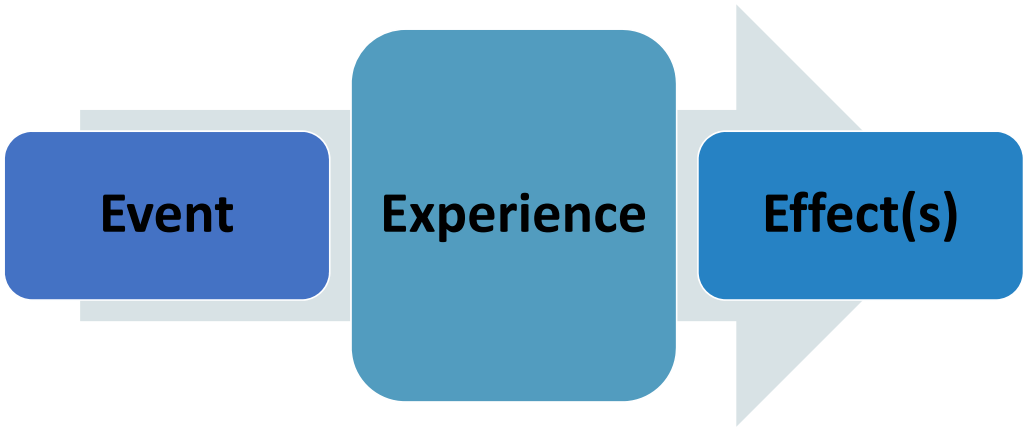
Defining "TRAUMA": SAMHSA

3 parts:

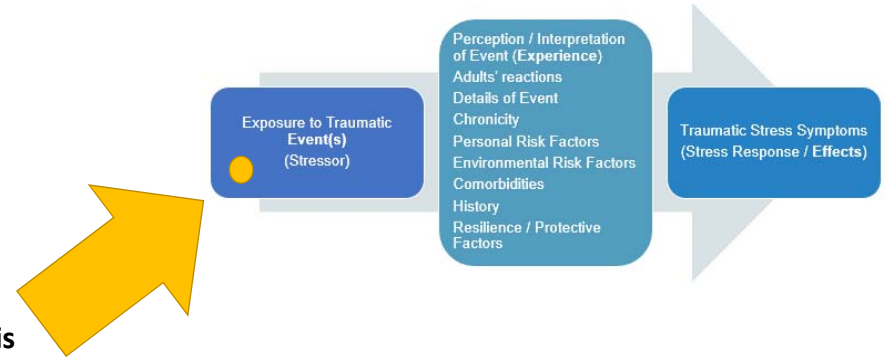
Individual trauma results from an **event**, *series of events, or set of circumstances that is* **experienced** *by an individual as physically or emotionally harmful or life threatening and that has lasting adverse* **effects** *on the individual's functioning and mental, physical, social, emotional,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

Source: Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Retrieved from http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-

Trauma Reactions – SAMHSA's 3 "E"s



Note: Crisis vs. trauma

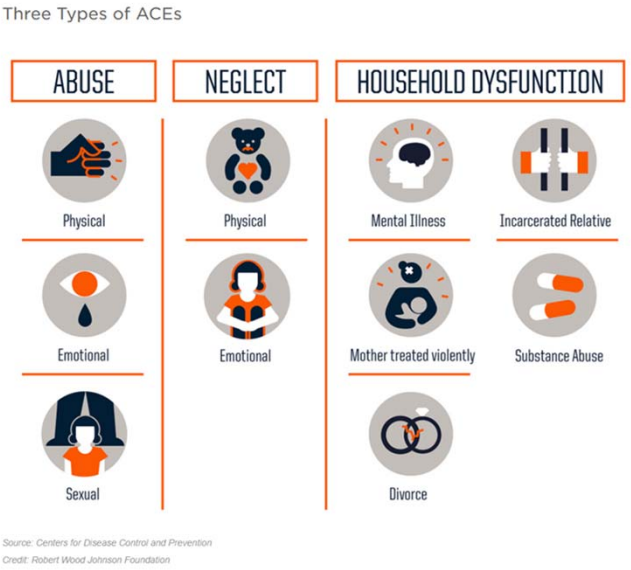


Crisis

- 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

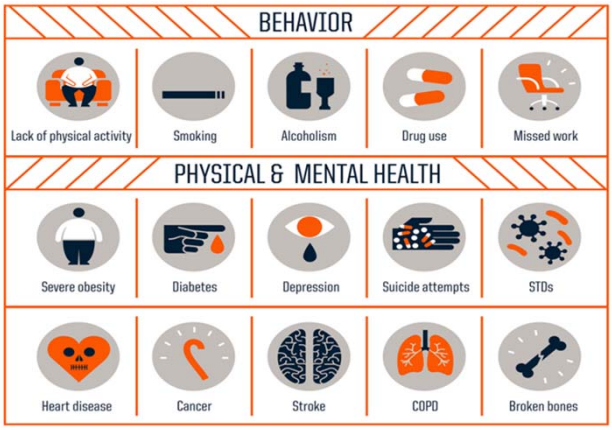
- Adverse
- Childhood
- Experiences



Infographics on this and following ACEs slides are from: http://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean - original ACEs study info here: https://www.cdc.gov/violenceprevention/acestudy/about.html

ACEs increase health risks

According to the Adverse Childhood Experiences study, the rougher your childhood, the higher your score is likely to be and the higher your risk for various health problems later.

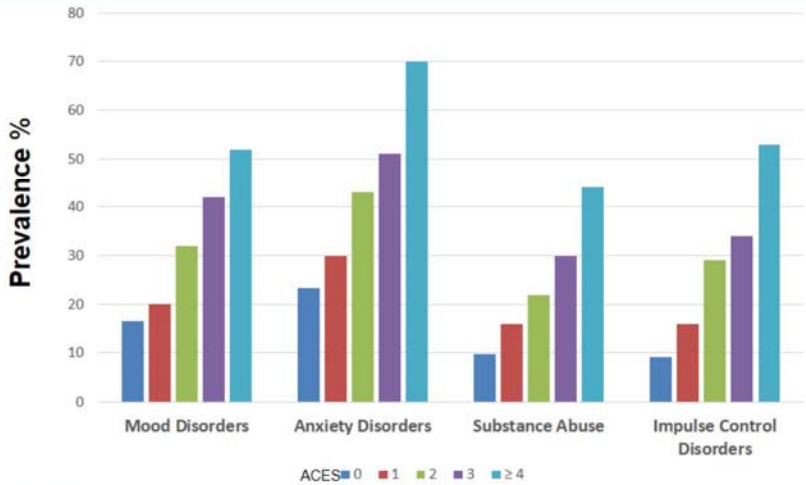


Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation

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

https://www.scientificamerican.com/article/childhood-adverse-event-life-expectancy-abuse-mortality/

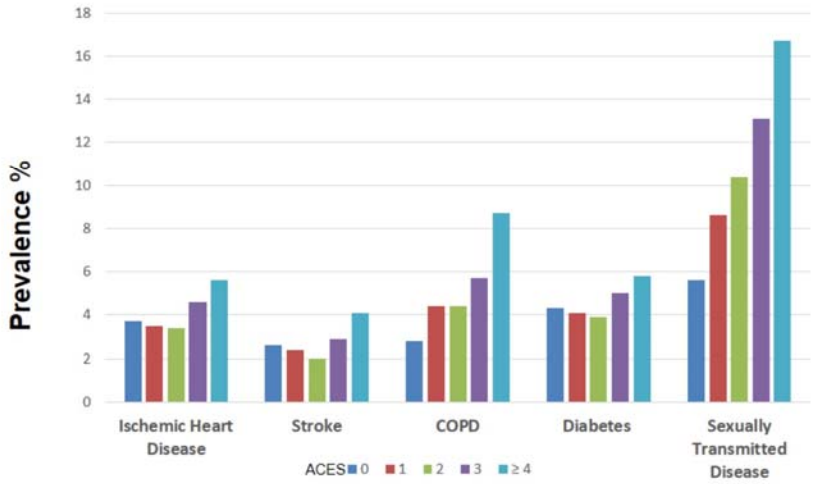
Cumulative ACES & Mental Health[1,2]



[1]Data from the National Comorbidity Survey-Replication Sample (NCS-R).
[2]Putnam, Harris, Putnam, J Traumatic Stress, 26:435-442, 2013.

CANarratives.org

Cumulative ACES & Chronic Disease[1]



[1]Felitti et al., (1998) American Journal of Preventive Medicine, 14:245-258.

CANarratives.org

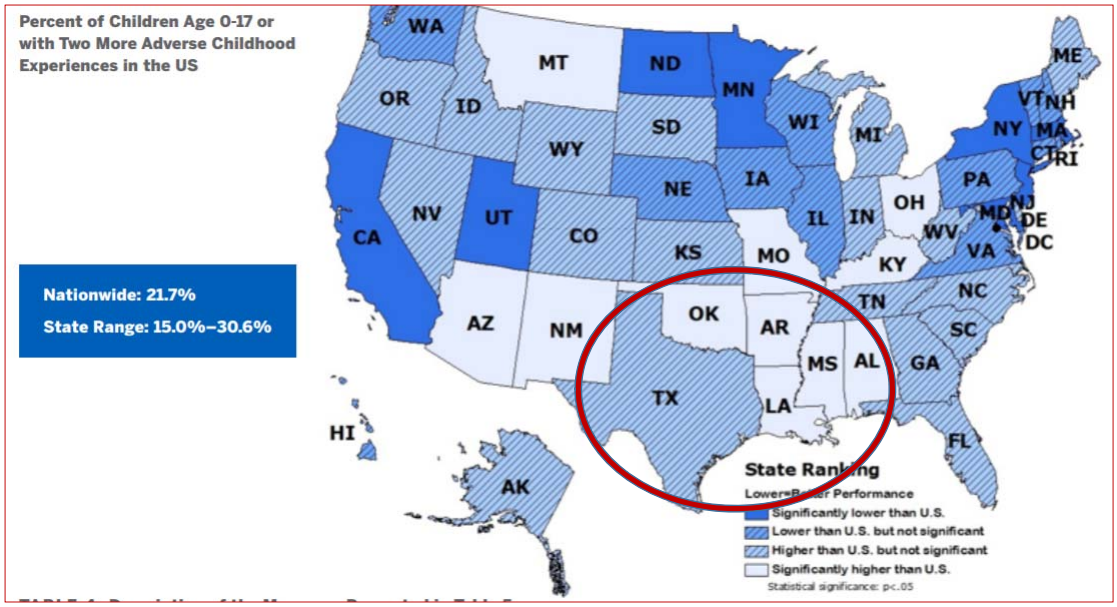
ACEs increase health risks

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

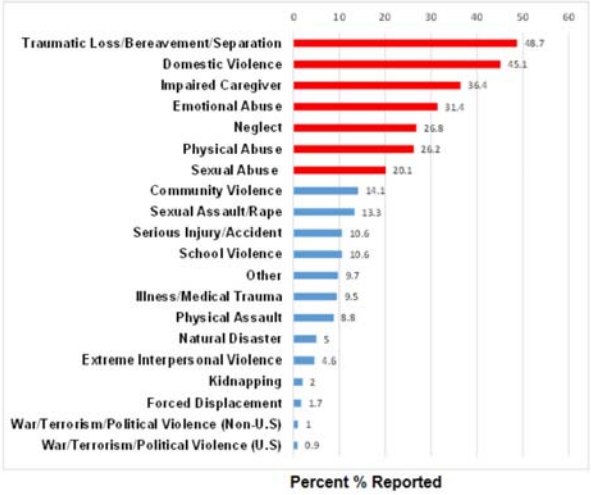
https://www.scientificamerican.com/article/childhood-adverse-event-life-expectancy-abuse-mortality/



Citation: Bethell, CD, Davis, MB, Gombojav, N, Stumbo, S, Powers, K. Issue Brief: A national and across state profile on adverse childhood experiences among children and possibilities to heal and thrive. Johns Hopkins Bloomberg School of Public Health, October 2017. http://www.cahmi.org/projects/adverse-childhood-experiences-aces/

The ACES are Among Many Childhood Traumas and Adversities Measured by the National Child Traumatic Stress Network N=10,991[1]

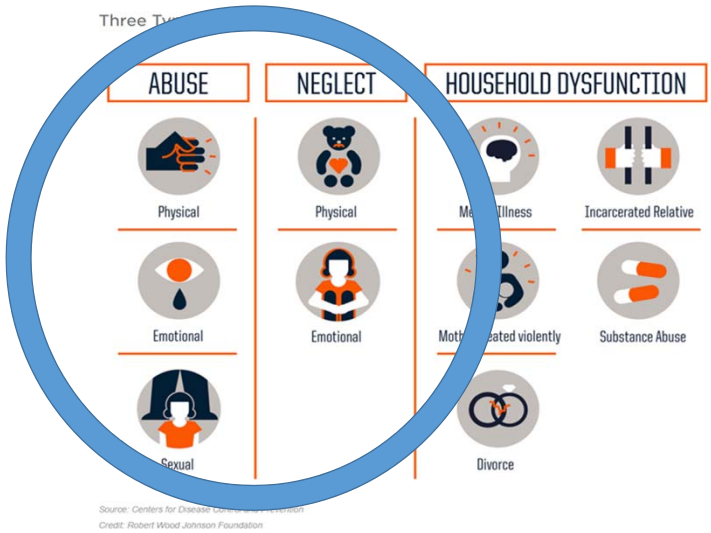
- The original ACES (**in red**) are among the most commonly reported traumas in studies that look at additional traumas.
- Over 40% of the children and adolescents served by the NCTSN experienced 4 or more different types of trauma and adversity.



[1]Pynoos et. al (2014). Psychological Trauma: Theory, Research, Practice and Policy. 6:S9-S13.

CANarratives.org

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**

Gabbay, V., Oatis, M.D., Silva, R.R. & Hirsch, G. (2004). Epidemiological aspects of PTSD in children and adolescents. In Raul R. Silva (Ed.), Posttraumatic stress disorder in children and adolescents: Handbook. (1-17). New York: Norton.
Silverman AB, Reinherz HZ, Giaconia RM. The long-term sequelae of child and adolescent abuse: a longitudinal community study. *Child Abuse Negl.*1996;20(8):709–723.

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-efficacy)
- 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

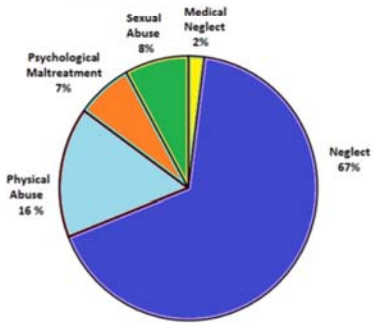
Social Problems
- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- High utilization of health and social services
- Shortened Lifespan

CANarratives.org

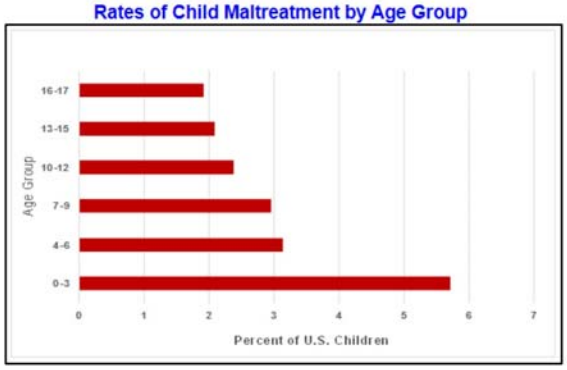
Rates of Maltreatment by Age[1]

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

Types of Child Maltreatment



Rates of Child Maltreatment by Age Group



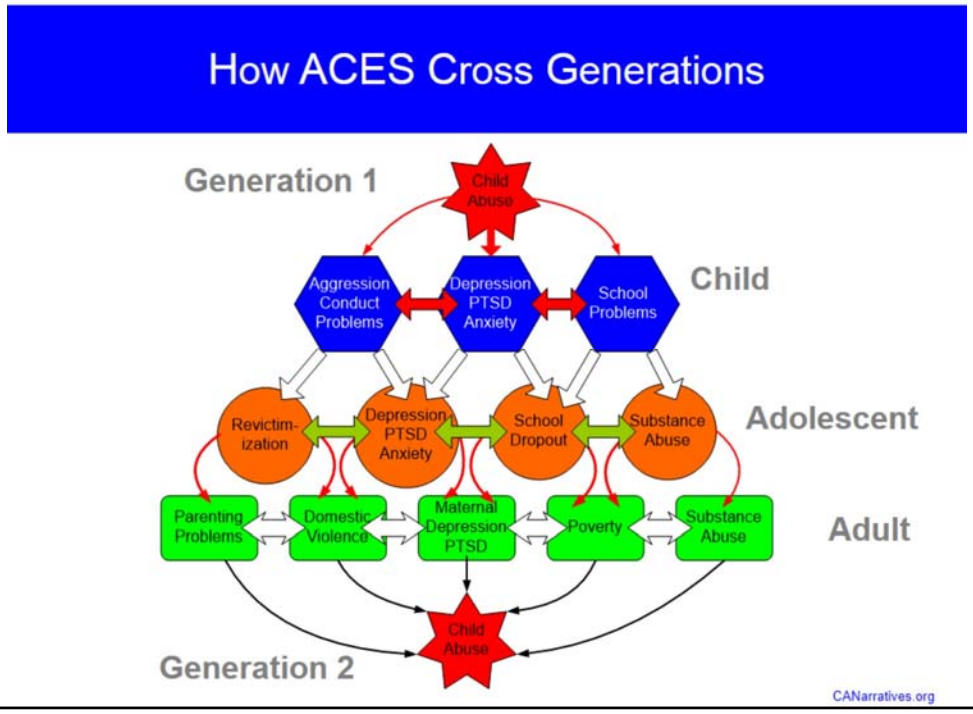
[1]Child Maltreatment 2012. Washington, DC: US Department of Health and Human Services; 2014.

CANarratives.org

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
U.S. Department of Health and Human Services. Administration on Children, Youth and Families, Children's Bureau. (2016). Child maltreatment 2014 [online] Available from: http://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf



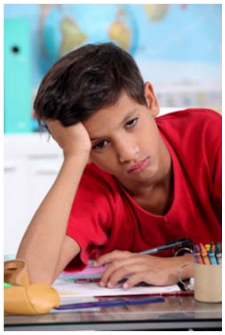
"Complex trauma"

- 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

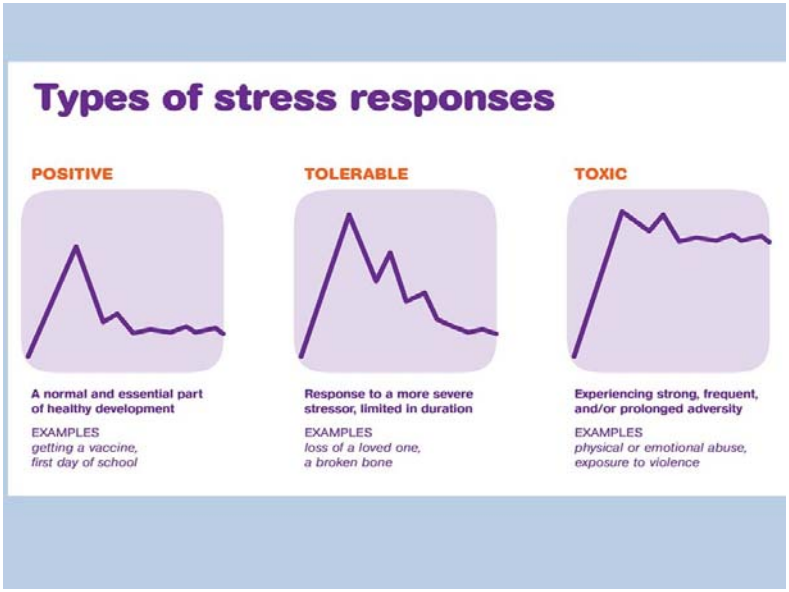
AKA developmental trauma, complex dev. trauma, interpersonal trauma, chronic maltreatment, etc.

Impact

Traumatic stress impacts learning, development, and behavior.



How? Dysregulation in the Stress Response

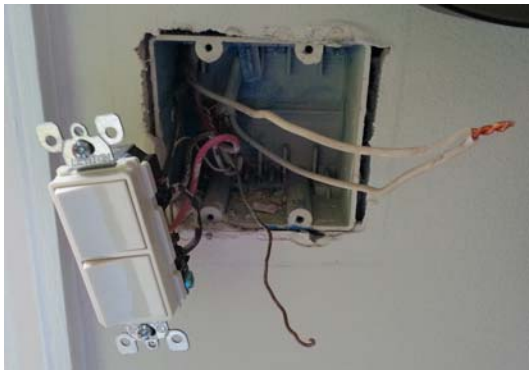


Three Core Concepts in Early Development

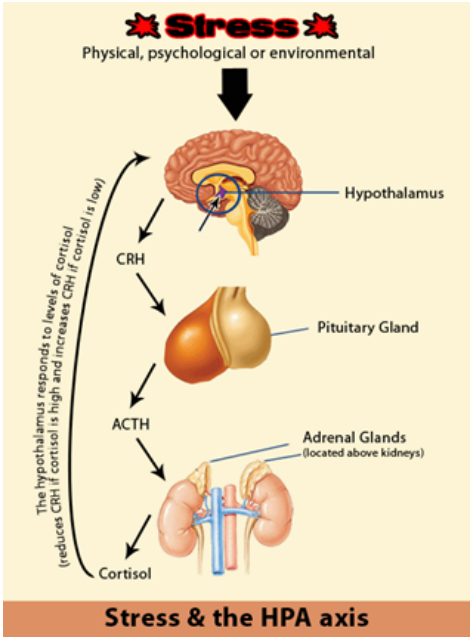
3 Toxic Stress Derails Healthy Development

NATIONAL SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD
Center on the Developing Child HARVARD UNIVERSITY

How?



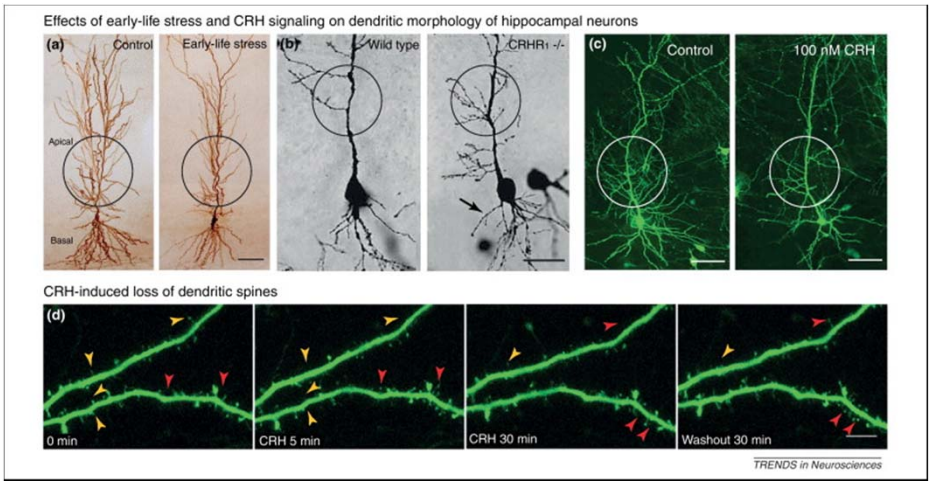
Stuck “on” or “off”



Stress & the HPA axis

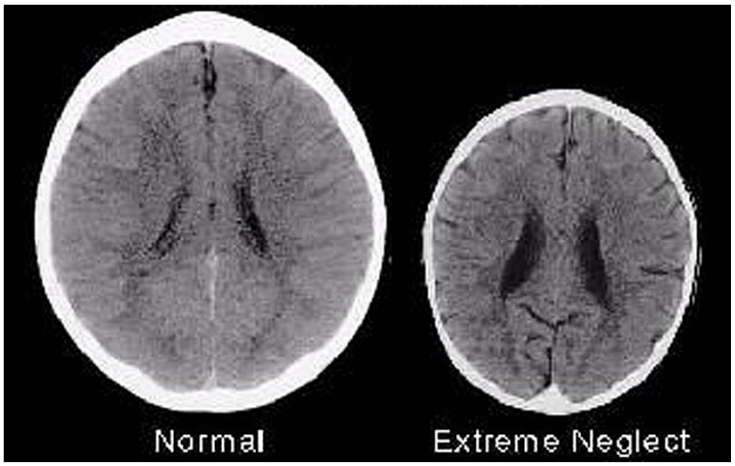
Source: http://www.total-body-psychology.com.au/stress-response---hpa-axis.html

How?



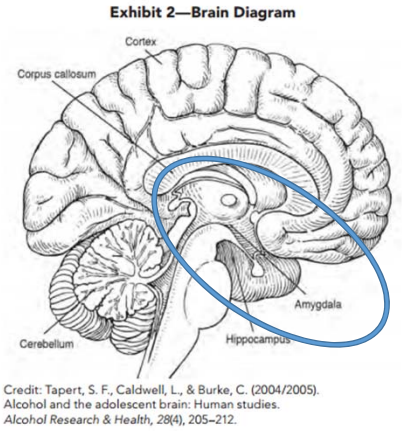
Maras, P. M., & Baram, T. Z. (2012). Sculpting the hippocampus from within: stress, spines, and CRH. *Trends in neurosciences*, *35*(5), 315-324.

How?



1. Experience grows the brain…
   - Lack of experience → **lack of growth**
2. *AND…*Traumatic stress **destroys** it.

MALTREATMENT IS ASSOCIATED WITH…



Abnormal levels of cortisol and adrenaline

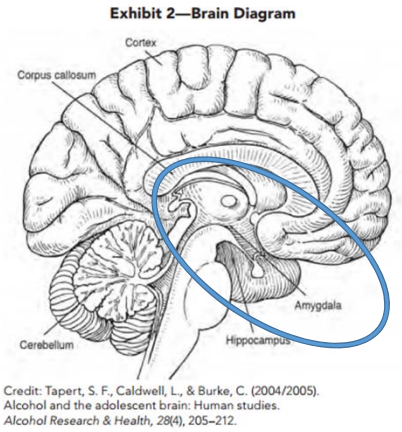
- Emotional/ behavioral reactivity, arousal, **stress regulation**

Source: Child Welfare Information Gateway. (2015). Understanding the effects of maltreatment on brain development. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/brain_development.pdf

MALTREATMENT IS ASSOCIATED WITH…

Overactive/ larger amygdala

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



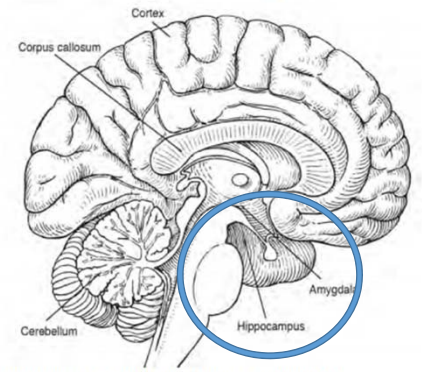
Abnormal levels of cortisol and adrenaline

- Emotional/ behavioral reactivity, arousal, **stress regulation**

Source: Child Welfare Information Gateway. (2015). Understanding the effects of maltreatment on brain development. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/brain_development.pdf

MALTREATMENT IS ASSOCIATED WITH…

Exhibit 2—Brain Diagram



Credit: Tapert, S. F., Caldwell, L., & Burke, C. (2004/2005). Alcohol and the adolescent brain: Human studies. *Alcohol Research & Health, 28*(4), 205–212.

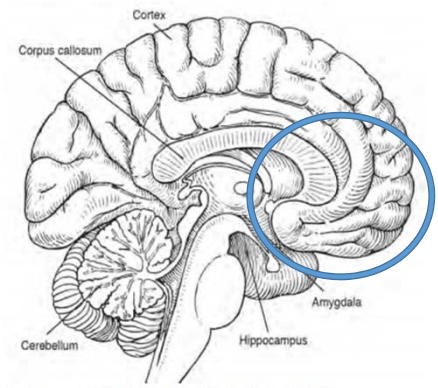
Decreased Hippocampal Volume

- Learning and memory
- "Wikipedia of the brain"

Source: Child Welfare Information Gateway. (2015). Understanding the effects of maltreatment on brain development. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/brain_development.pdf

MALTREATMENT IS ASSOCIATED WITH…

Exhibit 2—Brain Diagram



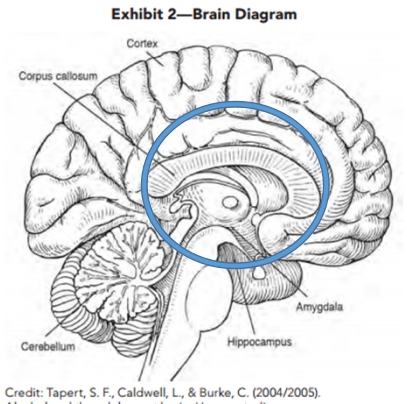
Credit: Tapert, S. F., Caldwell, L., & Burke, C. (2004/2005). Alcohol and the adolescent brain: Human studies. *Alcohol Research & Health, 28*(4), 205–212.

Decreased Prefrontal Cortex (PFC)

- Executive functioning, attention, decision-making, abstract thought, language, behavior/emotion regulation, etc

Source: Child Welfare Information Gateway. (2015). Understanding the effects of maltreatment on brain development. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/brain_development.pdf

MALTREATMENT IS ASSOCIATED WITH…



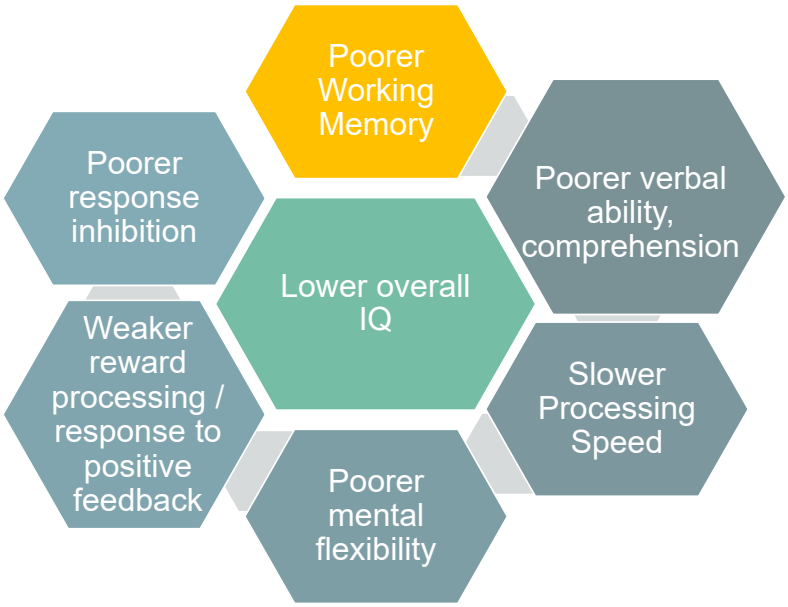
Credit: Tapert, S. F., Caldwell, L., & Burke, C. (2004/2005). Alcohol and the adolescent brain: Human studies. *Alcohol Research & Health, 28*(4), 205–212.

Decreased…

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

Source: Child Welfare Information Gateway. (2015). Understanding the effects of maltreatment on brain development. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/brain_development.pdf

Cognitive Endo**phenotypes** (scores)



Sources: Child Welfare Information Gateway. (2015). Understanding the effects of maltreatment on brain development. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/brain_development.pdf
Hart, H., & Rubia, K. Neuroimaging of child abuse: A critical review. Frontiers in Human Neuroscience, 6, article 52. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3307045/pdf/fnhum-06-00052.pdf
Viezel, K. D., Freer, B. D., Lowell, A., & Castillo, J. A. (2015). Cognitive abilities of maltreated children. Psychology in the Schools, 52(1), pp. 92-106

Meta-analysis of school-related outcomes

(506 studies; 1990-2015)

Cognitive

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

Perfect, M. M., Turley, M. R., Carlson, J. S., Yohanna, J., & Saint Gilles, M. P. (2016). School-related outcomes of traumatic event exposure and traumatic stress symptoms in students: A systematic review of research from 1990 to 2015. *School Mental Health, 8*(1), 7-43.

Meta-analysis of school-related outcomes

(506 studies; 1990-2015)

Cognitive

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

Social, Emotional, Behavioral

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

Perfect, M. M., Turley, M. R., Carlson, J. S., Yohanna, J., & Saint Gilles, M. P. (2016). School-related outcomes of traumatic event exposure and traumatic stress symptoms in students: A systematic review of research from 1990 to 2015. *School Mental Health, 8*(1), 7-43.

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

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

Perfect, M. M., Turley, M. R., Carlson, J. S., Yohanna, J., & Saint Gilles, M. P. (2016). School-related outcomes of traumatic event exposure and traumatic stress symptoms in students: A systematic review of research from 1990 to 2015. *School Mental Health*, 8(1), 7-43.

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!

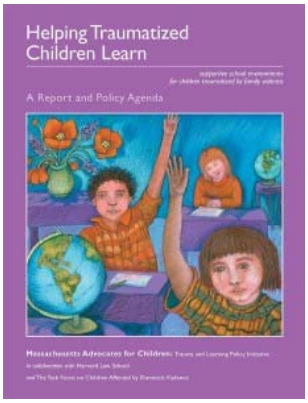
TABLE 1 Examples of multitiered service delivery options to address trauma in schools

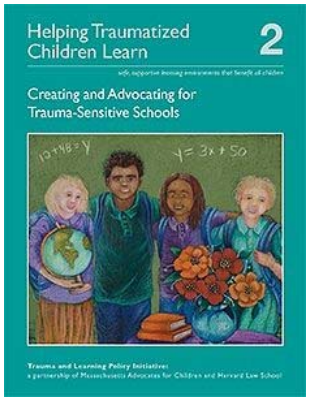
Tier	Assessment	Intervention	Practitioner Support
Three	University of California at Los Angeles PTSD Reaction Index (Steinberg et al., 2004) The Clinician-Administered PTSD Scale for DSM-5 Child/Adolescent Version (Pynoos et al., 2015) Child PTSD Symptom Scale (CPSS) (Foa et al., 2001) Child and Adolescent Needs and Strengths Manual (Kisiel et al., 2010)	Trauma-focused cognitive behavioral therapy (Cohen et al., 2006, 2012a)	Professional quality of life (Stamm, 2010) Employee assistance programs Referrals to outside clinicians
Two	Behavioral rating scale for children (Reynolds & Kamphaus, 2015) Achenbach System of Empirically Based Assessment (Achenbach & Rescorla, 2001) Trauma Symptom Checklist for Children (Briere, 1996)	Cognitive behavioral intervention for trauma in schools (Stein et al., 2003) Bounce Back (Langley et al., 2015) Support for Students Exposed to Trauma (Jaycox et al., 2009b) DBT skills groups (Mazza et al., 2016)	Consultations from SMH clinicians NCTSN online professional development (https://learn.nctsn.org)
One	Systematic Screening for Behavior Disorders (Walker & Severson, 1992) Behavioral and emotional screening system (Reynolds & Kamphaus, 2015) Strengths and Difficulties Questionnaire (Goodman, 1997) Social, Academic, and Emotional Behavior Risk Screener (Kilgus et al., 2016) Child Trauma Screening Questionnaire (Kenardy et al., 2006) Child Trauma Screen (Lang & Connell, 2017)	Social emotional learning curriculums (Durlak et al., 2011) School-wide positive behavior interventions & supports (Sugai & Horner, 2009) *Helping traumatized children learn* (Cole et al., 2009, 2013) Psychological First Aid in Schools (Brymer et al., 2012)	Attitudes Related to Trauma-Informed Care (Baker et al., 2016) Child Trauma Toolkit for Educators (NCTSN, 2008) Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals (NCTSN, 2011) Childhood Adversity Narratives (https://www.canarratives.org) (Putnam et al., 2015)

Note. This table contains examples of services to address student trauma across various components of multitiered systems of support (MTSS) in schools and is not intended to represent a comprehensive review of all available options. Inclusion in the table is not an empirical judgment on the quality of the evidence-base nor a blanket practice recommendation. See results section for a more thorough discussion of the example and its fit into MTSS logic.

Reinbergs, E. J., & Fefer, S. A. (2018). Addressing trauma in schools: Multitiered service delivery options for practitioners. *Psychology in the Schools*, *55*(3), 250-263.

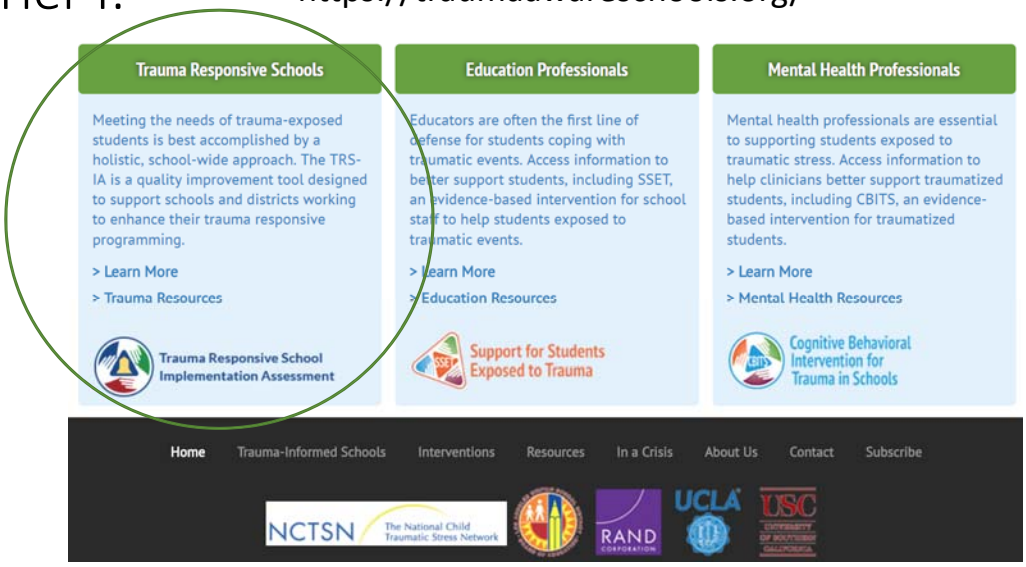
Tier I: Trauma Sensitive Schools



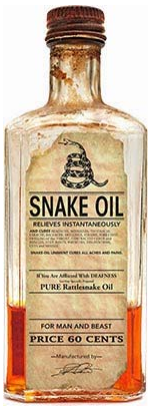


- 6 attributes: https://traumasensitiveschools.org/trauma-and-learning/the-solution-trauma-sensitive-schools/
- 6 elements – operations: https://traumasensitiveschools.org/trauma-and-learning/the-flexible-framework/

Tier I: https://traumaawareschools.org/

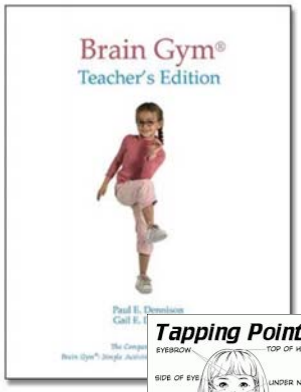


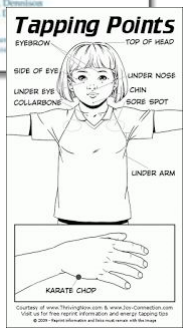
Caveat



"Not all things that sound good are effective."

–*Christopher Greeley, MD, MS, FAAP (TCH & Baylor College of Medicine)*





MedGenMed
Medscape General Medicine

MedGenMed. 2005; 7(3): 6.
Published online 2005 Aug 9.

PMCID: PMC1681667
PMID: 16369232

Coercive Restraint Therapies: A Dangerous Alternative Mental Health Intervention

Jean Mercer, PhD, Professor of Psychology

Author information ► Copyright and License information ► Disclaimer

This article has been cited by other articles in PMC.

Abstract and Introduction — Go to:

Abstract

Physicians caring for adopted or foster children should be aware of the use of coercive restraint therapy (CRT) practices by parents and mental health practitioners. CRT is defined as a mental health intervention involving physical restraint and is used in adoptive or foster families with the intention of increasing emotional attachment to parents. Coercive restraint therapy parenting (CRTP) is a set of child care practices adjuvant to CRT. CRT and CRTP have been associated with child deaths and poor growth. Examination of the CRT literature shows a conflict with accepted practice, an unusual theoretic basis, and an absence of empirical support. Nevertheless, CRT appears to be increasing in popularity. This article discusses possible reasons for the increase, and offers suggestions for professional responses to the CRT problem.

Tier II: Evidence Based Intervention Programs

Cognitive Behavioral Intervention for Trauma in Schools

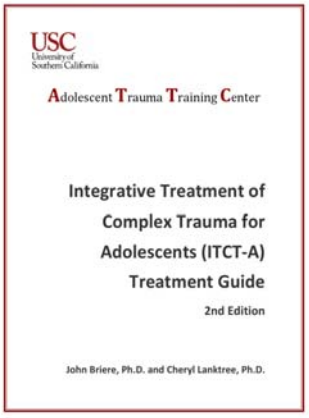
Evidence Ratings
- Trauma- and Stress-Related Disorders and Symptoms
- Anxiety Disorders and Symptoms
- Social Competence
- Non-Specific Mental Health Disorders and Symptoms
- Self-Concept
- Depression and Depressive Symptoms
- Educational Achievement
- Self-Regulation

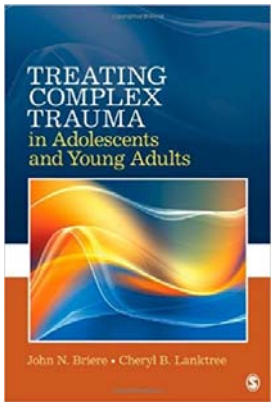
Bounce Back
An Elementary School Intervention for Childhood Trauma

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

https://nrepp.samhsa.gov/ProgramProfile.aspx?id=205 and SSET https://nrepp.samhsa.gov/ProgramProfile.aspx?id=170

Evidence Based Intervention Programs





- Download (free) Manual here: http://keck.usc.edu/adolescent-trauma-training-center/wp-content/uploads/sites/169/2016/06/ITCT-A-TreatmentGuide-2ndEdition-rev20131106.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

MUSC
Medical University of South Carolina

HOME INTRODUCTION RESOURCES CONTACT US REGISTER LOGIN

TF-CBT Web 2.0 | *A course for Trauma-Focused Cognitive Behavioral Therapy*

- Foundations of TF-CBT
- Psychoeducation
- Parenting Skills
- Relaxation
- Affect Identification & Regulation
- Cognitive Coping
- Trauma Narration and Processing I
- Trauma Narration and Processing II
- In Vivo Mastery
- Conjoint Parent-Child Sessions
- Enhancing Safety & Future Development

Allegheny Health Network | Rowan Medicine CARES INSTITUTE | NCTSN

- ✓ Depression and Depressive Symptoms
- ✓ General Functioning and Well-Being
- ✓ Non-Specific Mental Health Disorders and Symptoms
- ✓ Social Competence
- ✓ Trauma- and Stress-Related Disorders and Symptoms
- ✓ Anxiety Disorders and Symptoms
- ✓ Cognitive Functioning
- ✓ Disruptive Behavior Disorders and Symptoms

Evidence Based Intervention Programs

PCIT INTERNATIONAL

Scientific Rating:

1

Well-Supported by Research Evidence

See scale of 1-5

Teacher-Child Interaction Training (TCIT)

http://www.tcit.org/research/

- ✓ Disruptive Behavior Disorders and Symptoms
- ✗ School Climate

(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…

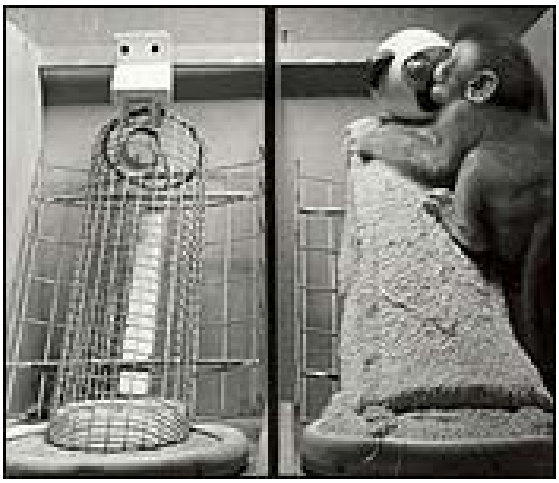
- What if I don't have the time/$/support/role to implement manualized intervention protocols in my school?
- What if my school isn't "trauma-informed" yet?
- How can I do this in a way that is…
  - Flexible…
  - But still evidence-informed (i.e., effective and not harmful)?

Break ☺

The ARC Model

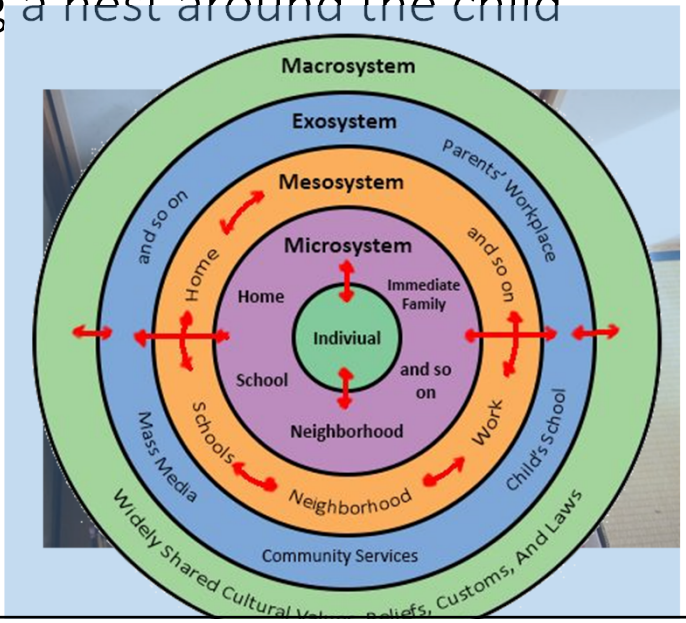
ARC Theoretical/empirical basis

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



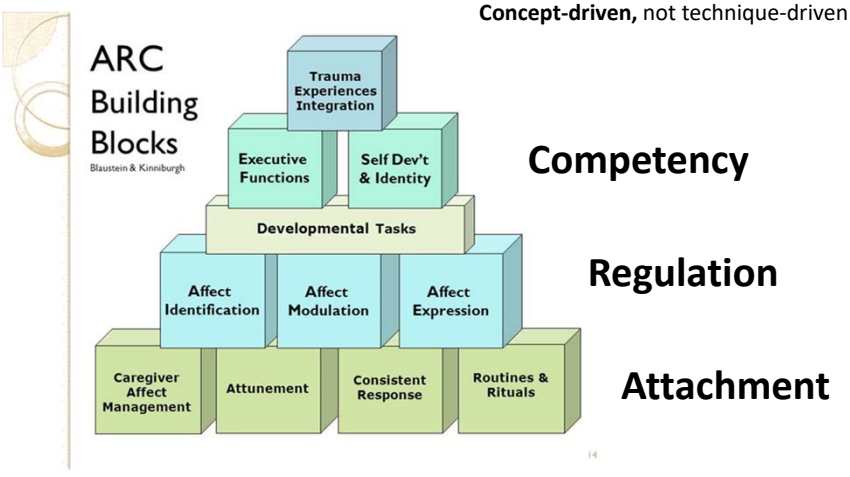
Building a nest around the child

Building a nest around the child



Attachment, Regulation, & Competency (ARC) Model

Concept-driven, not technique-driven

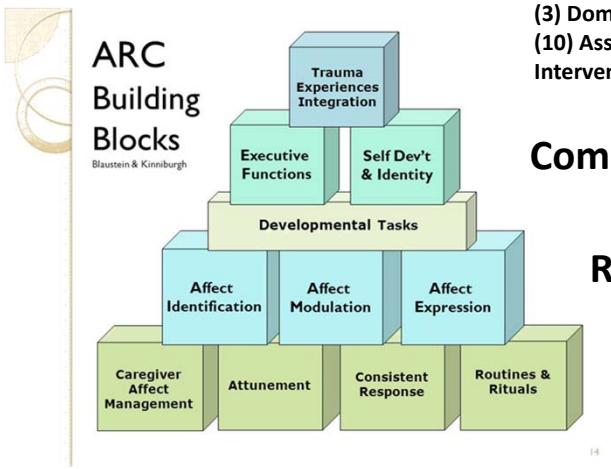


http://arcframework.org/what-is-arc/

Attachment, Regulation, & Competency (ARC) Model

Skills and competencies shown to be **negatively impacted** by traumatic stress and caregiver disruptions…

which, when addressed, **predict resilient outcomes**



(3) Domains and (10) Assessment and Intervention targets

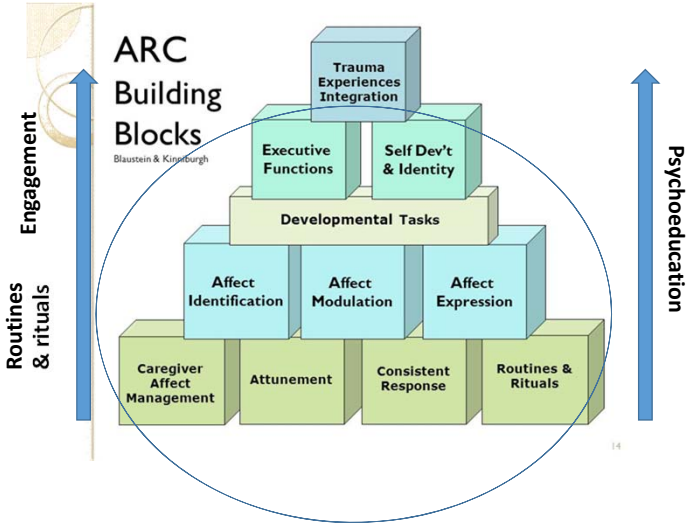
Competency

Regulation

Attachment

http://arcframework.org/what-is-arc/

Attachment, Regulation, & Competency (ARC) Model



ARC Evidence Base

[1] Hodgdon, H. B., Kinniburgh, K., Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and implementation of trauma-informed programming in youth residential treatment centers using the ARC framework. *Journal Of Family Violence, 28*(7), 679-692.
[2] Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., … & Blaustein, M. E. (2011). Treatment of complex trauma in young children: Developmental and cultural considerations in application of the ARC intervention model. *Journal of Child & Adolescent Trauma, 4*(1), 34-51.
[3] Hodgdon, H. B., Blaustein, M., Kinniburgh, K., Peterson, M. L., & Spinazzola, J. (2016). Application of the ARC model with adopted children: supporting resiliency and family well being. *Journal of Child & Adolescent Trauma, 9(1)*, 43-53.
[4]Bartlett, J. D., Barto, B., Griffin, J. L., Fraser, J. G., Hodgdon, H., & Bodian, R. (2015). Trauma-informed care in the Massachusetts child trauma project. *Child maltreatment*, 1077559515615700.
[5]Gabowitz, D. & Spinazzola, J. (2007, November). Partnering with other systems. Paper presented at the New Grantee Orientation of the National Child Traumatic Stress Network, Richmond, VA.
Source: http://arcframework.org/what-is-arc/research/
[6]Holmes, C., Levy, M., Smith, A., Pinne, S., & Neese, P. (2015). A model for creating a supportive trauma-informed culture for children in preschool settings. *Journal of child and family studies*, *24*(6), 1650-1659.

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_trial.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.

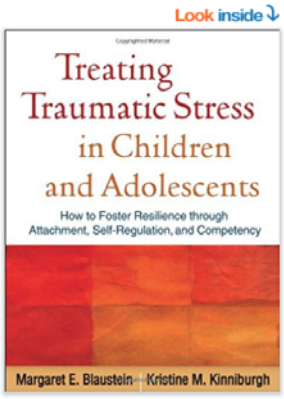
Adapted from: NCTSN ARC Factsheet http://nctsn.org/sites/default/files/assets/pdfs/arc_general.pdf

ARC Resources

http://www.traumacenter.org/research/ascot.php

http://arcframework.org/

**specific school providers forum*



ISBN-13: 978-1606236253
ISBN-10: 1606236253

A new edition will be published October 17, 2018.

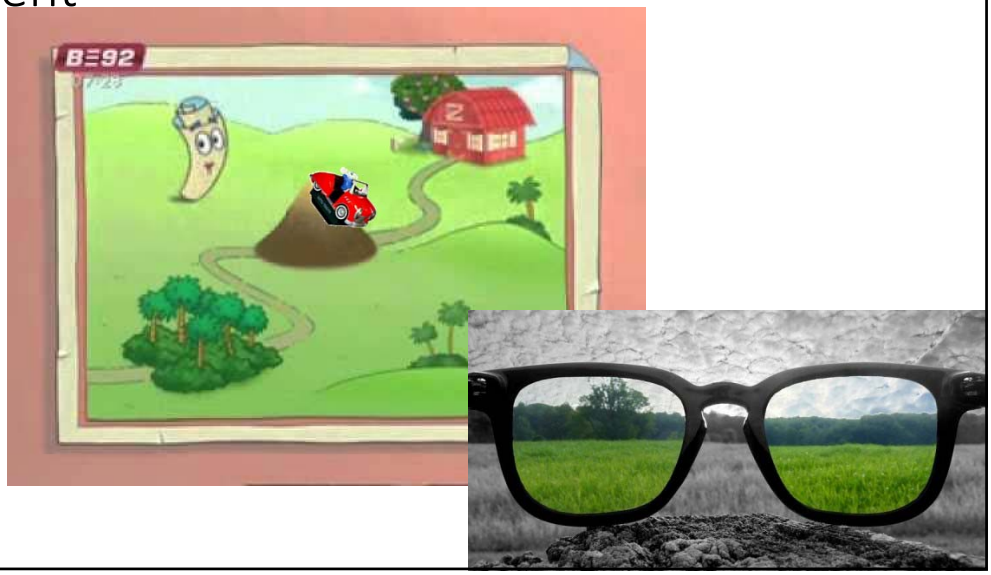
ARC framework applied in schools

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/

ARC-guided case conceptualization and assessment



What would your school do with this child?

Demographics — Sam

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

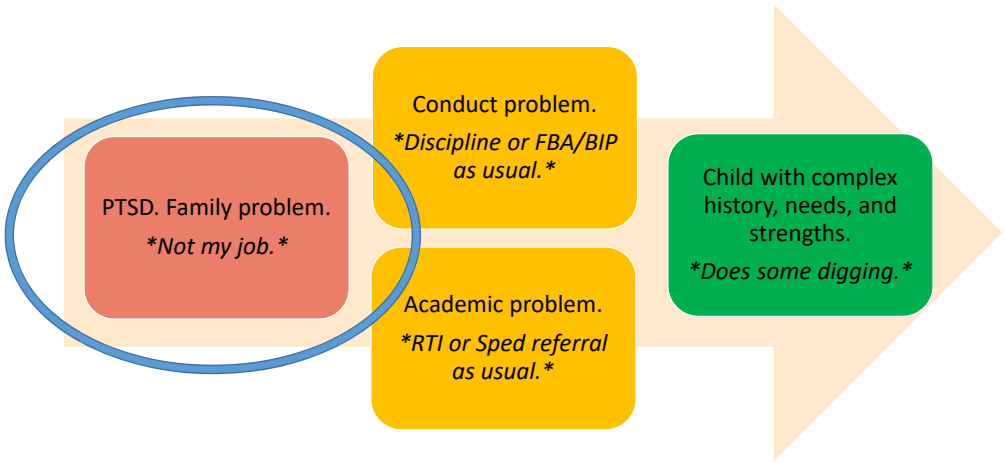
Learning

- 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**

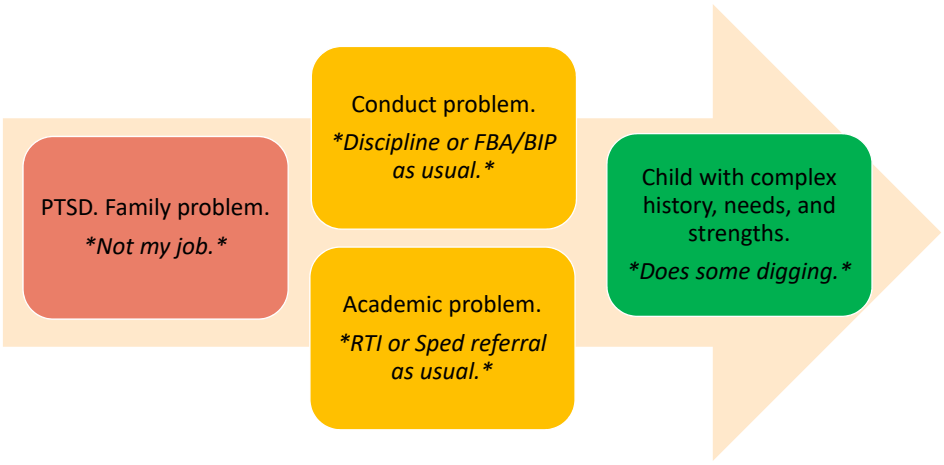
Common response



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



What would your school do with this child?

Demographics Andre

- Age 7
- Black
- Male
- Resides in large urban area

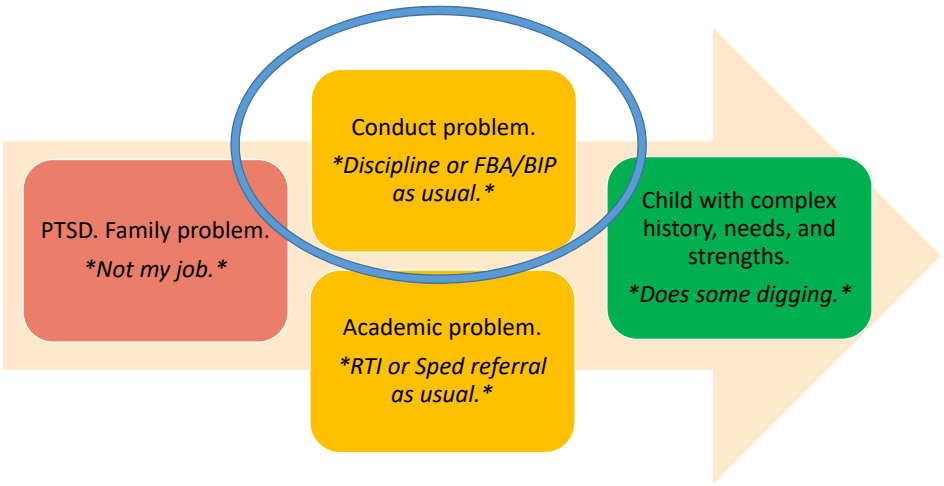
Learning

- 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**

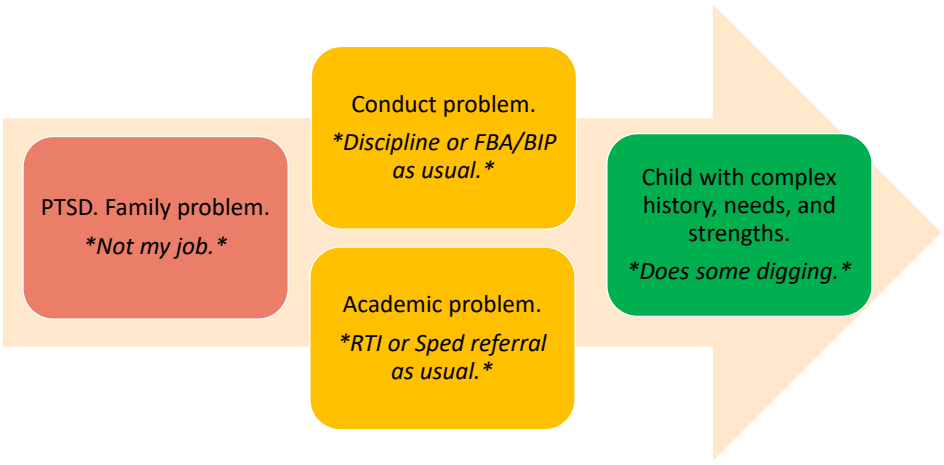
Common response



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



What would your school do with this child?

Demographics — Louisa

- Age 5
- Bi-racial
- Female
- Resides in large urban area

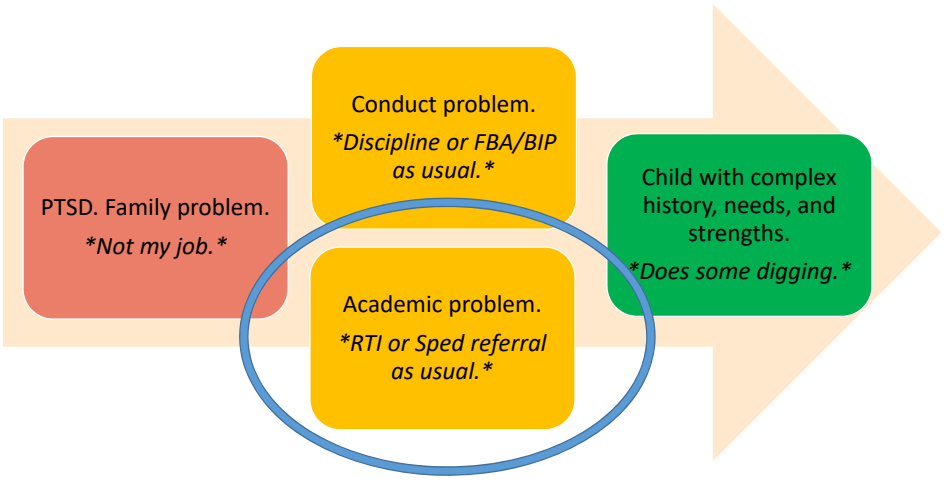
Learning

- 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

Common response



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.)

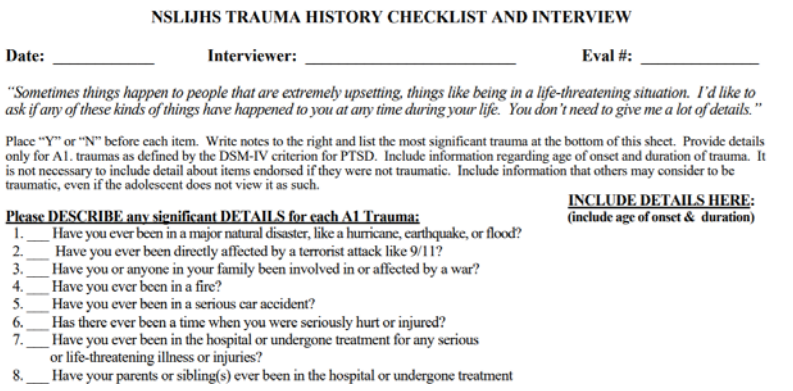
Question #1.

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



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 these kinds of things have happened to you at any time during 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. traumas as defined by the DSM-IV criterion for PTSD. Include information regarding age of onset and duration of trauma. It is not necessary to include detail 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: **INCLUDE DETAILS HERE: (include age of onset & duration)**

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. ___ Has 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 injuries?
8. ___ Have your parents or sibling(s) ever been in the hospital or undergone treatment

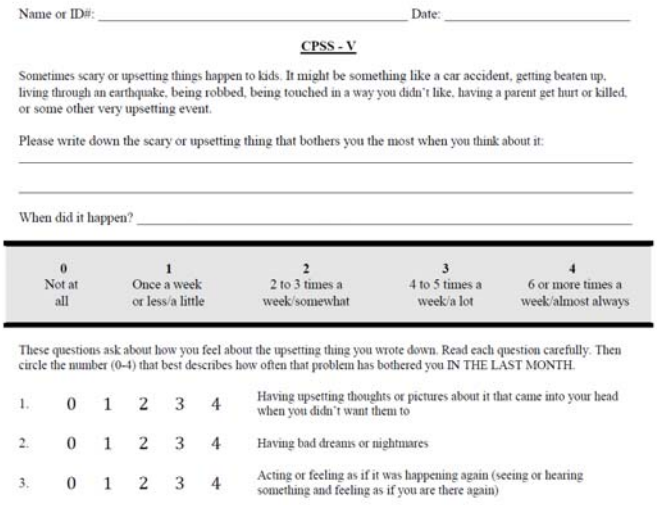
- Available here: http://www.mc.vanderbilt.edu/coe/tfcbt/workbook/Assessment/NSLIJHS%20Trauma%20History%20Checklist%20and%20Interview.pdf

Question #2.

- If exposure is known (or highly suspected)…

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

Symptoms



Name or ID#: _____ Date: _____

CPSS - V

Sometimes scary or upsetting things happen to kids. It might be something like a car accident, getting beaten up, living through an earthquake, being robbed, being touched in a way you didn't like, having a parent get hurt or killed, or some other very upsetting event.

Please write down the scary or upsetting thing that bothers you the most when you think about it:

_____

_____

When did it happen? _____

0 Not at all	1 Once a week or less/a little	2 2 to 3 times a week/somewhat	3 4 to 5 times a week/a lot	4 6 or more times a week/almost always

These questions ask about how you feel about the upsetting thing you wrote down. Read each question carefully. Then circle the number (0-4) that best describes how often that problem has bothered you IN THE LAST MONTH.

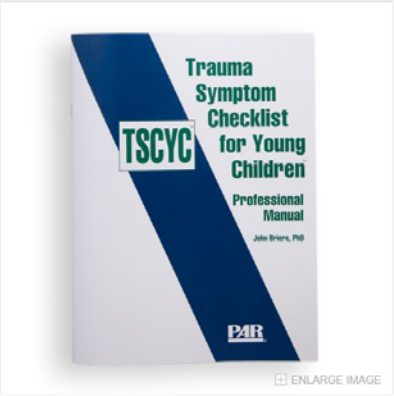
1.	0	1	2	3	4	Having upsetting thoughts or pictures about it that came into your head when you didn't want them to
2.	0	1	2	3	4	Having bad dreams or nightmares
3.	0	1	2	3	4	Acting or feeling as if it was happening again (seeing or hearing something and feeling as if you are there again)

- Available here:
- http://www.afcbt.org/materials/Downloads/CPSS-V%2003-15-17.pdf

Symptoms

(TSCYC) Trauma Symptom Checklist for Young Children

By John N. Briere, PhD



(TSCYC) Trauma Symptom Checklist for Young Children

BENEFITS	Provides a standardized, broadband trauma measure for very young children
AGES	3 to 12 years
ADMIN TIME	Less than 20 minutes
FORMAT	Behavior rating scale completed by caregiver
SCORES	Scale scores plus a summary score for PTSD
NORMS	Based on a stratified national sample of 750 children; presented separately for males and females in three age groups (3 to 4, 5 to 9, and 10 to 12 years)
PUBLISH DATE	1999
QUALIFICATIONS	Level C required. About Qualification Levels

- 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.

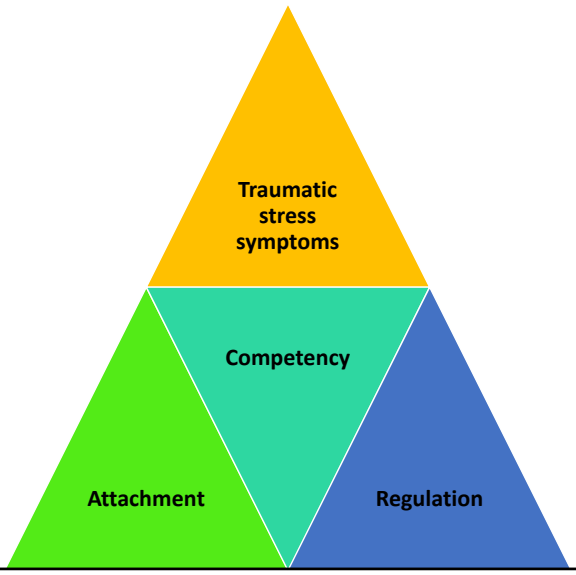
Rossen, E., & Cowan, K. (2013). The role of schools in supporting traumatized students. *Principal's Research Review*, *8*(6), 1-7.

Question #2.

- If exposure is known (or highly suspected)…
- And child is experiencing symptoms (even if no "PTSD")…

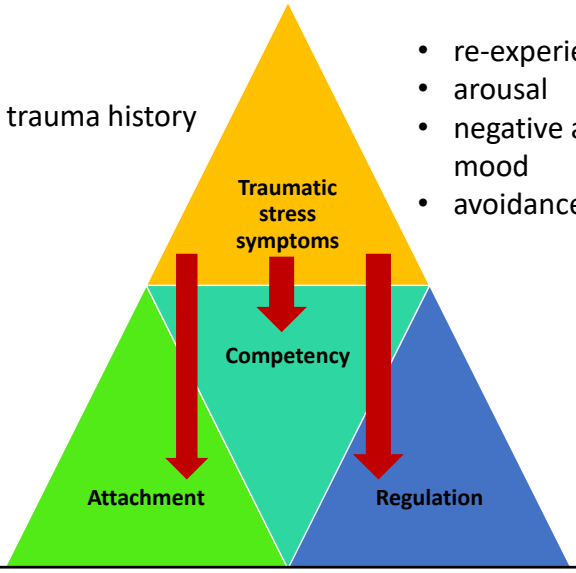
How might this child's **history** (exposure) and **symptoms *contribute*** to the observed academic, social, emotional, and/or behavioral difficulties?

Can you reframe the child's difficulties?



Can you reframe the child's difficulties?

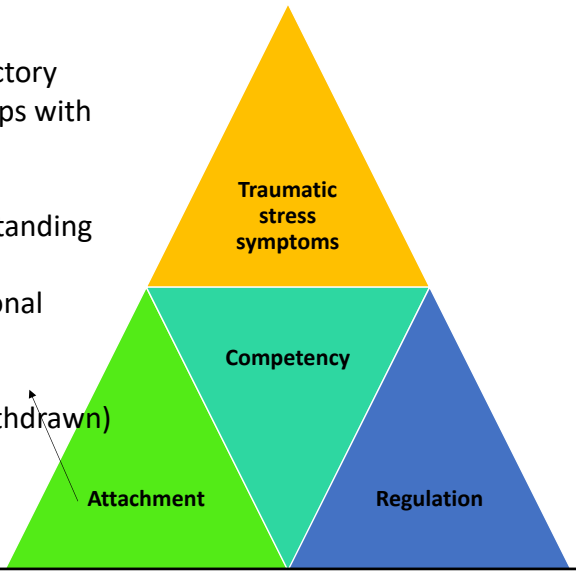
Known or suspected trauma history



- re-experiencing
- arousal
- negative alterations in cognition, mood
- avoidance

Can you reframe the child's difficulties?

- "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

Evidence-Based Practice in Child and Adolescent Mental Health

ISSN: 2379-4925 (Print) 2379-4933 (Online) Journal homepage: http://www.tandfonline.com/loi/uebh20

A RADical Idea: A Call to Eliminate "Attachment Disorder" and "Attachment Therapy" From the Clinical Lexicon

Brian Allen

ABSTRACT

"Attachment disorder" and "attachment therapy" are common terms used in applied clinical practice. However, these terms are not typically employed in research settings or published scientific papers. In this article, the author reviews the theoretical tenets and empirical research of attachment theory and discusses how these two terms fail to coincide with the scientific knowledge. The historical development of these phrases is considered, as well as the potential impact they have on clinical practice. The ultimate conclusion is that the "attachment disorder" and "attachment therapy" constructs are hindrances to evidence-based clinical practice and should be eliminated from the clinical lexicon.

Assessment: Attachment problems

Even in Eastern European orphanages ("grossly pathogenic care"), only **4.6%** showed inhibited, **31.8%** disinhibited "RAD" criteria (Gleason et al., 2011)

"…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,…"

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 Eastern European orphanages ("grossly pathogenic care"), only **4.6%** showed inhibited, **31.8%** disinhibited "RAD" criteria (Gleason et al., 2011)

"…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)

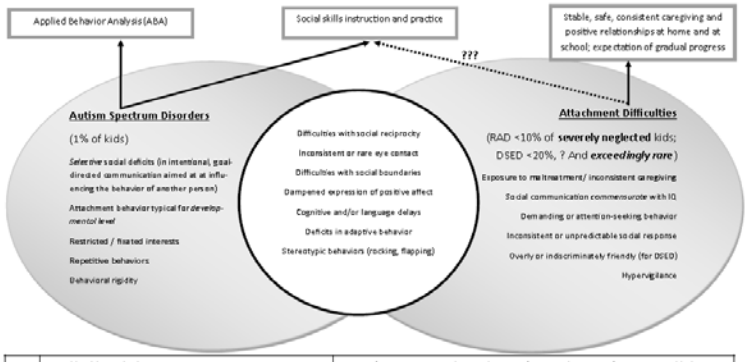
Assessment: Attachment problems

"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



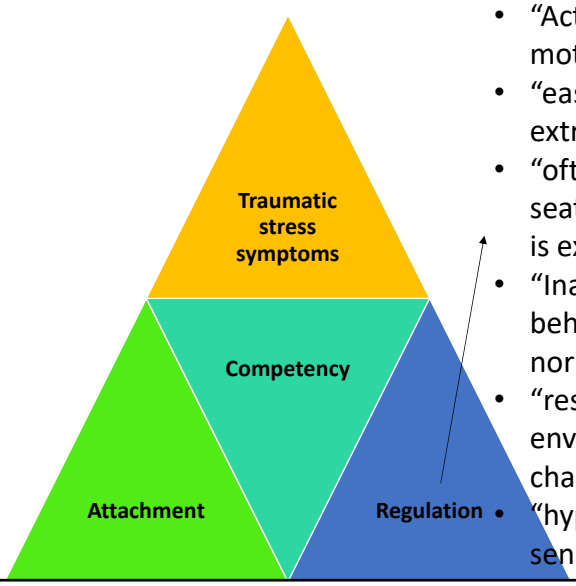
R	Mental health, medical, DFPS	History of trauma exposure (onset, duration, frequency); course of symptoms and behaviors; timeline of child's life; family tree/genogram
I	Parent or caregiver—NSLIJHS Trauma History Checklist and Interview	Developmental history (age at symptom onset?); screen for trauma 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	Evaluate quality and consistency of social interactions; attention-seeking, checking-in, and comfort-seeking behaviors; reactions to others' coming and going
T	Child PTSD Symptom Scale (CPSS), UCLA PTSD Index Teacher Relationship Problems Questionnaire (RPQ) (?) Cognitive, language, and adaptive measures	Exposure to possibly traumatic events; traumatic stress symptoms Quality of relationships and social interactions/responses *Note: Children with maltreatment histories but NO ASD commonly receive elevated scores on ASD rating scales (ASRS, SRS, GARS, etc.) Global vs. specific deficits in language/communication, intellectual functioning, socialization

Assessment: Attachment problems

R	Mental health, medical, DFPS	History of trauma exposure (onset, duration, frequency); course of symptoms and behaviors; timeline of child's life; family tree/genogram
I	Parent or caregiver—NSLIJHS 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	Evaluate quality and consistency of social interactions; attention-seeking, checking-in, and comfort-seeking behaviors; reactions to others' coming and going
T	Child PTSD Symptom Scale (CPSS), UCLA PTSD Index Teacher Relationship Problems Questionnaire (RPQ) (?) Cognitive, language, and adaptive measures	Exposure to possibly traumatic events; traumatic stress symptoms Quality of relationships and social interactions/responses *Note: Children with maltreatment histories but NO ASD commonly receive elevated scores on ASD rating scales (ASRS, SRS, GARS, etc.) Global vs. specific deficits in language/communication, intellectual functioning, socialization

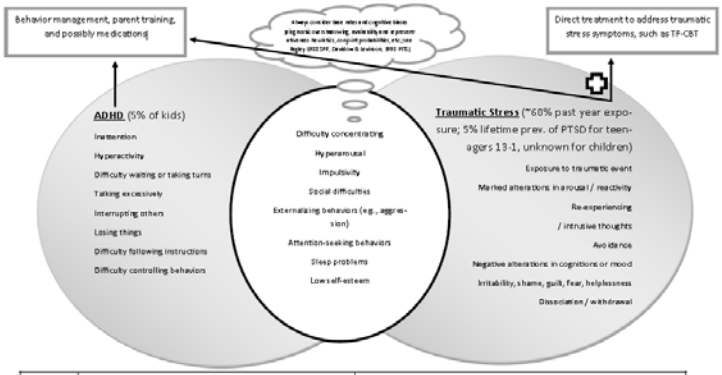
Sources: DSM-5; National Center for PTSD; NCTSN; Davidson et al., 2015 RIDD; Perfect et al., 2016; Weinstein , Staffelbach, & Biaggio, 2000

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



R	Mental health, medical, DFPS	History of trauma exposure (onset, duration, frequency); course of symptoms and behaviors; timeline of child's life; family tree/genogram
I	Parent or care giver—NSLIHS Trauma History Checklist and Interview Child	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
O	Multiple settings and days/times, esp. during unstructured times	Evaluate setting events, possible antecedents or "triggers"
T	Child PTSD Symptom Scale (CPSS), UCLA PTSD Index Trauma Symptom Checklist for Children (TSCC or TSCYC)	Exposure to possibly traumatic events PTS symptoms, dissociation, sexual concerns

Sources: DSM-5; National Center for PTSD; NCTSN; Davidson et al., 2015 RIDD; Perfect et al., 2016; Weinstein, Staffelbach, & Biaggio, 2000

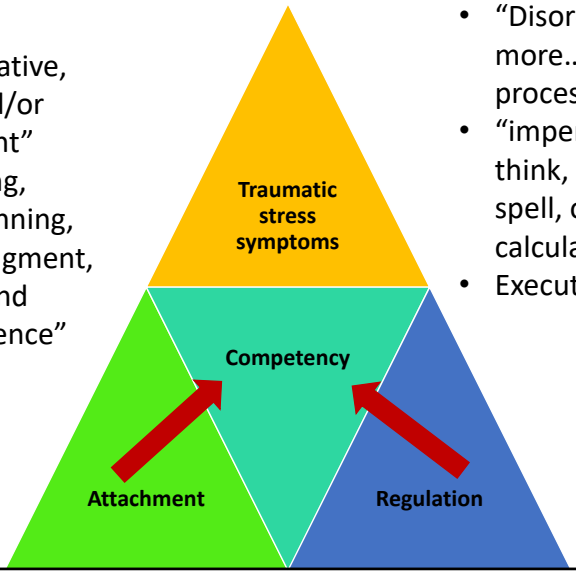
Assessment: Self-Regulation problems

R	Mental health, medical, DFPS	History of trauma exposure (onset, duration, frequency); course of symptoms and behaviors; timeline of child's life; family tree/genogram
I	Parent or caregiver—NSLIJHS Trauma History Checklist and Interview Child	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
O	Multiple settings and days/times, esp. during unstructured times	Evaluate setting events, possible antecedents or "triggers"
T	Child PTSD Symptom Scale (CPSS), UCLA PTSD Index Trauma Symptom Checklist for Children (TSCC or TSCYC)	Exposure to possibly traumatic events PTS symptoms, dissociation, sexual concerns

Sources: DSM-5; National Center for PTSD; NCTSN; Davidson et al., 2015 RIDD; Perfect et al., 2016; Weinstein , Staffelbach, & Biaggio, 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

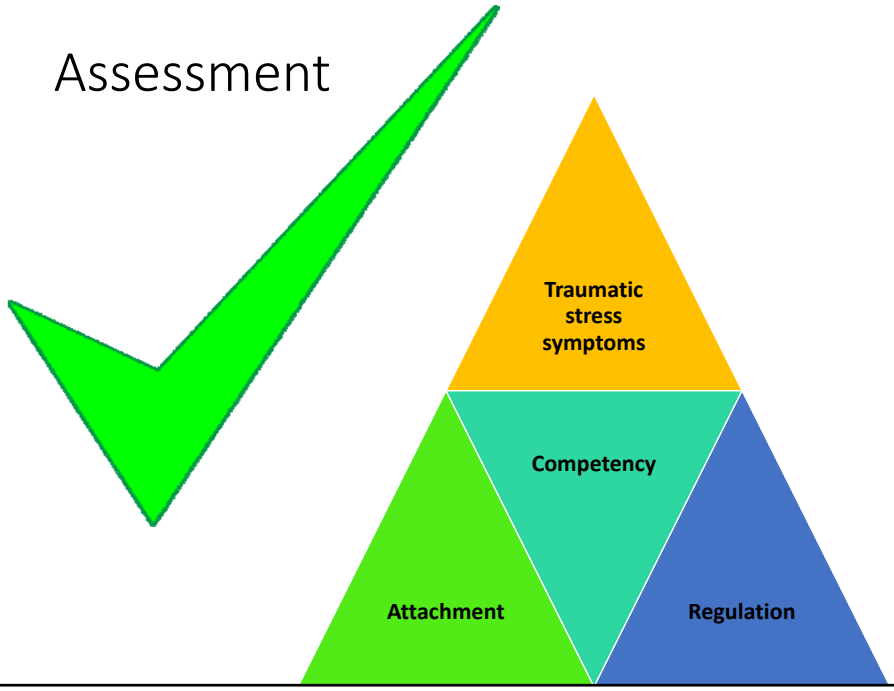
Assessment: Competency

- 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)

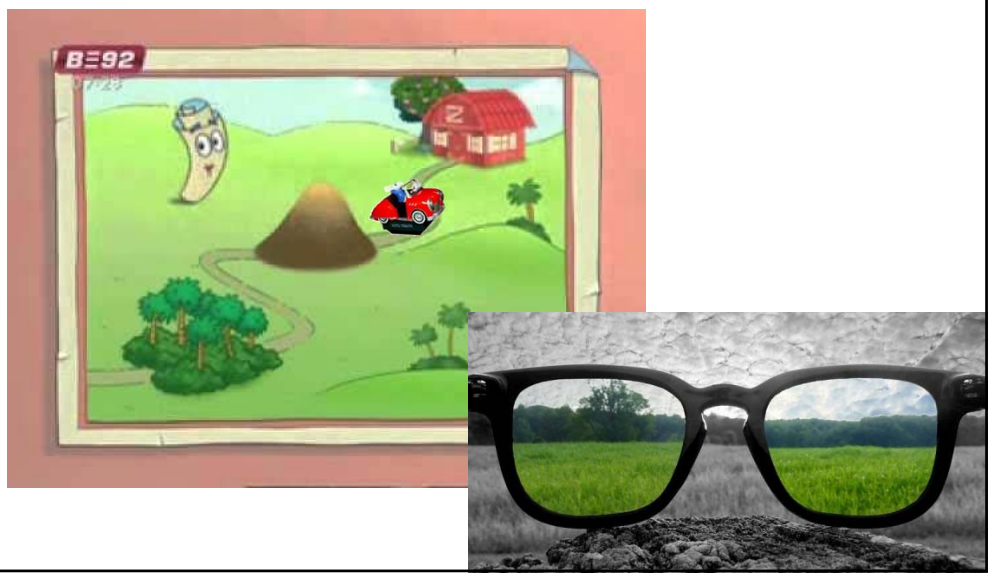
Assessment: Competency

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

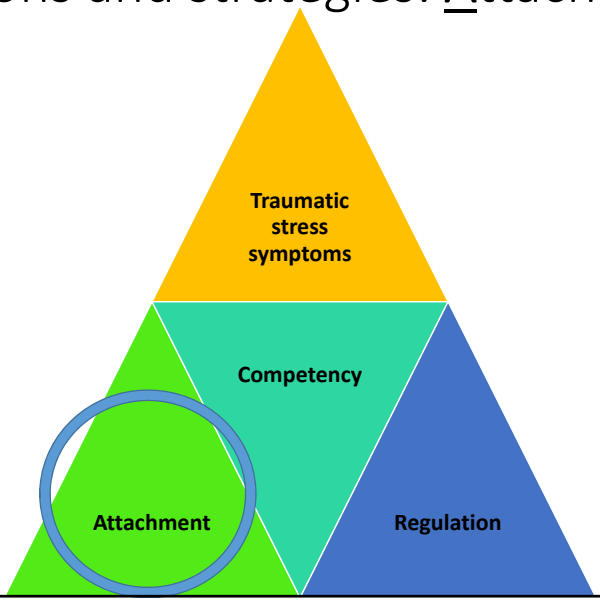
Assessment



ARC-informed interventions and strategies



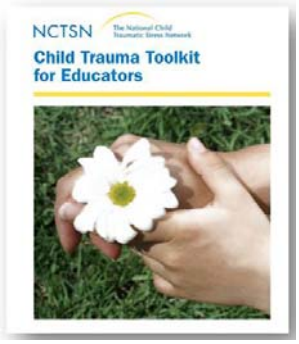
Interventions and strategies: Attachment



Psychoeducation about trauma's impact, child's history

- Help teachers understand:

Behavior is the language of trauma



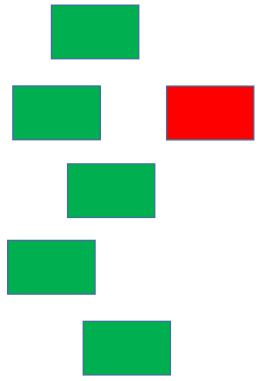
http://www.nctsn.org/resources/audiences/school-personnel/trauma-toolkit

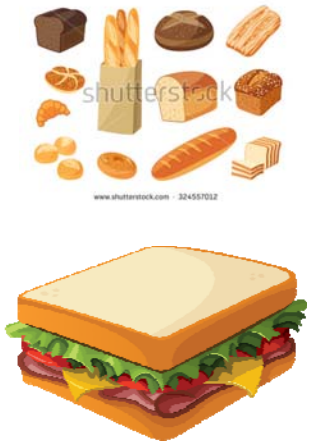
Build teacher's awareness of their own emotional reactions to child behaviors

Help teacher with attunement

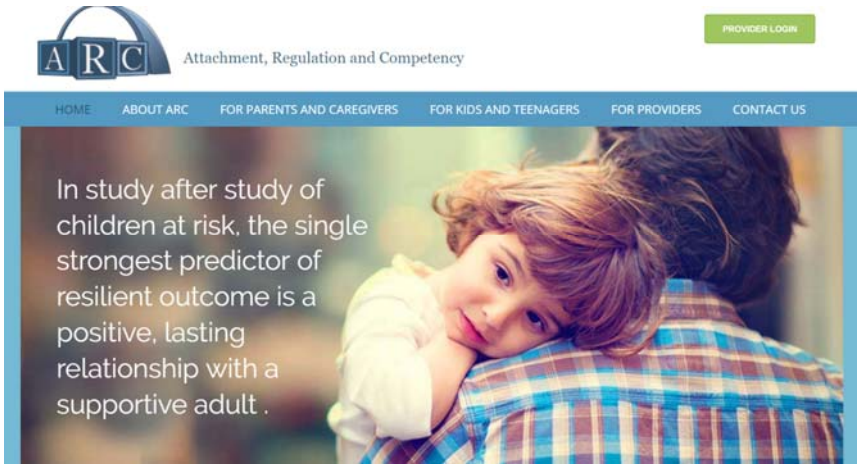
- AKA antecedent awareness ☺
  - "Tuning in" to the child's cues (needs, subtle signals)
  - Anticipating student's needs and possible triggers

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

Youth put up bookbags, listen to morning announcements and sit in circle

↓

Staff put out felt color blocks, and youth choose color based on mood meter. if any youth on RED, follow Youth on RED Process

↓

Teacher gives general greeting and guides youth in check-ins, making reflective/mirroring statements for each youth

↓

Address Weekly Theme based on SEL Curriculum

Define, Identify, Practice

Developed by Jen Packard, LCSW, CHRIS Counseling Center, Atlanta, GA
Based on Attachment, Regulation and Competency (ARC) – Blaustein & Kinniburgh, 2010; Kinniburgh & Blaustein, 2005

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) Paraproffessional 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 Packard, LCSW, CHRIS Counseling Center, Atlanta, GA
Based on Attachment, Regulation and Competency (ARC) – Blaustein & Kinniburgh, 2010; Kinniburgh & Blaustein, 2005

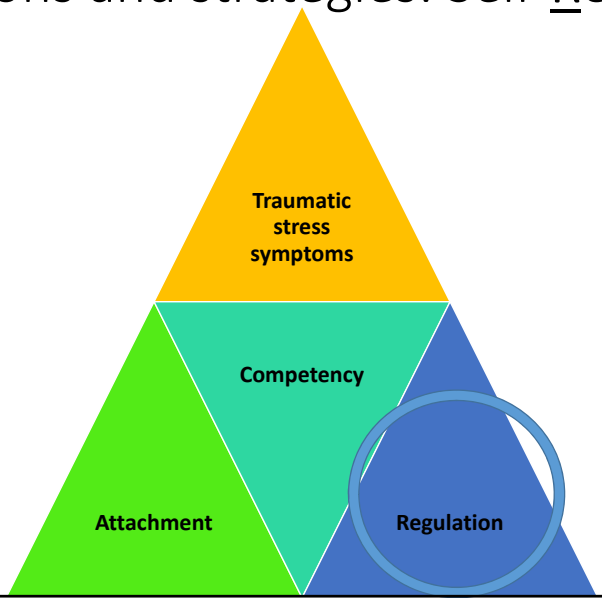
Train (and support) <u>all</u> teachers and staff

- Trauma's impact on learning, behavior
- Recognizing signs
- Consistent and **effective response**
- **Self-care!**

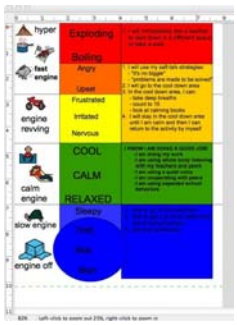
Built-in time for relationship building

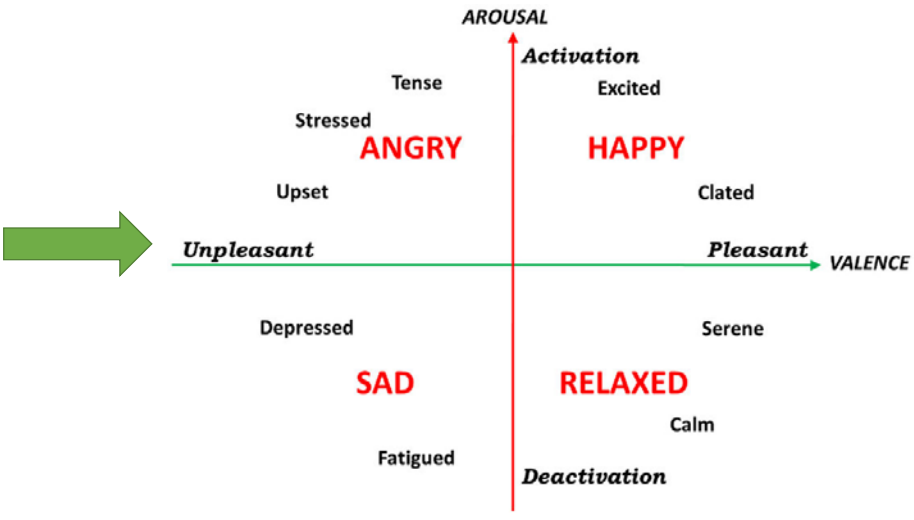
Strong family-school communication and collaboration

Interventions and strategies: Self-Regulation



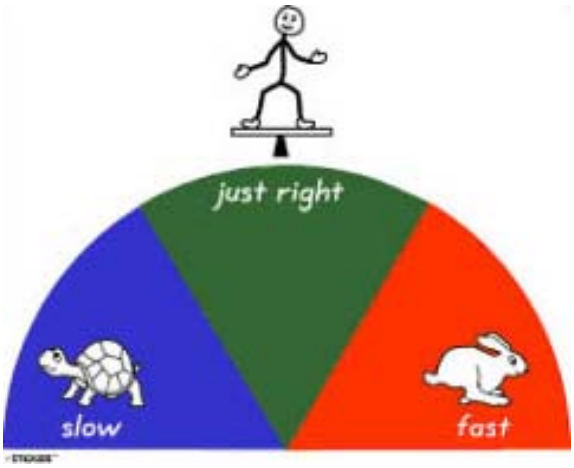
"Affect" and granularity



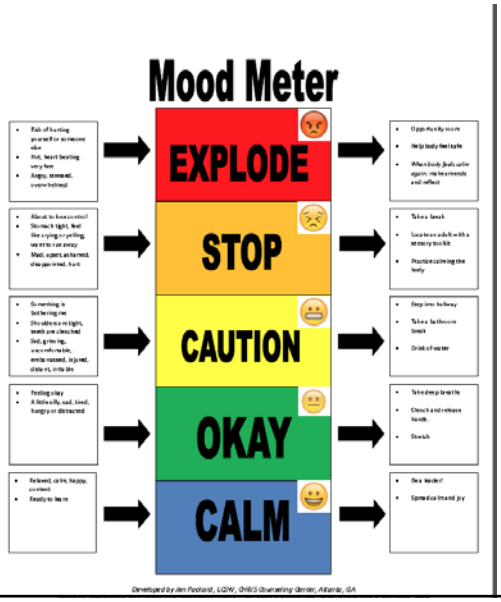


Valenza, G., Citi, L., Lanatá, A., Scilingo, E. P., & Barbieri, R. (2014). Revealing real-time emotional responses: a personalized assessment based on heartbeat dynamics. *Scientific reports*, *4*, 4998.

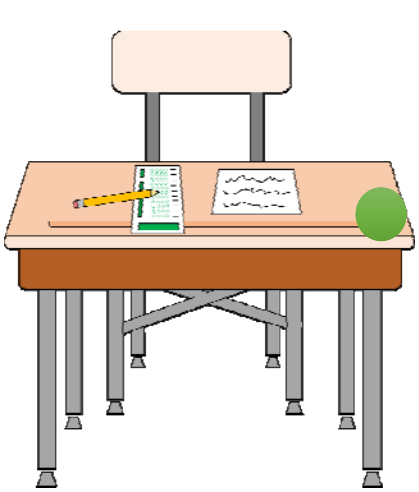
Regulating arousal



Include coping skills for high arousal + high negativity



Help teachers cue and reinforce appropriate responses



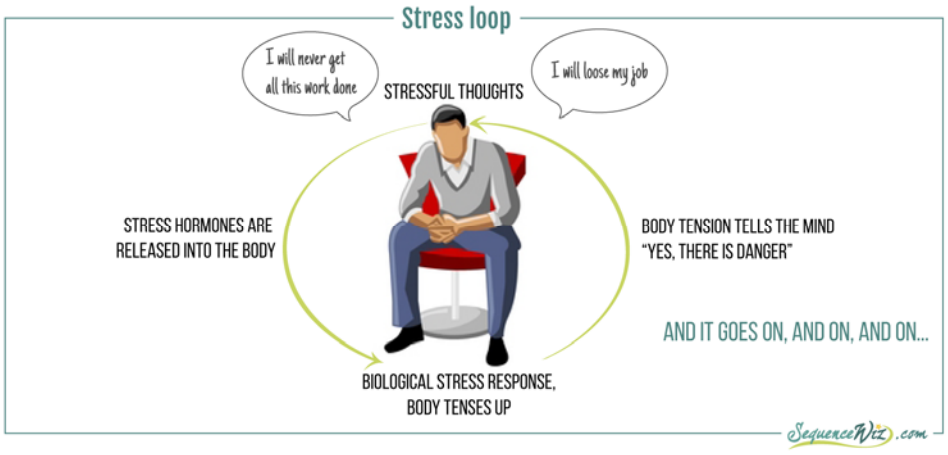
Individual counseling

Cognitive Behavioral approaches

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

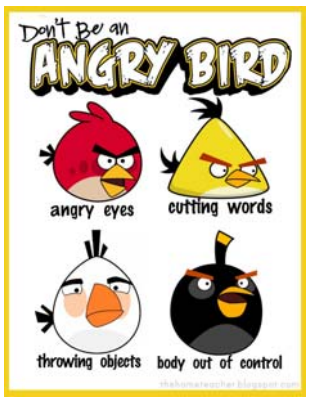
http://www.nctsn.org/sites/default/files/assets/pdfs/effective_treatments_youth_trauma.pdf

CBT techniques



CBT techniques

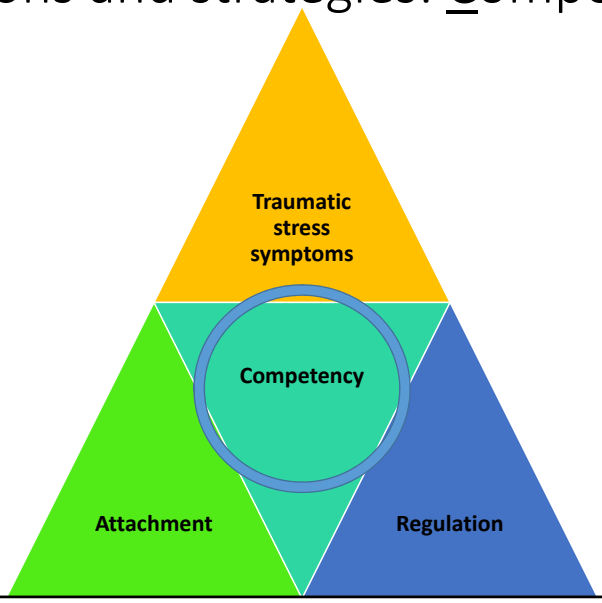
Relaxation, stress management skills – In the moment:



Relaxation, stress management skills – regular practices ("flossing")

Mindful Minute: Quick Mindfulness Meditation Exercise for Kids by GoZen!

Interventions and strategies: Competency

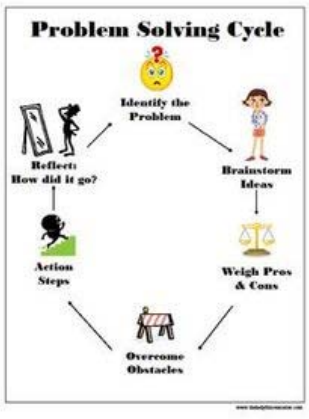


This is the stuff you already know how to do!

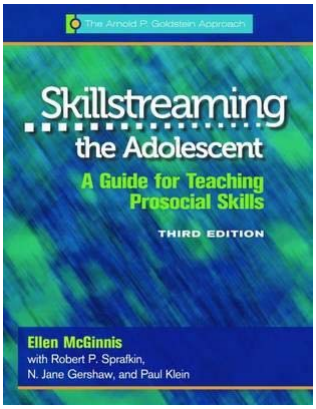
- Targeted interventions for skills deficits…
  - Developmental domains
  - Adaptive skills
  - Achievement (reading, math, writing – SLD)
- Teach (and cue and reinforce)…
  - **Social skills** (SEL, groups) – including safety, problem solving, conflict mgmt
  - **Executive skills** (coaching, individual,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

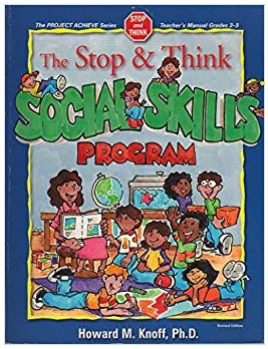
Teach social skills

Image courtesy of E-Learning



Teach social skills

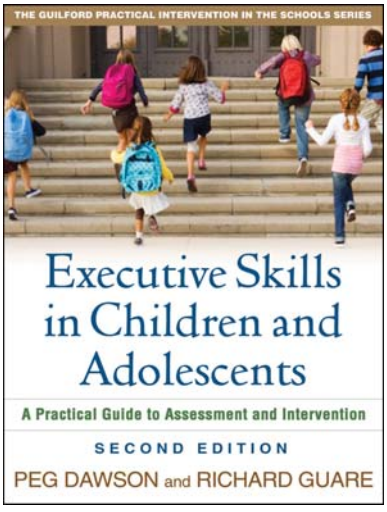


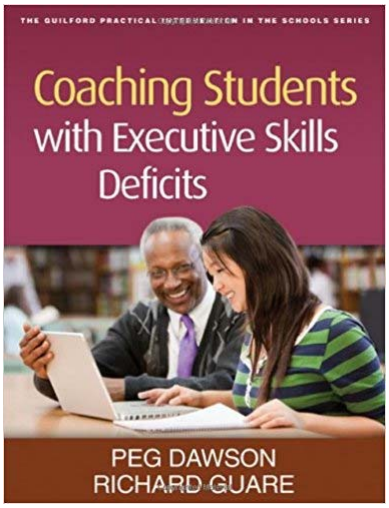


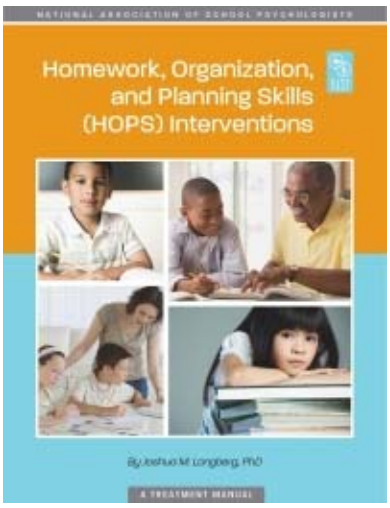
Teach executive skills

Teach executive skills

Teach executive skills

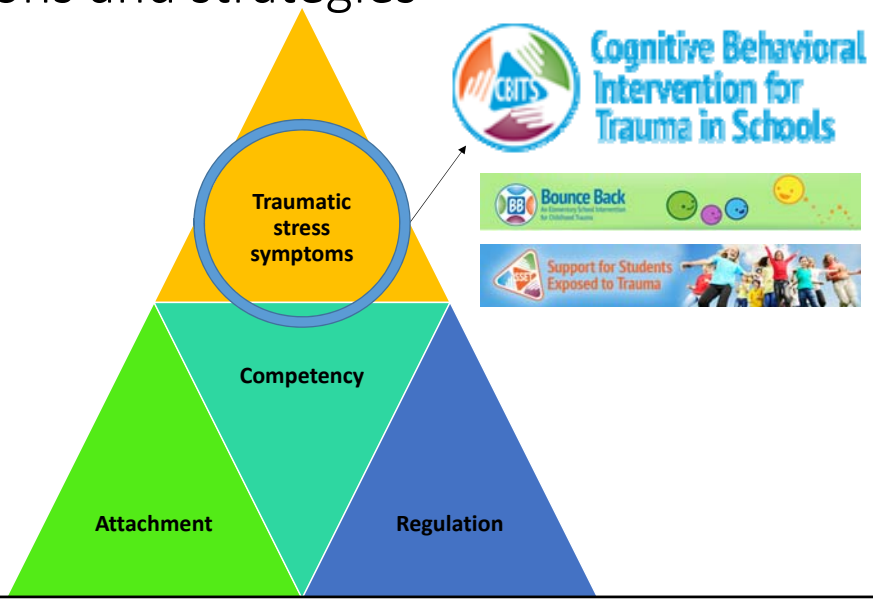




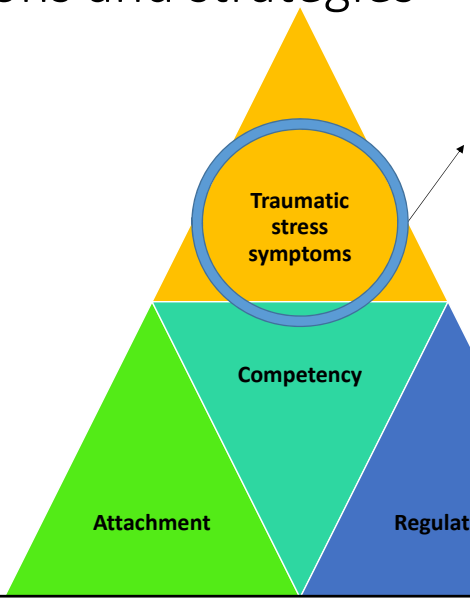


Identify and use strengths, interests

Interventions and strategies



Interventions and strategies



TF-CBT

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

R Relaxtion
Relaxation skills individualized to the child and parent

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

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

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

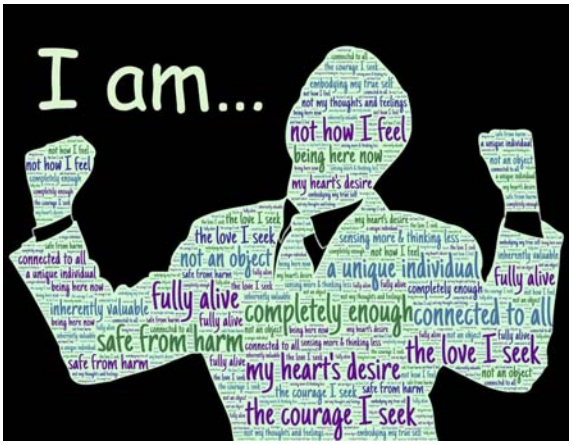
I InVivo Exposure
Mastery of trauma reminders

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

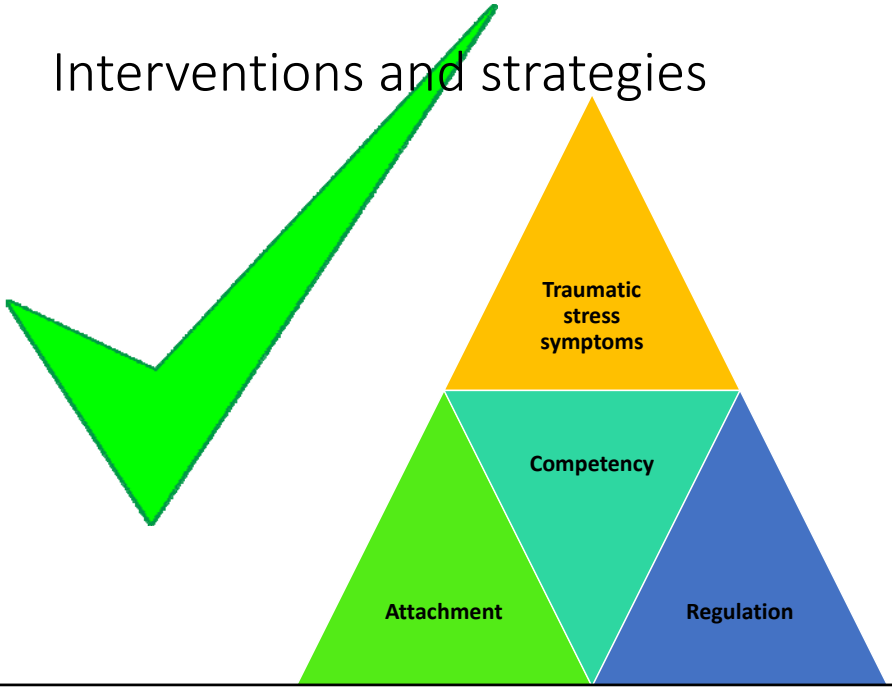
E Enhancing Safety and Development
Enhancing future personal safety and optimal developmental trajacetory by providing safety planning and social skills training

TF-CBT

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



Interventions and strategies



Move from "What's wrong with you" to…

What **happened** to you?

Thank you!

straitj@uhcl.edu