Trauma Informed Resources (2015): Amy Lansing, Ph.D.

- **Colorado**

Colorado Coalition Against Domestic Violence
http://ccadv.org/what-we-do/special-projects/tic/

"CCADV is uniquely situated to provide trainings and technical assistance to help ensure that trauma-informed interventions are at the core of working with victims and their children." They hold monthly TIC workgroup to train professionals and agencies so that the concept of TIC can be better applied in practices. "CCADV partnered with the National Center on Domestic Violence, Trauma, and Mental Health to distribute a survey to program Directors on current trauma-informed advocacy practices. The data from the survey will be reviewed by the TIC Workgroup to help identify areas of practice strength and opportunity, and set the goals for our work."

The TIC Workgroup will also:

- Read and share highlights from expert resources
- Present webinars on TIC in advocacy work
- Provide input on upcoming 'Beyond Trauma' learning circles
- Develop expertise and support one another's advocacy work!

Kempe Center for the Prevention and Treatment of Child Abuse and Neglect
http://www.kempe.org/traumaprogram

"The primary goal of the **Kempe Child Trauma Program** is to bring evidence-based, culturally-informed mental health treatment to children who have experienced trauma and their families. We do this by (1) providing clinical service, (2) training professionals and parents, and (3) conducting community-based research on intervention development, dissemination, and implementation." They have the child trauma clinic, which treats children of age 0 to 18 and families who are traumatized. This family-based, short-term, goal-oriented treatments help children's to improve in emotion regulation, coping skills, and healthy parent-children relationship.

Evidence-based interventions used include:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Child Parent Psychotherapy (CPP)
- Alternatives for Families: Cognitive Behavioral Therapy (AF-CBT)
- A Family Focused Emotion Communication Training Program (AFFECT)

- **New Mexico**

Clinical

Trauma Informed Practices Project (TIPP)

New Mexico was selected to be one of three states that will receive extensive training and technical assistance on trauma informed practice from the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH). This initiative is called the Trauma Informed Practice Project ("TIPP") and includes a broad range of topics (trauma and children, organizational healing, the intersection of DV and mental health, the intersection of DV and substance abuse, the Advocacy Beyond Leaving model). Researchers involved with this project helped to develop an evidence base and to integrate trauma perspectives into practice. A comprehensive introduction to "Trauma-Informed Domestic Violence Services: Understanding the Framework and Approach" at: http://www.vawnet.org/advanced-search/summary.php?doc_id=3527&find_type=web_desc_SC .

Research

Las Cumbres Community Services, Inc., An Evidence-Based Trauma-Informed Practice Model

Funding Period: [2012 - 2016]

Description: An Evidence-Based Trauma-Informed Practice Model will be developed to build a comprehensive network of evidence-based, trauma-informed service providers to reach children aged 0–6 and their families throughout the rural/frontier area of northern New Mexico. The target populations are

predominantly living in poverty, are about 75 percent Latino/Latina, and are at very high risk for traumatic experiences. The project will provide direct trauma-focused services to 1,580 individuals during the four years of the grant. A wide variety of integrated evidence-based, trauma-informed strategies will be used including Child-Parent Psychotherapy (CPP), Dialectical Behavior Therapy (DBP), Circle of Security™, art therapy, and Child-Centered Play Therapy (CCPT).

Contact: Stacey Frymier
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University of New Mexico Health Sciences Center, Addressing Childhood Trauma through Intervention, Outreach, and Networking
Funding Period: [2012 - 2016]
Description: The Addressing Childhood Trauma through Intervention, Outreach, and Networking (ACTION) initiative will support the university's Children's Psychiatric Center Outpatient Services (CPC-OS) in implementing an outpatient trauma-informed specialty clinic serving children and adolescents aged 5–18 who have experienced trauma, with special emphasis on serving children/youth from military families and Native American children/youth. ACTION plans to enroll 165 children and adolescents over the life of the grant.

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- **Texas**

Texas Department of Family and Protective Services
http://www.dfps.state.tx.us/training/trauma_informed_care/

They provide training for families, and care providers so they can better understand trauma-informed care, and child traumatic stress. They have a link to the trauma-informed care guide so after the training, trainees can go back to the guide to be reminded of what they learned. The training is online, and it takes about 2 hours.

Additional Information for Child-Placing Agencies and Residential Operations
This online training satisfies the requirements of **Residential Child Care Contract Attachment C B502.03** as long as residential child care providers and foster parents comply with the additional requirements:

B502.03 Each direct care staff must receive trauma informed care training annually. Each newly hired direct care staff must receive trauma informed care training within 60 days of hire or foster home verification. Certification of completed trauma informed care training must be placed in staff and foster parent records containing the training staff signature, completion date and number of hours. STAR Health Trauma Informed Care training is available at no cost at the following website: http://www.fostercaretx.com/about-us/centene-corporation/training/*External Link*.

Note: No minimum hours of trauma informed care training is required. Hours earned for trauma informed care training may be counted towards pre-service training requirements.

→Additional Website Resources

- **The National Child Traumatic Stress Network**
  http://www.nctsnet.org/
- **Education Law Clinic/Trauma and Learning Policy Initiative** (Harvard Law Clinic)
  http://www.law.harvard.edu/academics/clinical/clinics/education.html
- **National Center for Trauma Informed Care**
  http://www.samhsa.gov/nctic/trauma-interventions

Trauma Informed Resources (2015): Amy Lansing, Ph.D.

- **Article written about Trauma Sensitive School movement**
  http://acestoohigh.com/2012/05/31/massachusetts-washington-state-lead-u-s-trauma-sensitive-school-movement/
- **Strangers No More – documentary on school in Tel Aviv**
  http://www.strangersnomoremovie.com/

Table 1. Among Children Aged Birth to 17, Percentage Reported to Have Had Zero, One or Two, or Three or More Adverse Childhood Experiences (ACEs), Nationally, and by State

State	Number Of Adverse Childhood Experiences		
	0	1 OR 2	3+
United States	54	35	11
Alaska	51	35	14
Alabama	48	40	12
Arkansas	45	41	14
Arizona	44	40	15
California	57	33	9
Colorado	57	33	10
Connecticut	61	32	7
District of Columbia	51	37	11
Delaware	52	35	13
Florida	49	42	9
Georgia	53	38	9
Hawaii	56	35	9
Iowa	55	33	12
Idaho	50	35	15
Illinois	59	32	9
Indiana	49	36	15
Kansas	54	34	12
Kentucky	46	37	16
Louisiana	50	38	12
Massachusetts	58	33	9
Maryland	61	31	8
Maine	48	37	15
Michigan	51	35	14
Minnesota	56	34	10
Missouri	52	35	12
Mississippi	46	39	15
Montana	48	35	17
North Carolina	52	36	12
North Dakota	58	32	10
Nebraska	56	32	11
New Hampshire	55	33	12
New Jersey	61	32	7
New Mexico	47	39	14
Nevada	47	40	13

Table 1. Among Children Aged Birth to 17, Percentage Reported to Have Had Zero, One or Two, or Three or More Adverse Childhood Experiences (ACEs), Nationally, and by State

State	NUMBER OF ADVERSE CHILDHOOD EXPERIENCES		
	0	1 OR 2	3+
New York	58	34	8
Ohio	50	36	14
Oklahoma	45	38	17
Oregon	50	35	15
Pennsylvania	54	34	12
Rhode Island	53	37	11
South Carolina	49	39	12
South Dakota	58	30	11
Tennessee	48	38	13
Texas	54	36	10
Utah	59	31	9
Virginia	58	34	8
Vermont	50	38	11
Washington	53	36	11
Wisconsin	54	35	11
West Virginia	48	36	16
Wyoming	52	34	15

Economic Hardship is the Most Common Adverse Childhood Experience

By far, the most common ACEs in all 50 states are economic hardship, and parental divorce or separation (Table 2). Nationally, just over one in four children ages birth through 17 has experienced economic hardship somewhat or very often. Only in Iowa, Michigan, and Vermont is divorce more prevalent than economic hardship (in Wyoming and Oklahoma they are equally prevalent). In most states (45), living with a parent who has an alcohol- or drug-use problem is the third-most-prevalent ACE (national prevalence is about one in ten children). Death of a parent is experienced by three percent of children nationally and is relatively rare in all states: only in the District of Columbia and Mississippi is prevalence greater than five percent (seven and six percent, respectively).

Table 2. Four Most Common Adverse Childhood Experiences (and percentage prevalence) Among Children Ages Birth through 17, Nationally, and by State

State	Highest	2nd	3rd	4th
United States	Economic Hardship (26)	Divorce (20)	Alcohol (11)	Violence (9) Mental Illness (9)
Alaska	Economic Hardship (25)	Divorce (24)	Alcohol (15)	Mental Illness (11)
Alabama	Economic Hardship (29)	Divorce (23)	Alcohol (11)	Mental Illness (10)
Arkansas	Economic Hardship (33)	Divorce (26)	Alcohol (13)	Mental Illness (11)
Arizona	Economic Hardship (34)	Divorce (24)	Alcohol (16)	Violence (11)
California	Economic Hardship (22)	Divorce (17)	Alcohol (11)	Violence (8)
Colorado	Economic Hardship (23)	Divorce (21)	Alcohol (10)	Mental Illness (9)
Connecticut	Economic Hardship (22)	Divorce (16)	Alcohol (8)	Mental Illness (8)
District of Columbia	Economic Hardship (24)	Violence (17)	Divorce (15)	Incarceration (8)
Delaware	Economic Hardship (25)	Divorce (21)	Violence (12)	Alcohol (7)
Florida	Economic Hardship (30)	Divorce (20)	Alcohol (9)	Incarceration (8)
Georgia	Economic Hardship (26)	Divorce (19)	Violence (8) Alcohol (8) Incarceration (8)	Domestic Violence (7)
Hawaii	Economic Hardship (21)	Divorce (17)	Violence (11) Alcohol (11)	Domestic Violence (8)
Iowa	Divorce (22)	Economic Hardship (22)	Alcohol (13) Mental Illness (13)	Domestic Violence (8)
Idaho	Economic Hardship (27)	Divorce (25)	Alcohol (14)	Mental Illness (13)
Illinois	Economic Hardship (23)	Divorce (16)	Alcohol (9)	Violence (8)
Indiana	Economic Hardship (28)	Divorce (24)	Alcohol (13)	Incarceration (11) Mental Illness (11)
Kansas	Economic Hardship (28)	Divorce (22)	Mental Illness (10) Alcohol (10)	Violence (8)
Kentucky	Economic Hardship (30)	Divorce (29)	Alcohol (14)	Incarceration (13)
Louisiana	Economic Hardship (27)	Divorce (23)	Mental Illness (10) Alcohol (10) Violence (10)	Incarceration (8)
Massachusetts	Economic Hardship (22)	Divorce (19)	Alcohol (11)	Mental Illness (9)
Maryland	Economic Hardship (20)	Divorce (17)	Alcohol (8) Violence (8)	Mental Illness (7)
Maine	Economic Hardship (29)	Divorce (27)	Alcohol (14)	Mental Illness (13)
Michigan	Divorce (26)	Economic Hardship (25)	Alcohol (13)	Mental Illness (11)
Minnesota	Economic Hardship (22)	Divorce (20)	Alcohol (13)	Mental Illness (9)

Table 2. Four Most Common Adverse Childhood Experiences (and percentage prevalence) among Children ages Birth through 17, Nationally, and by State

State	Highest	2nd	3rd	4th
Missouri	Economic Hardship (28)	Divorce (23)	Alcohol (11) Mental Illness (11)	Violence (8)
Mississippi	Economic Hardship (32)	Divorce (22)	Alcohol (13)	Violence (12)
Montana	Economic Hardship (28)	Divorce (26)	Alcohol (19)	Mental Illness (14)
North Carolina	Economic Hardship (27)	Divorce (21)	Mental Illness (10) Violence (10) Alcohol (10)	Domestic Violence (9)
North Dakota	Economic Hardship (22)	Divorce (20)	Alcohol (13)	Mental Illness (10)
Nebraska	Economic Hardship (22)	Divorce (21)	Alcohol (12)	Incarceration (9)
New Hampshire	Economic Hardship (23)	Divorce (22)	Alcohol (12)	Mental Illness (11)
New Jersey	Economic Hardship (22)	Divorce (15)	Alcohol (9)	Mental Illness (6)
New Mexico	Economic Hardship (28)	Divorce (25)	Alcohol (17)	Violence (12)
Nevada	Economic Hardship (30)	Divorce (23)	Alcohol (13)	Mental Illness (10)
New York	Economic Hardship (22)	Divorce (15)	Violence (10)	Domestic Violence (7)
Ohio	Economic Hardship (27)	Divorce (23)	Violence (13)	Alcohol (12)
Oklahoma	Economic Hardship (30) Divorce (30)	Alcohol (17)	Violence (13)	Mental Illness (12)
Oregon	Economic Hardship (29)	Divorce (23)	Alcohol (17)	Mental Illness (14)
Pennsylvania	Economic Hardship (25)	Divorce (19)	Alcohol (10) Mental Illness (10) Violence (10)	Domestic Violence (8)
Rhode Island	Economic Hardship (29)	Divorce (19)	Alcohol (12)	Mental Illness (11)
South Carolina	Economic Hardship (27)	Divorce (23)	Alcohol (11)	Mental Illness (10)
South Dakota	Economic Hardship (21)	Divorce (19)	Alcohol (12)	Incarceration (8)
Tennessee	Economic Hardship (31)	Divorce (25)	Alcohol (12)	Mental Illness (11)
Texas	Economic Hardship (29)	Divorce (20)	Alcohol (10)	Mental Illness (8)
Utah	Economic Hardship (24)	Divorce (17)	Mental Illness (10) Alcohol (10)	Domestic Violence (7)
Virginia	Economic Hardship (21)	Divorce (18)	Alcohol (8) Mental Illness (8)	Violence (7)
Vermont	Divorce (26)	Economic Hardship (25)	Alcohol (15)	Mental Illness (11)
Washington	Economic Hardship (25)	Divorce (21)	Alcohol (12) Mental Illness (12)	Violence (9)
Wisconsin	Economic Hardship (25)	Divorce (20)	Alcohol (10) Mental Illness (10)	Violence (8)
West Virginia	Economic Hardship (29)	Divorce (28)	Alcohol (14)	Mental Illness (12)
Wyoming	Economic Hardship (25) Divorce (25)	Alcohol (13) Mental Illness (13)	Violence (10)	Incarceration (9)

The Prevalence of Specific Adverse Childhood Experiences Varies by Age (Except for Economic Hardship)

The prevalence of most ACEs naturally increases by age, since parents were asked whether their child had "ever" had the experience. As Table 3 shows, older children are more likely than younger children to have ever experienced each of the adverse childhood experiences, except for economic hardship, which is reported for 25 to 26 percent of children regardless of age. This reflects the high rates of poverty experienced by families with young children.

Divorce is the second-most-common ACE experienced by children in each age group. About equal numbers of children ages birth to five have lived with someone who has an alcohol or drug problem, or have lived with someone with mental illness. Living with someone with an alcohol or drug-use problem is reported among 12 percent of 6- to 11-year-olds and 15 percent of 12- to 17-year-olds. One in seven 12- to 17-year-olds (14 percent) was the victim of, or witness to, neighborhood violence.

State-level rates for specific ACEs vary greatly for a given age group. For example, in the District of Columbia, 32 percent of 12- to 17-year-olds have experienced violence, compared with 14 percent nationally and 10 percent in Connecticut. In Mississippi, 15 percent of 12- to 17-year-olds, and nine percent of children under five, have witnessed domestic violence in their home, compared with national rates of ten and four percent, respectively.

Table 3. Prevalence of Specific Reported Adverse Childhood Experiences (ACEs), Total, and by Age

ACE	National Prevalence (Percentage)	Range of State-Level Prevalence (Lowest - Highest Percentage)
Somewhat or very often hard to get by on income		
All children	26	20 (MD) - 34 (AZ)
0 to 5	25	17 (ND) - 34 (AZ)
6 to 11	26	18 (HI) - 34 (NJ)
12 to 17	26	17 (VT) - 38 (AZ)
Lived with parent/guardian who separated/divorced		
All children	20	15 (DC) - 30 (OK)
0 to 5	10	6 (NY) - 18 (KY)
6 to 11	22	14 (CT) - 35 (OK)
12 to 17	28	21 (NJ) - 39 (OK)
Lived with someone with alcohol or drug problems		
All children	11	6 (NY) - 19 (MT)
0 to 5	6	1 (DC) - 14 (MT)
6 to 11	12	6 (NY) - 20 (NM)
12 to 17	15	10 (VA) - 26 (AZ)

Table 3. Prevalence of Specific Reported Adverse Childhood Experiences (ACEs), Total, and by Age

ACE	National Prevalence (Percentage)	Range of State-Level Prevalence (Lowest - Highest Percentage)
Lived with someone who was mentally ill		
All children	9	5 (CA) - 14 (MT)
0 to 5	6	2 (ND) - 10 (MI)
6 to 11	8	4 (CA) - 17 (MT)
12 to 17	12	7 (VA) - 19 (ME)
Victim or witness to violence in neighborhood		
All children	9	5 (NY) - 17 (DC)
0 to 5	3	1 (IL) - 6 (OH)
6 to 11	8	4 (NJ) - 19 (DC)
12 to 17	14	10 (CT) - 32 (DC)
Witness to domestic violence		
All children	7	5 (NJ) - 11 (OK)
0 to 5	4	2 (CO) - 9 (MS)
6 to 11	8	4 (NJ) - 13 (OK)
12 to 17	10	6 (CT) - 15 (MS)
Lived with parent/guardian who served time in jail		
All children	7	3 (NJ) - 13 (KY)
0 to 5	5	1 (HI) - 12 (KY)
6 to 11	8	2 (NY) - 16 (NM)
12 to 17	8	4 (NY) - 15 (KY)
Lived with parent/guardian who died		
All children	3	2 (CT) - 7 (DC)
0 to 5	1	0 (KS) - 4 (DC)
6 to 11	3	1 (MN) - 8 (MS)
12 to 17	5	1 (CT) - 12 (DC)

States in the Lowest and Highest Quartiles for Each Adverse Childhood Experience

Identifying which states fall into the highest and lowest quartiles of the distribution of prevalence rates provides another perspective on state-level variation. Although, as Table 3 shows, the states with the highest and lowest prevalence vary by ACE and by age group, some states stand out as having consistently high or low prevalence.

Two states–Connecticut and New Jersey–have rates in the lowest quartile for all eight ACEs, whereas Oklahoma has rates in the highest quartile for all ACEs (see Table 4). Other states have consistently high or low prevalence, relatively speaking, across most, but not all, ACEs. For example, Virginia is in the lowest quartile for all ACEs, except for the death of a parent, for which prevalence falls around the national average. Michigan is among the states with the highest prevalence for three ACES: ever lived with someone with mental illness, ever had a parent in jail, and ever lived with a parent who divorced or separated. However, Michigan is also among the states with the lowest prevalence of having witnessed domestic violence, and around the national average for all other ACEs. Policymakers may benefit from taking a closer look at the prevalence of specific adverse experiences among the children in their own state.

Table 4. States in the Lowest and Highest Quartiles for Prevalence of Reported Adverse Childhood Experience, and State Percentage Prevalence

	Economic hardship		Divorce/ Separation		Alcohol/ Drug		Mental illness		Violence		Incarceration		Death		Domestic violence	
Lowest Quartile	MD	20	DC	15	NY	6	CA	5	NJ	5	NJ	3	CT	1	NJ	5
	HI	21	NY	15	DC	7	FL	6	CT	6	NY	4	UT	2	CT	5
	VA	21	NJ	15	VA	8	GA	6	UT	6	CT	5	ME	2	VT	6
	SD	21	CT	16	GA	8	NJ	6	VA	7	RI	5	MN	2	MA	6
	MA	22	IL	16	CT	8	NY	7	NE	7	CO	5	WA	2	VA	6
	MN	22	CA	17	MD	8	IL	7	NH	7	MA	5	ND	2	IL	6
	ND	22	MD	17	IL	9	MD	7	TX	7	UT	5	NE	2	CO	6
	IA	22	HI	17	NJ	9	HI	7	ND	7	MN	5	IA	2	MD	6
	NY	22	UT	17	FL	9	DC	8	IA	7	HI	5	SD	2	RI	7
	NJ	22	VA	18	NC	10	SD	8	WI	8	NH	5	NV	2	UT	7
	CT	22	RI	19	TX	10	VA	8	FL	8	CA	5	CA	2	CA	7
	NE	22	PA	19	CO	10	CT	8	CA	8	VA	6	NJ	2	TN	7
Highest Quartile	RI	29	WY	25	IN	13	KY	11	NY	10	AR	9	NC	4	IN	8
	WV	29	NM	25	WV	14	NH	11	AK	11	WV	9	OH	4	OH	8
	TX	29	TN	25	ID	14	MI	11	IN	11	NE	9	KY	4	NC	9
	ME	29	ID	25	ME	14	WA	12	HI	11	WY	9	IN	4	AK	9
	KY	30	AR	26	KY	14	OK	12	AZ	11	AK	10	SC	4	AR	9
	NV	30	MI	26	VT	15	WV	12	WV	11	TN	10	LA	4	AZ	9
	OK	30	MT	26	AK	15	IA	13	DE	12	NM	10	NM	4	NM	9
	FL	30	VT	26	AZ	15	WY	13	MS	12	MI	10	GA	5	WV	9
	TN	31	ME	27	NM	17	ME	13	NM	12	OH	10	OK	5	KY	10
	MS	32	WV	28	OR	17	ID	13	OH	13	OK	10	AL	5	MT	10
	AR	33	KY	29	OK	17	OR	14	OK	13	IN	11	MS	6	MS	11
	AZ	34	OK	30	MT	18	MT	14	DC	17	KY	13	DC	7	OK	11

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2. PTSD: National Center for PTSD. (n.d.). Retrieved November 11, 2014.

3. Post Traumatic Stress Disorder DSM IV Criteria. (n.d.). Retrieved November 11, 2014, from http://www.mental-health-today.com/ptsd/dsm.html

Information provided by Cognitive and Neurobehavioral Studies in Aggression, Coping, Trauma and Stress; University of California, San Diego

DSM-IV & DSM-V Criteria

Post Traumatic Stress Disorder

DSM-IV Criteria

Criteria A: The individual experiences a ***traumatic event*** through direct exposure, witnessing or confrontation that involves actual death or injury and/ or threat of death or injury. *The person's response must also include fear, helplessness and/or horror.*

Criteria B: ***Re-experiencing symptoms:*** The individual persistently experiences one or more of the following: (1) intrusive recollections of the event; (2) recurring dreams of the event; (3) acting or feeling as if the event is happening or recurring; (4) intense psychological distress upon exposure to external or internal stimuli to remind the individual of the event; and/or (5) physiological reactivity on exposure to internal or external stimuli.

Criteria C: ***Avoidance*** of stimuli that reminds the individual of the trauma including three or more of the following: (1) effortful avoidance of thoughts, feelings, or conversations, (2) activities, people, or places. (3) the inability to recall events; (4) diminished interest in activities; (5) detachment from others; (6) restricted range of effect, (e.g., inability to have loving feelings); and/or (7) and sense of foreshortened future.

Criteria D: The individual will also have persistent symptoms of ***increased arousal*** in two of the following: (1) difficulty sleeping; (2) irritability; (3) difficulty concentrating;(4) hypervigilance; and/or (5) exaggerated startle response.

Criteria E: ***Persistence*** of symptoms (B, C, D) for more than one month.

Criteria F: The ***disturbance*** causes significant distress in social or occupational areas.

PTSD may occur after experiencing, witnessing or hearing about life-threatening events.

Most survivors of trauma experience some disruption in their life but feel better over time. However, some people have stress reactions that do not go away or even get worse.

People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping and/or trouble concentrating and may feel detached or estranged. These symptoms can impair the person's daily life.

DSM-IV: An individual can experience ***Acute*** (lasts for less than 3 months); ***Chronic***, (lasts for > than 3 months); ***Delayed onset*** PTSD, which means the symptoms begin at least 6 months after the post stressor.

DSM-V: An individual may also experience ***Depersonalization*** (experience of being "out of body" or detached from yourself) or ***Derealization*** (experience of distortion of the world is not real); ***Preschool Subtype*** where the child is ≤ 6 years of age. There is ***Delayed expression*** PTSD, which means the symptoms begin ≥ 6 months after the post stressor.

DSM-V Criteria

Criteria A: The individual experiences a ***stressor*** that includes direct exposure or witness of a death, sexual violence, or other trauma; indirect exposure by having a close friend or relative who experienced trauma; and/or has repeated or extreme indirect exposure to aversive details of trauma, usually in the course of professional duties.

Criteria B: ***Intrusion*** symptoms. One of the following is required: (1) re-experiencing the trauma involuntarily through nightmares, flashbacks, or memories and/or (2) stress and physiological symptoms occur.

Criteria C: ***Avoidance***. One is required: (1) avoidance of any external stimuli related to their trauma; (2) and/or avoiding trauma of any thoughts that stimulate thoughts of trauma.

Criteria D: ***Negative alterations in cognitions and moods***. Two of the following are required: (1) inability to recall key features of trauma not due to head injury, alcohol, or drugs; (2) persistent negative and distorted thoughts of oneself; (3) persistent distorted blame of oneself or others for causing the trauma; (4) persistent trauma related emotions such as fear, horror, anger, guilt; (5) lack of interest in pre traumatic activities; (6) feeling alienated from others; (7) and/or inability to experience positive emotions.

Criteria E: ***Alterations in arousal or reactivity***. Two of the following are required: (1) Irrational/ aggressive behavior; self destructive or reckless behavior; (2) hyper vigilance; (3) exaggerated startle response; (4) and/or problems in concentration; (5) sleep disturbance.

Criteria F: ***Duration*** of persistent symptoms 1-5 for longer than one month.

Criteria G is ***functional significance*** meaning significant symptom related stress in a social or occupational setting.

Criteria H: ***Exclusion*** meaning the disturbances are not due to medication, substance use or illness.

Trauma Information Pamphlet For Teachers

You are the key ingredient in a Trauma Informed System

Traumatic events cause terror, intense fear, horror, helplessness, and physical stress reactions (for example, heart beating fast, strong startle, stomach dropping, shakiness). The impact of these events does not simply go away when they are over. Instead, traumatic events are profound experiences that change the way children, adolescents and adults see themselves and their world.

Common Psychological Effects of Traumatic Experiences

- Many individuals who have had traumatic experiences suffer from ongoing reactions to them. These reactions are called **Posttraumatic Stress Reactions**. These reactions are common, understandable, and expectable, but are nevertheless serious and can lead to many difficulties in daily life.

There are three types of posttraumatic stress reactions.

Intrusive reactions are ways in which the traumatic experience comes back to mind. These reactions include distressing thoughts or images of the event (for example, picturing what one saw) that can occur while one is either awake or dreaming. Intrusive reactions also include upsetting emotional or physical reactions to reminders of the experience. Some people may act like one of their worst experiences is happening all over again. This is called "a flashback" and can occur in response to a traumatic reminder.

Avoidance and withdrawal reactions are ways people use to keep away from, or protect against, intrusive reactions. They include efforts to avoid talking, thinking and having feelings about the traumatic event and to avoid any reminders of the event, including places and people connected to what happened. Emotions can become restricted, even numb, to protect against distressing emotional reactions to thoughts or reminders of what happened. Feelings of detachment and estrangement from others may lead to social withdrawal. There may be a loss of interest in usually pleasurable activities.

Physical arousal reactions are physical changes that make the body react as if danger is still present. These reactions include constantly being "on the lookout" for danger, startling easily or being jumpy, irritability or outbursts of anger, difficulty falling or staying asleep, and difficulty concentrating or paying attention.

- Trauma survivors have also may suffer many types of losses - of loved ones, of home, possessions, and their community. The loss of important things often leads to **Grief Reactions**, which may include: feelings of sadness, anger, guilt or regret over the loss, missing or longing for the deceased, and dreams of seeing the person or possession again. These reactions are normal, vary from person to person, and can last for many years after the loss. Although they may be painful to experience, especially at first, grief reactions are healthy reactions to loss, and reflect the ongoing significance of the loss. Over time, grief reactions tend to include more pleasant thoughts and activities, such as positive reminiscing about the lost person or possession, or finding positive ways to memorialize or remember them.

- Many people have endured both trauma ***and*** loss. More specifically, people who have suffered the ***sudden*** or ***traumatic loss*** of a loved one often find grieving the loss more difficult. The person may become preoccupied with memories of the disturbing circumstances of the death, such as its tragic and sudden nature, or with issues of human accountability (for example, in regard to building construction practices). This preoccupation can lead to **Complicated Bereavement.**

- Complicated bereavement is often characterized by intrusion of disturbing images of a traumatic death into ***positive remembering*** and ***reminiscing***. This interferes with important ways of grieving that allow survivors to accept and adjust to the loss of a loved one. Complicated bereavement is also characterized by the avoidance of positive activities or relationships because they remind one of the traumatic loss. Due to its influence in constricting activities, complicated bereavement may interfere with normal life activities and normal child and adult development.

- An additional major concern for safeguarding the mental health of trauma survivors is the risk for **Depression**. Depression is different from posttraumatic stress, and carries its own risks. Its symptoms include: persistent depressed or irritable mood, loss of appetite, difficulty concentrating, greatly diminished interest or pleasure in life activities, fatigue or loss of energy, feelings of worthlessness or guilt, feelings of hopelessness, and sometimes thoughts about suicide.

- In addition to the psychological reactions described above, trauma survivors may experience **Physical Symptoms,** even in the absence of an underlying physical illness. These symptoms include headaches, stomachaches, rapid heart beating, tightness in the chest, appetite problems, and bowel problems (e.g., constipation and diarrhea). Physical symptoms often accompany posttraumatic, grief, and depressive reactions. More generally, they may signal elevated levels of life stress.

Consequences of These Reactions

Posttraumatic stress, grief, and depressive reactions can be extremely distressing, and may significantly interfere with daily activities. Intrusive memories of past traumatic experiences can interfere in serious ways with learning, school and occupational performance, causing unexplained interruptions in concentration and attention. Avoidance of reminders can lead adolescents to place restrictions on their current activities, relationships, interests, thoughts, and plans for the future. Irritability and reactions to reminders can interfere with getting along with family members and friends. It is particularly difficult when family members have been together during a traumatic experience, because afterwards they can serve as traumatic reminders to each other, leading to unrecognized disturbances in family relationships. Problems with sleeping, concentration and attention can especially interfere with academic or occupational function and performance. People may respond to a sense of emotional numbness or estrangement by using alcohol or drugs. They may engage in reckless behavior and self-endangering actions. Adolescents may rely too much on their adolescent group for deciding about risk-taking behavior and have trouble in turning toward parents for counseling about risks and dangers. They may become inconsistent in their behavior, as they respond to reminders with withdrawal and avoidance or overly aggressive behavior.

Depressive reactions can become quite serious, leading to a major decline in school or occupational performance and learning, social isolation, loss of interest in normal activities, self-medication with alcohol or drugs, acting-out behavior to try to mask their depression, and, most seriously, attempts at suicide. Complicated bereavement can lead to inability to mourn, to reminisce and remember, to fear a similar fate or sudden loss of loved ones, and to difficulties in establishing or maintaining new relationships. Adolescents may respond to traumatic losses by trying to become too self-sufficient and independent from parents and other adults, or by becoming more dependent and taking less initiative.

What Makes These Reactions Worse?

Posttraumatic Stress Reactions are often evoked by **trauma reminders.** Many people continue to encounter places, people, sights, sounds, smells, and inner feelings that remind them of past traumatic experiences, even years afterwards. These reminders can bring on distressing mental images, thoughts, and emotional/physical reactions. Common examples include: sudden loud noises, destroyed buildings, the smell of fire,

sirens of ambulances, locations where they experienced the trauma, seeing people with disabilities, funerals, anniversaries of the trauma, and television or radio news about the trauma.

Grief reactions are often evoked by **loss reminders.** Those who have lost loved ones continue to encounter situations and circumstances that remind them of the absence of the loved one, even years after the loss. These reminders can bring on feelings of sadness, emptiness in the survivor's life, and missing or longing for the loved one's presence. There are several types of loss reminders: **Empty situations** are ones in which the person is reminded of the absence of the loved one in his/her current life. These include: the empty place at the dinner table, activities that were once shared with the loved one, and special occasions like birthdays and holidays. Adolescents also are reminded by the everyday changes in their lives, especially hardships, as a **consequence of the loss**. Examples include decreases in family income, depression and grief reactions in other family members, disruptions in family functioning, increased family responsibilities, lost opportunities (for example, sports, education, other activities) and the loss of a sense of protection and security.

In addition to the distress evoked by **trauma** and **loss reminders**, **current trauma-related life adversities** constitute a significant source of distress. Efforts devoted to contending with these adversities may significantly deplete a person's coping and emotional resources, and in turn reduce or interfere with the ability to recover from posttraumatic stress, grief and depressive reactions. . Children respond to the stress of relocation, of loss of school and friends, reduced family resources and added responsibilities. The current trauma and loss may serve as a reminder to adults and children of **prior trauma and loss experiences** that can re-evoke prior feelings and symptoms, and increase their overall level of reaction. Children with pre-existing anxiety conditions may have a more severe reaction, more difficulty calming down after trauma reminders and more persistent fears of recurrence.

How Can I Help?

Teachers can play an important role in helping their students. Resumption of schooling is important to promote the welfare of children and their families. The following are suggestions to assist you in your work with children, adolescents and their families.

Taking Care of Yourself

First, because you are so important to your students, it is especially important that you also take care of yourself. You may have suffered the same type of traumatic experiences, losses and secondary stresses as the students you are teaching. Working with the students in your class may remind you of your own experiences or those of your family and friends. Therefore, you need to prepare yourself to be able to support the

students.

- Make sure that you, with your group of teachers, schedule ongoing times to talk together in order to give each other support.

- Make sure you take good physical care of yourself, including eating, sleeping and proper medical care. It is sometimes difficult to be teaching when you are undergoing your own course of recovery. Therefore:

    - Put aside the time to take care of the personal needs of your own family. It can be useful for teachers to share covering for each other in case something comes up that you need to take care of right away.

    - Even though you may feel very committed to the students you teach, take special time with your own family members or friends.

Educational Goals and Activities

Remember that the goals of being in school are somewhat changed. You should remember that you and your students are both changed by what has happened. Keep in mind that traumatized students often have difficulties with their concentration, attention and behavior. Some students may be very quiet and withdrawn, while others may be disruptive and overly active. Many will have difficulties with learning and their academic functioning will be impaired.

- For a while, plan for shorter lessons, go at a slower pace and with similar but less homework than would be usual.

- It is helpful to set aside scheduled classroom time over the next few months, at the beginning of the new school year, and at appropriate reminders, e.g. the anniversary, to talk about practical issues related to the recovery of students and the school community. This can help with problem solving to find ways that improve their ability to cope with the many reminders they face.

- It is important to invite students and parents to let you know when a student is affected by some change in their personal life so that you can better understand any change in classroom behavior or school performance.

- Teachers vary in the extent to which they express or show feelings. What is most important is to remain genuine. Students are very good at observing how their teachers are doing in their recovery. It is O.K. to express ongoing sadness or reactivity to a reminder as long as you also convey the progression of your own recovery so that students have confidence in your recovery and their own, even if it is taking longer than they expected.

How to Handle Changes in Your Students' Classroom Conduct

- Traumatized students may exhibit irritability and aggressive behavior at school with their schoolmates.

    - It is especially difficult for teachers to have students acting more irritable or disruptive in their behavior. Remember that some of these changes are common posttraumatic stress reactions. They may also occur in response to specific loss reminders. For example, a student who has lost a close friend may have trouble when other students are speaking about their close relationships.

    - Some younger children may become more aggressive in their play. It is important to remember that many of them have been exposed to levels of trauma far beyond their capacity to understand or deal with. Sometimes the behavior takes the form of what is referred to as "reenactment behavior," in which a student acts out, sometimes dramatically, protective behaviors which they think would have changed the trauma or its lethal outcome.

    - One way to handle irritable, disruptive or aggressive behavior is to be clear about the behavior that is expected. At the same time, you may try to understand and help them understand why they are angry in the particular situation. It can be helpful to offer them some private time to speak with you about their current concerns and anger. Then, negotiate with the student how they can better control their behavior. If these behaviors persist, the student may be referred for mental health counseling.

- Students may exhibit regressive behavior.

    - Students may have more anxiety at being separated from other family members or from their teachers during activities. They may cling more to their teachers, be less independent in their work, and, at times, have trouble coming to school. Even adolescents may show these signs of separation anxiety, far beyond an age when they might be expected. Parents may contribute to these reactions, for example by being overly clinging, because they, too, find it harder to be away from their children after the trauma.

    - One way to handle regressive behaviors is to negotiate a timetable with the adolescent so that they can help govern their own return to prior levels of functioning. It is important to remain understanding so that any timetable needs to be flexible to allow for some temporary setbacks. It can be helpful to offer them some private time to speak with you about their current concerns, fears and anxiety. Refrain from using ridicule or harsh criticism in addressing these reactions. If these behaviors persist, the student may be referred for

mental health counseling.

- Children may become withdrawn or excessively quiet.

    - Some children may become withdrawn and excessively quiet. They may present no problems in the classroom. However, they may also be distressed or depressed. These students need to be identified and assisted just as much as the students who acts more aggressively. They may need help to regain a participating role in the classroom and with their friends. They will need reassurance and encouragement. It can be helpful to offer them some private time to speak with you about their current concerns and continued pre-occupations with past experiences and losses. If left unassisted, they can become more isolated, fall behind in their studies and continue to lose opportunities to promote their social skills and participate in normal social activities.

- Be careful not to label students because of these problems. It can be too easy to label a child or adolescent as a "troublemaker" or "delinquent," as a "slow learner" or having "learning problems," or as "unmotivated" or "uninterested in their schooling." It is important to recognize the effects of trauma, loss and adversity on their school performance and conduct, and that, with proper help, many of these problems may be resolved.

- Many traumatized students suffer from lack of restful sleep.

    - Students often wake up at the slightest noise and have trouble returning to sleep. They often have fitful sleep or nightmares, and do not feel rested when they wake up. A tired students often cannot concentrate or learn well and can be irritable with friends and teachers. If a student is having any of these latter problems, it is important to ask them and their parents or caretakers about their sleep.

- Recovery comes in stages over weeks, months and years. Don't become discouraged because some children or adolescents take more time than others, or show temporary setbacks.

    - It is very important to engage pre-adolescents and adolescents in pro-social activities to help rebuild their school community and social life.

    - Traumatized adolescents are at risk of reckless behavior, including behavior that leads to accidental injury (for example, motor vehicle accidents), use of drugs and alcohol, and delinquent behavior. It is helpful to talk discuss these risks, their relationship to trauma and loss reminders, and the temporary need to be more careful in the weeks and months ahead.

- It is important to set up a trusting relationship where adolescents can share with you concerns over suicidal thoughts or plans. These should always be taken seriously and students should be referred for mental health assistance.

It is important to address issues of acknowledging the loss of students who are missing from the classroom, while going on to encourage a forward looking and positive attitude about the coming school year.

For the severely traumatized students, it may be helpful to provide them with a modified curriculum for a limited period of time, taking into account the interference with learning and memory as a result of their posttraumatic stress and grief reactions. This approach may be most helpful for students undergoing rehabilitation for physical injuries or experiencing intense traumatic/loss reminders that acutely interfere with learning or school performance.

- Some of the students will have lost a good friend or had friendships altered. Therefore it is important to help students in building new relationships or restarting relationships that have been disrupted.

These types of typical classroom pro-social activities take on special importance with traumatized students, who often retain a sense of being different, of feeling alone inside, or outside of everyday groups of other students.

Pro-social activities that have a practical tangible result are important to building a sense of community and citizenship. These activities can include:

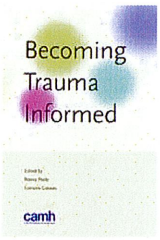
- a project to help improve their school or neighborhood
- a project to help others in their community

As noted in the first section, these activities are especially important to the recovery of traumatized adolescents because these efforts often answer an important need in them to improve their own lives and the lives of others. The school is an especially important place where they can take the first steps to do so in cooperation with other students and their teachers.

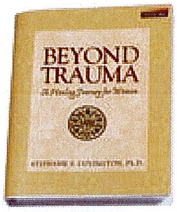
Provided by the National Center for Child Traumatic Stress.

TRAUMA-INFORMED PRACTICE RESOURCES

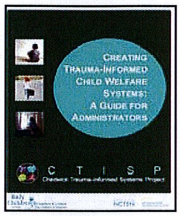
See below for treatment related resources and curricula. Some are focused solely on trauma-informed practices and others incorporate elements of both trauma-informed and trauma-specific approaches.



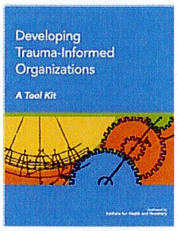
Becoming Trauma-Informed
Published by the Centre for Addiction and Mental Health in Ontario, this book offers examples of the ways in which practitioners have applied principles of trauma-informed practice in their work with diverse populations and in diverse settings within the MHSU field.
http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/Documents/becoming_trauma_informed.pdf



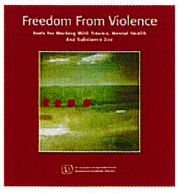
Beyond Trauma: A Healing Journey for Women
Created by Dr. Stephanie Covington, this trauma treatment manual makes the connection between women's experiences of trauma and their substance use. It can be used in a variety of settings, including residential and outpatient treatment settings, mental health programs, and criminal justice settings.
www.stephaniecovington.com/b_beyond.php



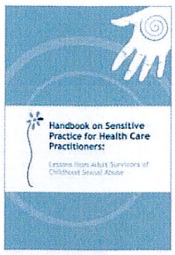
Creating trauma-informed child welfare systems: A guide for administrators (2nd ed).
Chadwick Trauma-Informed Systems Project. (2013) strives to support the evolution of public child welfare agencies into trauma-informed organizations – designed to support all agencies which impact children and families, including children's mental health in becoming a multi-dimensional, trauma-informed, and evidence-based system better able to meet the unique needs of abused and trauma-exposed children.
www.lacdcfs.org/katieA/docs/Trauma_Informed_CW_Systems_Guide.pdf



Developing Trauma Informed Organizations: A Tool Kit
The Tool Kit is designed to help organizations improve the quality of services offered by integrating an understanding of the impact of trauma and violence into the organization's policies, procedures, and interactions with those being served. It includes the principles for trauma-informed treatment, a self-assessment for provider organizations, an organizational assessment and instructions for using the assessments to provide trauma-informed, integrated care.
http://www.healthrecovery.org/publications/detail.php?p=30

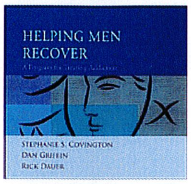


Freedom from Violence: Tools for working with Trauma, Mental Health and Substance Use
Developed by the Ending Violence Association of BC, this comprehensive toolkit offers specific, practical trauma-informed strategies for working with women who have substance use and mental health concerns. Strategies for discussing substance use, mental health concerns and for safety planning are included.
www.endingviolence.org/node/459



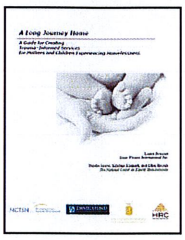
Handbook on Sensitive Practice for Health Care Practitioner: Lessons from Adult Survivors of Childhood Sexual Abuse

Published by the Public Health Agency of Canada, the handbook presents information designed to help health care practitioners practice in a way that is sensitive to the needs of adult survivors of childhood sexual abuse and other types of interpersonal violence.
www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook_e.pdf



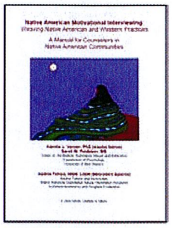
Helping Men Recover: A Program for Treating Addiction

This resource, developed by Dr. Stephanie Covington, describes a trauma-informed treatment program for men, making the links between substance use and trauma. There is also a version for women.
www.stephaniecovington.com/b_helping_men.php



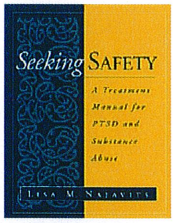
A Long Journey Home: A Guide for Creating Trauma–Informed Services for Mothers and Children Experiencing Homelessness

The Long Journey Home is intended to serve as a guide to agencies looking for practical ideas about how to create trauma-informed environments. Co-authored by Laura Prescott of Sister Witness, International and Phoebe Soares, Kristina Konnath and Ellen Bassuk, MD of the US National Center on Family Homelessness
www.homeless.samhsa.gov



Native American Motivational Interviewing: Weaving Native American and Western Practices

This practice manual, developed by Kamilla Venner and colleagues in New Mexico, is a cultural adaptation of a motivational interviewing approach. Although the connection with trauma is not explicit, practitioners will notice how the overall approach aligns with trauma-informed practices.
http://casaa.unm.edu/mimanuals.html

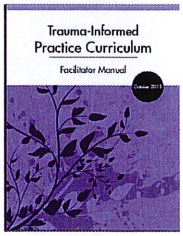


Seeking Safety

Created by Lisa Najavits, Seeking Safety is a widely used curriculum for Stage I trauma support. There are 25 topics that can be presented individually and in any order. The focus is on creating safety and recognizing the connection between substance use and trauma. It has been used in a variety of settings and with both men and women, as well as with youth.
http://www.seekingsafety.org/

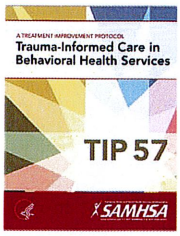
Trauma informed Practice Guide

This Guide was developed on behalf of the BC Provincial Mental Health and Substance Use Planning Council in consultation with researchers, practitioners and health system planners across BC. The TIP Guide and Organizational Checklist support the translation of trauma-informed principles into practice. Included are concrete strategies to guide the professional work of practitioners assisting clients with mental health and substance use concerns.
http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
www.bccewh.bc.ca/publications-resources/default.htm



Trauma informed Practice Curriculum

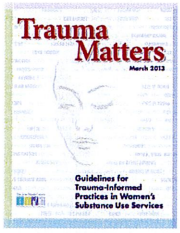
A 4 part curriculum developed to support learning by organizations and practitioners as they apply and integrate concepts on trauma-informed practice from the provincial Trauma-Informed Practice Guide and Trauma-Informed Practice Organizational Checklist.



TIP 57: Trauma-Informed Care in Behavioral Health Services

Published by the US Substance Abuse Mental Health Services Administration. Assists behavioral health professionals in understanding the impact and consequences for those who experience trauma. Discusses patient assessment, treatment planning strategies that support recovery, and building a trauma-informed care workforce.

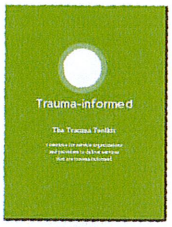
http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816



Trauma Matters

Guidelines developed by the Jean Tweed Centre, in consultation with service providers, experts, and women with lived experience from across Ontario, to support organizations that provide substance use treatment services for women. Designed to aid in understanding the interconnections of trauma and substance use, and provide better care for substance-involved women who have experienced trauma.

http://traumaandsubstanceabuse.files.wordpress.com/2013/03/trauma-matters-final.pdf

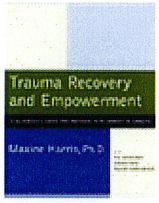


The Trauma Toolkit (1st and 2nd Edition)

Developed by Klinic Community Health Centre in Winnipeg, MB, this resource offers general guidelines for trauma-informed practice to assist service providers and agencies to increase their capacity in delivering trauma-informed services. The 2nd Edition is in press

www.trauma-informed.ca/

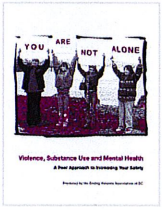
http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf



Trauma Recovery and Empowerment Model (TREM)

Offered by Community Connections in Washington DC, the TREM curriculum consists of 29 sessions focusing on empowerment, education about trauma, and building coping skills. There are versions for working with women, men, and youth.

www.communityconnectionsdc.org/web/page/657/interior.html



You are not alone: Violence, Substance Use and Mental Health—A peer approach to increasing your safety

Created by the Ending Violence Association of BC, this resource is for peer helpers and service providers to assist in discussions about relationship violence and sexual assault among women who may also have MHSU issues.

www.endingviolence.org/files/uploads/PAVEWorkbook.pdf