A TOOLKIT FOR ADDRESSING TRAUMA IN MENTAL HEALTH TREATMENT

Behavioral Wellness - Santa Barbara County

JUNE 2018

Natalia Jaramillo, M.A.
Jill Sharkey, Ph.D.
J.C. Gonzalez, B.S.
Luke Janes, M.A., M.Ed.

DEPARTMENT OF COUNSELING, CLINICAL, AND SCHOOL PSYCHOLOGY
INTERNATIONAL CENTER FOR SCHOOL-BASED YOUTH DEVELOPMENT
UNIVERSITY OF CALIFORNIA, SANTA BARBARA

Trauma Toolkit
Purpose

This toolkit was funded by a California Board of State and Community Corrections (BSCC) Reducing Racial and Ethnic Disparities (R.E.D.) Grant subcontract to the University of California, Santa Barbara via Santa Barbara County Probation. The ultimate goal of R.E.D is to reduce the overrepresentation of youth of color coming into contact with the juvenile justice system by a) reducing the number of youth of color in contact with the juvenile justice systems and b) reducing bias in juvenile justice system policies and practices.

The role of UCSB in this R.E.D. work is and has been to work with agencies responsible for the care of youth prior to and while they are involved in the criminal justice system; identifying and addressing R.E.D. in these agencies is critical to address R.E.D. in the juvenile justice system. UCSB has been working with Santa Barbara County Behavioral Wellness to address disparities in mental health systems to reduce the pipeline of all youths–and particularly youths of color–into the criminal justice system.

In this phase of the work, UCSB consulted with staff, clinicians, and administrators at the Department of Behavioral Wellness to implement system changes identified through five-year longitudinal study and in-depth focus groups with staff, youths, and parents. This trauma toolkit was developed because data identified the need for Behavioral Wellness to address trauma in their mental health services.

> *While many staff members expressed satisfaction with the breadth of training they received and also appreciation for being able to take time off to attend trainings, a few indicated that they would also like more specific trainings on types of therapy such as Trauma-Focused Cognitive Behavioral Therapy, as well as more time to really understand how to use these evidence-based practices with clients.*

Thus, the focus group recommended that Behavioral Wellness:

> *… delve deeper into topics such as specific culturally-relevant therapeutic techniques and trauma-specific trainings in addition to the broad trainings that staff currently receive.*

This toolkit is designed to provide accessible information about trauma-informed services in order to launch next steps for Behavioral Wellness to realize the goal of improving trauma-specific screening, assessment, and treatment for diverse clients, and particularly for their youth of color.

Trauma Toolkit
Table of Contents

INTRODUCTION

Trauma is characterized as an *emotional* and *physiological* response to unexpected event(s) that tend to feel out of the control to those encountering them. About 80% of youth report being exposed to at least one form of trauma (Breslau, 2009). In the aftermath of trauma, survivors can feel a sense of fear, vulnerability, loss, and confusion. The experience of trauma can also lead to Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD, American Psychological Association, 2013). Children exposed to chronic and pervasive trauma are especially vulnerable to the impact of subsequent trauma. However, many survivors of trauma recover to prior levels of functioning or even experience Post-Traumatic Growth (PTG, Calhoun, Cann, & Tedeschi; 2010). How trauma affects survivors is related to various factors including access to professional care and support from loved ones. Therefore, it is important to examine how to best provide resources and help people cope with the experience of trauma.

The goal of this trauma toolkit is to provide an overview of key information to assist mental-health providers in providing trauma-informed care and identifying how Behavioral Wellness can increase the implementation of trauma screening, assessment, and treatment to support youth. In this report we discuss the following areas:

1. the impact of trauma in youth,
2. providing specific assessment strategies and interventions,
3. reviewing trauma screening and the evidence-based interventions that have been found to be effective in treating children and adolescents,
4. providing an overview of cultural considerations that can influence trauma in youth, and
5. providing specific recommendations for how Behavioral Wellness can become a trauma-informed organization and implement trauma care in Santa Barbara County.

UNDERSTANDING THE IMPACT OF TRAUMA IN YOUTH

Below is a list of important considerations to keep in mind when responding to traumatic stress in children and adolescents. These core concepts serve as an overview of how trauma can affect survivors psychosocially and are listed to help clinicians better understand what youth and families may experience in the aftermath of a traumatic event.

Core Concepts – Recommendations from the National Child Traumatic Stress Network

1. Traumatic experiences are inherently complex.
2. Trauma occurs within a broad context that includes children's personal characteristics, life experiences, and current circumstances.
3. Traumatic events often generate secondary adversities, life changes, and distressing reminders in children's daily lives.

4. Children can exhibit a wide range of reactions to trauma and loss.
5. Danger and safety are core concerns in the lives of children who have experienced trauma.
6. Traumatic experiences affect the family and broader caregiver systems.
7. Protective and promotive factors can reduce the adverse impact of trauma and even promote post-traumatic growth (PTG).
8. Trauma and post-trauma adversities can strongly influence development.
9. Developmental neurobiology underlies children's reactions to traumatic experiences.
10. Culture is closely interwoven with traumatic experiences, response, and recovery.
11. Challenges to the social contract, including legal and ethical issues, that can affect trauma response and recovery.
12. Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care. Providers need their own support too.

Adapted from the National Child Traumatic Stress Network: https://www.nctsn.org/resources/12-core-concepts-concepts-understanding-traumatic-stress-responses-children-and-families

EVENTS THAT CAN CAUSE TRAUMA

In the following section we provide a perspective of the types of traumatic events that children and adults may experience. The type of trauma can have a significant impact on how the person might react and how the event might be perceived by close ones or the community (APA Presidential Task Force on PTSD, 2008). It should be noted that the duration, reactions, and subsequent exposure can also play a role in how the person copes and recovers from the trauma. Examples of traumatic events may include:

- Sexual abuse
- Physical abuse
- Domestic violence
- Community and school violence
- Medical trauma
- Motor vehicle accidents
- Acts of terrorism and war
- Natural and human-made disasters
- Suicides and violent or sudden death
- Being involved or witnessing a car accident
- Life-threatening illness

HOW DO CHILDREN REACT TO TRAUMA?

Children and adolescents vary in the nature of their responses to traumatic experiences. The reactions of youth may be influenced by their developmental level, ethnic/cultural factors, previous trauma exposure, the severity and type of trauma experienced, available resources, and preexisting child and family problems. However, trauma recovery typically occurs in three phases. In the first phase the person works to regain a sense of safety, in the second phase they process the trauma, and in the third phase they work to create a new sense of self and future. Nearly all children and adolescents express some kind of distress or behavioral change during their recovery from a traumatic event. Not all short-term responses to trauma are problematic and some behavior changes may reflect adaptive attempts to cope with a difficult or challenging experience.

Children may experience irritability that manifests in temper tantrums and intrusive memories that may not appear distressing. Additionally, they may exhibit posttraumatic play or reenactment of the trauma by play, drawings, or verbalization. Adolescents are more likely to engage in traumatic reenactment by incorporating aspects of the traumatic event(s) such as carrying a weapon to protect themselves after experiencing violence or developing romantic relationships with partners who are abusive in a similar way to others who have harmed them.

Many of the reactions displayed by children and adolescents who have been exposed to traumatic events are similar or identical to behaviors that mental health professionals see on a daily basis in their practice. Survivors of trauma may also experience co-occurring mental illnesses with overlapping symptoms, which highlights the importance and difficulty of distinguishing responses that are specifically related to trauma. The reactions to trauma may include:

- The development of new fears
- Separation anxiety (particularly in young children)
- Sleep disturbance, nightmares
- Sadness
- Loss of interest in normal activities
- Reduced concentration
- Decline in schoolwork
- Anger
- Somatic complaints
- Irritability
- Change in mood
- Ineffective coping strategies (especially avoidance)
- Drug use

- Self-harm or suicidality

Functioning in the family, peer groups, or at school may be impaired as a result of such symptoms. Therefore, when working with children who may display these types of reactions, the clinician must make a careful assessment of possible exposure to trauma.

It is also important to keep in mind that people who experience trauma or have PTSD are more likely to have co-occurring mental health disorders and substance abuse disorders. In a study conducted with 384 adolescents (mean age 17.9), results showed that participants with PTSD were also at higher risk for experiencing major depression and substance dependence. The youth who endorsed trauma did not have a co-occurring disorder, but were more likely to have alcohol and drug dependence (Giaconia et al., 2000). Oftentimes, it can be difficult for clinicians to discern what is a symptom associated with trauma versus another mental health disorder, such as anxiety. Therefore, it is important to conduct a thorough assessment in order to identify the signs and symptoms of trauma and differentiate between diagnoses.

Adapted from 2008 Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents. http://www.apa.org/pi/families/resources/children-trauma-update.aspx

TRAUMA AND SUICIDE IDEATION

Childhood trauma is also associated with suicidal ideation. More specifically, children and adolescents that experience child abuse are at a greater risk for experiencing suicidality. Research findings have shown a strong association between child abuse and suicidality in adulthood. Notably, in a study that reviewed 200 adult (ages 18-69) client files in a community mental health center in New Zealand, found that child sexual abuse strongly predicted suicidality during adulthood (Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001). Additionally, for adults with a mental health diagnosis such as depression, the childhood abuse was still a stronger predictor of suicidality than the current diagnosis (e.g., depression). Another study examining abuse and suicidality used a sample of 211 healthy adults (ages 20-32) who had completed self-report measures on childhood trauma, mental health functioning and suicidality. Path analysis results showed that perceived social support mediated the relationship between neglect and suicidal ideation (Bahk, Jang, Choi, & Lee, 2017). For this reason, it is crucial that mental health providers have an awareness about the association between child abuse and suicidality when working with clients who have experienced abuse and/or are screening for suicidal ideation. Notably, it is also important to encourage and build social support for survivors of child abuse as social support has been recognized as a protective factor that can reduce suicidal risk.

OPTIMAL ASSESSMENT STRATEGIES

Traumatic stress can interfere with daily functioning and warrants clinical attention. In children and adolescents, it can interfere with development, cognition, and social interaction with peers and family. Therefore, comprehensive assessment and treatments are imperative in order to treat youth with trauma and prevent detrimental outcomes in adulthood. For example, an interdisciplinary review found that childhood trauma was associated with negative mental health outcomes (e.g., depression, anxiety, suicide) as well as physical health outcomes (e.g., chronic fatigue syndrome, fibromyalgia, liver and lung disease; Mulvihill, 2005).

Assessing children and adolescents for symptoms of PTSD and Acute Stress can be a complex and lengthy process due to the fact the symptomatology can vary drastically depending on the developmental stage of the child or adolescent (Perrin, Smith, & Yule, 2000). There are, however, key domains that should be considered in every comprehensive assessment. The assessment process should include gathering developmental and medical history and trauma history, which includes asking as much background information possible to evaluate the history and details of the traumatic event, the age when the child or adolescent was exposed as well as the circumstances associated with the trauma (Carrion & Steiner, 2000).

A face-to-face interview should be conducted with the child or adolescent and parents or guardians in order to gather information from multiple sources (Perrin et al., 2000). It can be helpful to gather reports from teachers and school records in order to assess academic as well as social functioning and attention difficulties prior to a traumatic event.

Youth who are severely affected by a traumatic event might refuse to talk openly about the event or symptoms, which can lead a clinician to misinterpret symptomology and miss a diagnosis of PTSD (Pynoos, Steinberg, & Wraith, 1995). Most children and adolescents with trauma exposure or trauma-related symptoms that warrant treatment are not accurately assessed and therefore do not meet criteria for PTSD (APA Presidential Taskforce on PTSD, 2008). As a result, these children are unable to acquire an appropriate diagnosis and gain access to mental health services (La Greca et al., 2008).

Clinicians should:

1. Review records of the child's cognitive, social, emotional, and academic functioning prior to the traumatic event (e.g., Medical, psychological, and school records).

2. Conduct semi-structured clinical interviews to gather vital information that psychological testing cannot measure.

3. Use self-report measures that are valid for use considering factors such as gender, age, language, and cultural background.

4. Obtain information from as many sources as possible

    a. The child

b. Parents or guardians

c. Teachers

d. Other medical or mental health professionals

5. Be aware that the child may feel inappropriate responsibility, guilt, shame, or be in a state of confusion, curiosity, or disbelief of the reality of the traumatic situation.

Assessment Strategies that may be useful:

- Direct inquiry
- Verbal prompts
- Beginning sentences for the child
- A standardized self-report tool that is validated for the child's age, culture, language, and ethnicity
- Helping the child feel safe, comfortable, and that they are in a therapeutic environment
- Keep the child well-informed about what will occur. Ask for consent and provide choice without any hint of coercion.
- Ask the child permission to have a discussion with their parents or guardians about how the child should be behaving moving forward and importantly, how the parents should be behaving.
    - A child's reaction to trauma may be influenced by how they view the reactions of their parents to their trauma

Additional Considerations for Assessment:

There are a variety of additional considerations that can influence the assessment process and the way that youth experience and express trauma. Some populations are more exposed to trauma than others, including children living in poverty, people of color, families with a history of psychopathology, and neighborhoods exposed to community violence. In addition, some people have a higher likelihood of developing PTSD after exposure to trauma, including girls or women, people with prior psychiatric disorders, and children with insecure or fearful attachment styles. Aspects of the traumatic event itself has an impact on the likelihood of PTSD. More severe events, greater personal exposure to the event, and events perpetrated with human intent all increase the likelihood of PTSD developing (Dyregrov & Yule, 2006).

Children may refuse or not want to talk about a traumatic event that they were exposed to or share symptoms. Parents may also minimize their children's symptoms or the traumatic event that they experienced. It may be beneficial to explain to parents that most children

experience at least one form of trauma and provide information about common responses to trauma in order to normalize discussions about trauma and decrease stigma.

Clinicians may interpret quiet or anxious behavior from a child as symptomology related to posttraumatic stress or acute stress due to the traumatic event that they are being seen for and incorrectly diagnose the child with PTSD (Nickerson, Brock, & Reeves, 2006). Considering cultural and context-specific factors, determining whether other PTSD symptoms are also present, and comparing the child's present behavior to their behavior prior to the trauma can help (Ozer & Weiss, 2004).

It is also important to consider complex PTSD, which refers to exposure to multiple events and the wide-range and long-term effects of exposure to trauma. The process of assessment should evaluate complex PTSD responses such as dissociative symptoms, memory and sleeping difficulties, difficulties dealing with emotions and impulses, a loss of meaning and hope, an inability to form healthy attachments, and dramatically more distorted self-perceptions (Ozer & Weiss, 2004).

Some clients may report positive aspects of their experience after a traumatic event. This could be an indication that the client is experiencing Post-Traumatic Growth (PTG, Elderton, Berry, & Chan, 2015), which is a common and positive long-term outcome of adequate processing of trauma. However, it could also be a sign that the client is coping with the difficult parts of post-traumatic stress using avoidance as a coping strategy, which can contribute to greater PTSD in the long-term (Amirkhan & Marckwordt, 2017). Clinicians should familiarize themselves with PTG in order to navigate these situations with their clients. See the section on PTG within this toolkit for more information.

RECOMMENDED SCREENING TOOLS FOR TRAUMA

Self-report instruments can be useful in screening youth for trauma and determining their reaction to a range of traumatic events. By utilizing self-report measures, clinicians can gather information about the event and the symptomatology that the child or adolescent might be experiencing without doing a lengthy or in-depth interview. There are a variety of widely used self-report measures for youth, parents, and providers that can be helpful in screening for trauma. Below is a list of self-report measures we recommend that Behavioral Wellness could use in conjunction with clinical interviewing when screening youth for trauma.

Trauma Screening Measures Available for Use with Youth

Traumatic Events Screening Inventory for Children (TESI-C; Ford et al, 2002)

A 24-item assessment to identify potential experience of a variety of traumatic events. Ages vary according to version of the TESI-C (6-18). There are also parent- and provider-report versions available.

The Trauma Symptom Checklist for Children (TSCC; Briere,1996).

A 54-item assessment to identify the severity of traumatic stress in a child or adolescent (ages 8-16) that has experienced traumatic events, this assessment

examines situations that may require a risk-assessment follow-up such as suicidality.

Recommended Semi-Structured Assessment

The University of California, Los Angeles (UCLA) PTSD Reaction Index (PTSD-RI; Steinberg, Brymer, Decker, & Pynoos, 2004).

This is semi-structured interview assesses trauma history and the full range of DSM-5 PTSD diagnostic criteria in school-aged children and adolescents (ages 7-18).

When screening for trauma it is important to be specific about the process of assessment, particularly aspects of confidentiality and parental involvement, in order to build rapport and trust with the youth. Only professionals with training in trauma, trauma assessment, and trauma intervention should engage in trauma screening. It is important to note that trauma is a very difficult and sensitive topic and many children and families may be hesitant to accurately report their experiences of trauma. Taking the time to develop rapport and ensure safeguards by a trained and licensed mental health professional is key to an accurate and effective intervention.

A database of different self-report measures for different types of traumatic events can be found on the National Child Traumatic Stress Network Website:

https://www.nctsn.org/treatments-and-practices/screening-and-assessments/measure-reviews/all-measure-reviews?search=trauma+&domain_assessed=All&for_specific_population=All

DIFFERENTIATING ADVERSE CHILDHOOD EXPERIENCES SCREENING FROM TRAUMA SCREENING

In the following section we broadly explain Adverse Childhood Experiences (ACEs) and how this is associated with trauma. We also discuss how to assess for ACEs and specific considerations to keep in mind that differentiate the experience of ACEs and traumatic stress.

What are ACEs?

Adverse Childhood Experiences (ACE)s is meant to screen different events potentially experienced before the age of eighteen (e.g., abuse, sexual assault, neglect, poverty, parental divorce, community violence, family history of alcohol abuse, incarceration, and mental abuse) that have been shown to influence health and well-being (Kisiel et al. 2014). The ACEs paradigm encompasses those early distressful experiences that are oftentimes described as being harmful, reoccurring, cumulative, and/or varying in severity (Kalmakis & Chandler, 2014). Research shows that experiencing ACEs is common, for example, study findings show that almost 40% of participants reported two or more ACEs and those who report multiple ACEs have increased health risks (Leitch, 2017; Hughes et al., 2017). Furthermore, ACEs research has identified that children who come from impoverished communities are at a higher risk for experiencing ACEs. Those that encounter a higher number of ACEs have a much greater likelihood for experiencing deleterious outcomes in

many areas (e.g., behavioral, mental, physical health problems) (Kalmakis & Chandler, 2014).

Is ACEs different than trauma?

A person who experiences ACEs may or may not consider the event(s) traumatic and therefore special consideration is warranted when using discussing ACEs and traumatic stress. For example, youth with high ACEs scores may not necessarily be experiencing trauma-related symptoms but could experience high levels of life stress which can put them at a higher risk for a range of mental health and physical problems. ACEs is meant to identify potential risk for trauma but is not explicitly a traumatic-stress screener and should not be used interchangeably when referring to trauma (Finkelhor, 2017). Notably, ACE scores do not evaluate how positive experiences or social support can be protective against traumatic stress for youth. Furthermore, because of mandatory reporting requirements, there is often an emphasis on generating a total ACE score rather than identifying the specific trauma events that may be causing traumatic stress for the person. Trauma screeners are designed to specifically detect exposure to a variety of traumatic events, the severity of traumatic-stress symptoms, and the need for further assessment. Trauma-focused assessments can determine strengths as well as clinical symptoms of traumatic stress, and can help inform a treatment plan (Finkelhor, 2017).

How is ACEs measured?

Screening for ACEs and intervening early can decrease a broad range of negative outcomes and reduce risky behaviors for youth (Finkelhor, 2017). In order to screen for ACEs, we recommend the Adverse Childhood Experience Questionnaire for Adolescents (ACE-Q), which has an informant version and a self-report version for adolescents (ages 13-19). The ACE-Q asks about a variety of different experiences associated with abuse, neglect, household stressors, mental illness, incarceration, separation and divorce (Bucci et al., 2015). There are also two other versions of the questionnaire, a child version (ages 0-12) as well as a parent/caregiver version for adolescents. For more information about the ACE-Q please see helpful online resources and books section. In screening for both ACES and Trauma, providers should avoid asking triggering questions while still being able to gather enough information about the overall risk experienced. It is important to emphasize again that people with high ACE scores might not necessarily have trauma or PTSD symptoms.

Recommendations for putting ACEs into practice

We recommend that Behavioral Wellness providers review and discuss the differences between ACEs and trauma screening in order to be able to accurately identify youth who are experiencing traumatic stress and who might need a trauma-focused treatment or intervention. Specifically, we encourage that providers engage with families and provide targeted education to help families to better understand the impact of chronic stress and also identify what families can do to increase well-being (Bucci et al., 2015). Screening for ACEs can be completed by a broad array of professionals, whereas screening for trauma should only be done by trained mental health professionals.

We propose that ACEs screening could be utilized as a routine process among child-serving agencies such as schools (by teachers and school counselors) medical facilities (by pediatricians and nurses), or after school programs (by activity counselors or directors) that can call attention to a variety of adverse experiences that youth might encounter. There should be a clear aim that those who endorse ACEs will be referred to counseling, medical services, or community interventions that can address their specific circumstances, build on resilience, and protect youth who have experienced abuse and other ACEs. In addition, it is also recommended to provide training for staff on the differences between ACEs and trauma as well as assess what staff support might be needed to screen for ACEs and manage clients who endorse adverse events or trauma (Bucci et al., 2015).

For youth who endorse high levels of ACEs, we recommend screening for trauma and PTSD in order to identify the impact of the adverse experiences. There is extensive research demonstrating an association between ACEs and a variety of mental health disorders including depression, somatic disorders, and PTSD (Kalmakis & Chandler, 2014). Trauma and PTSD screening could be done as a secondary step after screening for ACEs to better understand if children are experiencing traumatic stress and how to best target their course of treatment.

POST-TRAUMATIC GROWTH

Fortunately, after the initial stages of post-traumatic stress and recovery, as much as 70% of trauma-survivors exhibit Post-Traumatic Growth (PTG), compared only about 10% experiencing PTSD (Breslau, Troost, Bohnert, & Luo, 2012). PTG generally occurs in some of the following five areas (Elderton, Berry, & Chan, 2015):

- a greater appreciation of life,
- improved relationships with others,
- a better sense of personal strengths,
- recognition of new possibilities, and
- spiritual development.

PTG occurs after a prolonged process of rumination and reflection about a stress-inducing traumatic event that helps the survivor find greater purpose and meaning in their lives. This process can be facilitated and supported by clinicians, and clinicians may find some of their clients reporting positive changes at any time during assessment or treatment.

Clinicians can provide educate clients about PTG as a way to normalize positive responses and provide hope to clients that recovery is possible and even likely. However, clinicians should also be aware that trauma increases avoidant coping strategies, and clients may report only positive or neutral impacts of the trauma in order to escape having to process the traumatic experience (Amirkhan & Marckwordt, 2017). PTG does not occur in the absence of significant post-traumatic stress. There appears to be an "inverted U" association between post-traumatic stress levels and PTG, such that very low levels of post-traumatic stress do not trigger the rumination and reflection process that contributes to PTG,

and conversely that very high levels of post-traumatic stress can overwhelm coping strategies to the point where reflection and PTG is not possible (Meyerson, Grant, Carter, & Kilmer, 2011).

Thus, allowing clients adequate time to process the traumatic experience and their symptoms of post-traumatic stress is necessary, and clinicians should not rush or force the process of PTG (Kilmer, Gil-Rivas, & Griese, 2014). Not all survivors of trauma experience PTG, and PTG occurs on its own after a process of reflection and synthesis of an event. Clients should not be made to feel that something is wrong if they are not experiencing PTG. Most individuals, with proper support and treatment, are able to return to at least the same level of functioning and wellness after a traumatic event even if they do not experience PTG. This result is a sign of resilience and is cause for celebration.

Certain populations are more likely to develop PTG, including women, people of color, and individuals with lower education levels. People who participate in a religious community, who exhibit trait resilience, and who are guided by virtues are also more likely to report PTG after a traumatic event. Aspects of the traumatic experience itself can have an impact on PTG: trauma perpetrated with human intent predicts greater PTG, whereas shame, fear, psychological abuse, and self-blame predicts less PTG (Elderton et al., 2015). Thus, it appears that being able to externalize the source of the trauma aids in recovery and thriving.

Various factors are associated with PTG, including getting out of relationships with interpersonal violence, informal social support from friends and family, frequency and quality of relationships with professional social service supports, and, for female survivors, interacting with a role model survivor (Elderton et al., 2015). Various coping strategies are also helpful for PTG, including spiritual practices, acceptance, cognitive restructuring, emotional expression, empowerment (self-efficacy, mastery, ability to exert influence on own life), perceived control over recovery, and ruminating. Other coping strategies were negatively associated with PTG, such as avoidance coping (problem avoidance, social withdrawal), and self-blame (Elderton, Berry, & Chan, 2015).

PTG can be intensified during the therapeutic process (Schubert et al., 2015). In particular, connecting with others may be a prerequisite and particularly important factor to experiencing growth in the perception of self (Elderton, Berry, Chan, 2015; Kilmer, Gil-Rivas, Griese, 2014). Other factors are important predictors of PTG, including deliberate and constructive rumination, positive future expectations, hope, optimism, active coping skills, guidance, and in particular, positive reframing coping advice (a factor that may be especially important for younger children; Kilmer et al., 2014). A lot of these factors are already goals and approaches in existing treatment for PTSD, such as Trauma-Focused Cognitive Behavior Therapy.

TRAUMA INTERVENTIONS FOR YOUTH

Over the last few decades there have been a range of acute interventions developed to treat trauma for children and adolescents. Some of the strategies include psychoeducation, Trauma-Focused Cognitive Behavior Therapy (TFCBT), Eye Movement Desensitization and

Reprocessing (EMDR), Seeking Safety, art therapy and play activities, and mindfulness-based stress reduction. There are some approaches that tend to be more past-focused to understand the impact of the trauma and others that focus more on the present to manage symptoms.

Interventions have been delivered in a variety of modalities and locations, including individual and group in the classroom or community. The optimal length of intervention varies depending on the degree of exposure and loss, and severity of post-trauma adversity and distress. In the following section we explain important basic principles of the interventions that have been shown to be useful when treating traumatic stress.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is one of the most commonly used interventions for PTSD in children and adolescents (Cohen & Mannarino, 2008). TF-CBT is an evidence-based treatment that has been manualized and widely disseminated to treat children with PTSD who have experienced a wide range of traumas. TF-CBT is a parent/child intervention that consists of 90-minute weekly sessions, some sessions are conducted individually with the child and parent while other sessions are conjoint. In TF-CBT, a trained clinician guides the client through eight modules while keeping in mind the client's readiness. Some of the strategies include psychoeducation, cognitive coping, trauma narrative development and processing, gradual exposure, and enhancing safety/future development (Cohen, Mannarino, Berliner, & Deblinger, 2000). TF-CBT has been shown to be effective in reducing PTSD symptoms, depression and behavioral problems in youth immediately after treatment completion. The effects held for PTSD symptoms 12 months after treatment completion but not for depression or behavioral problems (Cary & McMillen, 2012). Overall, TF-CBT has shown to be the most pervasive treatment for children and adolescents with trauma.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS). CBITS is a school-based group and individual intervention that has been adapted for use outside of schools and by non-clinicians. It is designed for 5th-12th graders, and consists of 10 group sessions, 1-3 individual sessions, 2 parent psychoeducational sessions, and 1 teacher education session. It has good research support and is a recommended intervention in the Substance Abuse and Mental Health Services Administration (SAMHSA) Registry of Evidence-Based Programs and Practices for treating trauma, anxiety, social competence, and comorbid non-specific mental health disorders and symptoms (https://nrepp.samhsa.gov).

Creative Arts Therapy. The creative arts therapies (CATs) include art, dance, drama, music, and poetry and may be particularly well suited for children who have experienced trauma as CATs use nonverbal material (Johnson, 1987). CATs have been identified to help in various ways 1) allows for exploration of the association between neurological functioning and the creative arts processes, 2) uses both standardized and creative arts-based assessment tools, 3) may include the caregiver in treatment, and 4) incorporates creativity and self-expression in treatment.

Eye Movement Desensitization and Reprocessing (EMDR). Originally developed for adults, EMDR is used to decrease negative images, thoughts, and feelings through the course of eight-phases of treatment. The approach emphasizes the role of the brain's information processing system to improve the somatic and psychological consequences of traumatic events (Shapiro & Solomon, 2010). During treatment the client holds upsetting memory material in mind while following a rhythmic set of eye movements, which are meant to accelerate the processing of that material (Shapiro & Solomon, 2010). Adaptations have been made to treat children in different developmental states with PTSD. In a randomized-control trial conducted by Ahmad and colleagues (2007), clinicians adapted EMDR for children and compared the effects of EMDR with a waitlist condition. Participants were 33 children and teenagers (17 EMDR,16 waitlist) with PTSD recruited from an outpatient psychiatric clinic. The findings showed that the EMDR group experienced significant improvement in PTSD-related symptoms, specifically the re-experiencing type of symptoms. While EMDR has been shown to be effective, some of the limitations of this treatment include that younger children are sometimes unable to follow the procedures described and other means of helping children recall the traumatic event may need to be employed (Tufnell, 2005).

Seeking Safety. Seeking Safety is a present-focused, harm-reduction, coping skills therapy to help clients with substance abuse and trauma. It can be conducted in groups or individually, for adults or adolescents, does not require particular training or credentials from the facilitator, and can be peer-led. The curriculum covers 25 topics that can be used in any order depending on what is present for the client or group. There are no requirements for the number of sessions of the group, or that all topics be covered. The research on Seeking Safety is supported for adults and promising for adolescents. Najavits, Gallop, and Weiss (2006) conducted a random controlled trial comparing Seeking Safety to treatment as usual for 33 adolescent females and found positive effects of Seeking Safety in the area of substance use, PTSD, and comorbid psychopathologies (e.g., anorexia, somatization). Effect sizes were generally in the moderate to high range, and some were sustained at a 3-month follow-up.

Mindfulness-Based Stress Reduction (MBSR): In recent years, MBSR has been integrated as a form of treatment for trauma and PTSD. This technique utilizes meditation, body-scanning, and self-compassion to decrease PTSD symptoms (Sibinga et al., 2011). Thus far the treatment outcomes for this type of intervention are limited but with the increase in mindfulness as a whole in psychology more research studies are examining the results of this with people who experience trauma.

Information adapted from the Society of Traumatic Stress Studies
https://www.istss.org/treating-trauma/current-istss-treatment-guidelines.aspx

TRAUMA TRAININGS

There are numerous trauma trainings available, a few are summarized in the following table.

TRAINING	COST	WEBSITE
TF-CBT: Training is available to therapists with graduate degrees in a mental health discipline. It includes a 10-hour web-based training, a training package (two days of live training and 12 consultation calls with a TF-CBT expert). The optional Advanced Training (1 additional day) is strongly encouraged. Outcomes measurement using formal pre- and post-treatment assessment tools is a required part of the training process.	10-hour online training is free Training Package: $950 Therapist certification $250	10-Hour Online Training: https://tfcbt.musc.edu/index.php Resource Site: https://tfcbt.org/training/1084/
CBITS: The CBITS training is designed for mental health professionals who work in schools but is free for anyone. The manual and implementation materials are also free and downloadable from the website. Users have access to the online community of providers through a discussion board.	Free	https://cbitsprogram.org/
The National Child Traumatic Stress Network: The online learning center offers free webinars and continuing education certificates on various topics, including trauma-informed care. Training offered includes Child Trauma Toolkit for Educators, Child Welfare Trauma Training Toolkit, Resource Parent Curriculum Online, and Trauma Informed Juvenile Justice System.	Free	Resource Site. https://learn.nctsn.org
EMDR: The therapy basic training (Weekend 1 and 2) is designed for licensed mental health practitioners who treat adults and children in a clinical setting. Treatment requirements consist of completion of Weekend 1 and Weekend 2 trainings, readings, EMDR: Basic Principles, Protocols and Procedures, 10 hours of case consultation with an EMDR Institute Approved Consultant (5 hours are required prior to Weekend 2, and5 hours after Weekend 2).	$710-1,618	Resource Site: http://www.emdr.com/us-basic-training-overview/

CLINICAL STRATEGIES FOR PROVIDERS

The following are some general suggestions for providers to help facilitate trauma recovery.

- Some clients need to briefly describe the trauma(s) they have experienced, particularly in the early stages of recovery. Strategies that focus on re-experiencing the trauma, retrieving feelings related to the trauma, and bringing past experiences to the forefront should only be implemented if trauma-specific treatment planning and services are available.
- Understanding the trauma, especially in early recovery, should begin with educating the client about and normalizing trauma-related symptoms, creating a sense of safety within the treatment environment, and addressing how trauma symptoms may interfere with the client's life in the present.
- Identifying and exploring strengths in the client's history can help the client apply those strengths to their ability to function in the present.

Social factors have a strong effect on recovery from PTSD and the development of Post Traumatic Growth. Negative social factors, such as receipt of unwanted advice or unsympathetic behavior, appear to strongly increase the chance of developing PTSD after a trauma. Further, untreated PTSD symptoms can deteriorate social relationships, contributing to a feedback loop of decreased social support and increased PTSD symptoms. Thus, perhaps one of the more important treatments of PTSD is to work with survivors of trauma and their loved ones together to support positive social interactions and mitigate negative interactions. This could take the form of couple or family treatment, or information provided to the people surrounding the client about how to have positive supportive interactions (Wagner, Monson, & Hart, 2016).

Information Adapted from Substance Abuse and Mental Health Services Administration
https://www.ncbi.nlm.nih.gov/books/NBK207195/

PSYCHOPHARMACOTHERAPY FOR CHILDREN AND ADOLESCENTS

It can be helpful for providers to have a general understanding of the types of medications that may help reduce debilitating symptoms of PTSD in children's day-to-day lives and provide relief as they confront difficult material in psychotherapy (Donelly, 2003). One of the common reasons why children with traumatic stress might be prescribed medications is to treat or regulate sleep disturbance or sleeping disorders.

Here is some information regarding the medications that are used to help manage traumatic stress:

- Broad-spectrum agents such as SSRI's are a good first choice as they should target anxiety, mood, and re-experiencing symptoms. Some of the common names of SSRI medications are Zoloft, Paxil, Prozac, and Lexapro

- Other medications to target comorbid disorders such as attention-deficit/hyperactivity disorder (ADHD) used either alone or in combination with an SSRI may target severe or comorbid conditions.

- Reduction in even one disabling symptom, such as insomnia or hyperarousal, may have a positive ripple effect on a child's overall functioning.

- Medication can help relieve the symptoms but can't erase the memories and pain experienced as a result of trauma

Information Adapted from the International Society of Traumatic Stress Studies
https://www.istss.org/ISTSS_Main/media/Documents/ISTSS_g71.pdf

CULTURAL CONSIDERATIONS

When working with youth who have experienced trauma, it is crucial to consider how culture might be playing a role in their experience. Culture can influence the meaning they give to the trauma and their expectations for recovery. Thus, trying to understand the child's experience from the child's own point of view, as well from the view of family and community, can help guide intervention efforts.

Below are some key points to keep in mind when being culturally sensitive.

- Children and families from ethnic minority groups or from low socio-economic background may encounter additional barriers, including limited access to mental health services and insensitivity from the majority culture regarding the impact of racism and poverty on their experience of traumatic events.

- In some communities where trauma exposure is prevalent both currently and historically, particular attention must be paid to contextual and sociopolitical issues associated with the trauma. For instance, immigration to the United States from Latin American countries has a complex history where in some cases families seek refuge in the United States from life-threatening and traumatic conditions in their origin country that are partly a result of United States foreign policies. Native American and African American communities have suffered a history of intergenerational trauma in the United States that contribute to greater levels of poverty, violence, and trauma today. Kira (2010) notes that intergenerational trauma can present similarly to complex PTSD. Thus, additional interventions may need to include advocacy and political action (Ozer & Weiss, 2004) as well as social interventions and integrated services (e.g., addressing safety, family reunification, justice, employment). Restoring the social environment and healthy communities is important for recovery from the impacts of intergenerational trauma (Kirmayer, Kienzler, Afana, & Pedersen, 2010).

- It is important to be conscious of language, verbal communication, and cultural beliefs or practices related to the traumatic event. For instance, in some cultures it may be particularly difficult to divulge information that would potentially create

shame on senior members of the family. In those cases, it might be possible for clinicians to invite information about what happened to the client, but not by whom.

- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life. For instance, not having adequate time and space to pray or express cultural and religious identity in a workplace could be experienced as traumatic by Muslim Americans.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased. For instance, there is evidence that suggests that PTSD and PTG are both culturally-bound experiences, since they both occur much more frequently in the United States and in the United Kingdom than in other countries in the world (Kilmer et al., 2014). Given the importance of social support on the treatment of trauma, it may be the case that PTSD in the US and the UK is an artifact of a cultural tendency to isolate and stigmatize individuals who are showing signs of psychological distress.
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma; traumatic stress symptoms vary according to the type of trauma within the culture. For instance, *nervios, ataque de nervios,* and altered perceptions are experiences among U.S. Latinos that are largely independent yet related to western concepts of PTSD, depression, and dissociation, and hold predictive value and significant meaning for some Latinos in the U.S. (Lewis-Fernández et al., 2010).
- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help. In some cultures, seeking support for mental health professionals may carry significant stigma, shame, or be a sign of weakness. For example, somatic expression of trauma symptoms (as physical rather than mental health) are often expressed more often in certain cultural groups because physical health problems are legitimate whereas mental health problems are seen as shameful.
- Engaging community or spiritual leaders, school personnel, health professionals, and caregivers may be important in helping survivors heal from trauma. Culturally appropriate healers may be a more accessible resource in the community than western mental health professionals, including for example *curanderos/as,* shamans, seers, priests, African-American barbers and hairstylists, or Chinese herbalists and acupuncturists.
- Culture can provide a source of strength, unique coping strategies, and specific resources.

Adapted from the National Child Traumatic Stress Network and Center for Substance Abuse Treatment
https://www.nctsn.org/resources/nctsn-impact-newsletter-spring-2012

SELF-CARE TIPS FOR WORKING WITH TRAUMA CLIENTS

Vicarious trauma can occur in mental health professionals as a result of working in close contact with trauma survivors. Professionals who experience vicarious trauma might feel changes in their ability to feel safe, their sense of control, and ability to trust. Therefore, it is crucial that mental health providers consult with supervisors and develop strategies to cope with the stress associated with working with trauma survivors. Below there is a list of self-care activities for that can be helpful when working with clients who have trauma.

Take care of yourself: You owe it to yourself and those who care about you.

Get enough rest: Even when work demands are high you need to set limits.

Eat healthy meals and drink water regularly: Nutrition and hydration are critical for performance.

Monitor alcohol and tobacco intake: Substance use may help you cope in the short term but will reduce your ability to deal with stress in the long run.

Exercise: Take short breaks to walk or move around. Exercise will help increase your energy and better cope with stress.

Communicate and share your feelings: Talk to a colleague that you trust.

Review how you're coping: Check with others for another perspective.

Set aside quiet time: Take time to meditate, pray, listen to music, or focus on things that are uplifting.

Take a break from digital media: It is important to avoid relying on electronic media for self-care as overuse of electronic media can exacerbate mental health difficulties including depression.

Information adapted from the Society of Traumatic Stress Studies
https://www.istss.org/treating-trauma/self-care-for-providers.aspx

HELPFUL ONLINE RESOURCES AND BOOKS

https://www.istss.org
This is the website for the International Society for Traumatic Stress Studies, and contains relevant information regarding assessment, treatment interventions for mental health professionals. Some of the materials can be accessed freely but others require becoming a member of the organization.

https://www.nctsn.org/
This is a highly recommended website for healthcare providers who are working with youth who experience trauma. The network has a wide range of resources which include an explanation of childhood trauma, a variety of evidence-based treatments and practices, trauma-informed care, resources and workshops.

http://www.tfcbt.org/
This website provides more in-depth information about Trauma-Focused Cognitive Behavioral Therapy (TFCBT). There is information regarding certification on TFCT and research findings supporting this treatment.

http://www.apa.org/topics/ptsd/index.aspx
This is a website by the American Psychological Association. It provides information on PTSD-related news and literary resources for children. It also offers some information and advice on what individuals can do if they are suffering from PTSD. There is a link on the website that enables users to search for psychologists in their given location. This website is particularly focused on PTSD and Acute Stress Disorder.

http://www.mentalhealthamerica.net/conditions/post-traumatic-stress-disorder
This is a link for a website for Mental Health America, and specifically to the page regarding posttraumatic stress disorder. This page provides information on who can get PTSD, what the symptoms look like, current empirically supported therapies for treating PTSD, and various suggestions on how to practice self-care when recovering from PTSD.

https://www.wested.org/resources/trauma-informed-practices/
This is a link to a brief carried out by WestEd which is a non-profit research organization. WestEd conducted a series of interviews with people in the field of mental health, education, and social services with the objective of better capturing trauma-informed practices. The brief provides examples of how a trauma-informed approach has been implemented in a variety of settings and addresses different ways to respond and improve practices. In addition, the brief specifies key themes that resulted from the interviews that can help practitioners, educators, policy makers, and researchers, with the implementation of trauma-informed practices.

http://centerforyouthwellness.org/wp-content/uploads/2018/06/CYW-ACE-Q-USer-Guide-copy.pdf

This is a link that contains information regarding the ACE-Q materials for providers wanting to measure ACEs. See Adverse Childhood Experience Screening Versus Trauma Screening section.

Children's books on trauma:

A Terrible Thing Happened:
A Story for Children Who Have Witnessed Violence or Trauma
http://www.apa.org/pubs/magination/4416428.aspx

Brave Bart
A Story for Traumatized and Grieving Children
https://selfesteemshop.com/shop/brave-bart-a-story-for-traumatized-and-grieving-children/

Algo pasó y me da miedo decirlo
Un libro para jóvenes víctimas del abuso
http://www.chicagoreviewpress.com/algo-pas---y-me-da-miedo-decirlo-products-9781884734397

RECOMMENDATIONS FOR BEHAVIORAL WELLNESS

This toolkit is designed as a resource for Behavioral Wellness in developing their approach to treating trauma. A few additional steps might be considered to support this work.

1. It may be valuable to survey clinicians about their knowledge of trauma-focused care for children and adolescents. The survey could inquire about the level of comfort that providers feel in working with traumatic stress, how much they know about the assessment process, and whether they are currently assessing for trauma and post-traumatic stress in their clients. Results would establish a baseline for targeting training and monitoring agency capacity for addressing trauma.

2. In addition, or alternatively, a clinician survey could address the providers' acceptability of trauma-practices in order to understand their present level of engagement with trauma-resources and practices. This could also be useful in regards to understanding what providers identify as challenges or barriers when working with clients who have trauma-related distress. The Perceived Characteristics of Interventions Scale (PCIS; Cook, Thompson, & Shnurr, 2015) is a scale used to measure provider attitudes towards interventions across the following four subscales: 1) relative advantage, 2) compatibility, 3) complexity, and 4) potential for reinvention. This measure may be helpful in understanding Behavioral Wellness staff attitudes prior to implementation of a new intervention.

3. We recommend Behavioral Wellness increase the emphasis on training relating to trauma topics in order to increase their clinicians' level of confidence and skill in providing trauma-informed treatment to youth clients. It is recommended that Behavioral Wellness consider training clinicians in trauma-screening and treatments.

A trauma-focused training could be part of an initial orientation or an annual training. Another possibility that would increase the emphasis on trauma-care is to have clinicians complete the TF-CBT 10-hour training or initially have a few clinicians complete the full training for TF-CBT and have those clinicians bring back the information to Behavioral Wellness.

4. We recommend that Behavioral Wellness implement a thorough trauma screening, assessment, and treatment protocol that starts during the intake process with each client. Screening would need to be related to provision of services based on the need identified for trauma-specific treatment.

5. Finally, we recommend that Behavioral Wellness review the mandated reporting requirements as research shows that sometimes providers can be reluctant to inquire about trauma because of the requirements associated with reporting abuse (Chung, 2012). It would also be important for the organization to provide ongoing supervision for providers in order to support them with trauma-care services and related mandated reporting requirements.

Next Steps for Behavioral Wellness

- Identify everyday strategies that could increase a trauma-informed approach.
- Provide psychoeducation to families about the prevalence and impact of trauma, the common possibility for Post-Traumatic Growth, and the community, interpersonal, and intrapersonal factors that can aid in recovery.
- Identify the barriers of implementing a trauma-informed approach such as costs, providers changing often, and timing.
- Identify ways Behavioral Wellness can continue to collaborate with other organizations such as CALM in order to increase referrals.
- Select tools for screening, assessment, and treatment; support staff in getting certified.

Next Steps for UCSB:

- UCSB is available to develop and implement a staff survey to assess knowledge, skills, confidence, and/or acceptability of trauma-specific screening, assessment, and treatment.
- UCSB is available to help Behavioral Wellness develop their own data collection and reporting related to the provision of trauma-informed practices.

REFERENCES

Ahmad, A., Larsson, B., & Sundelin-Wahlsten, V. (2007). EMDR treatment for children with PTSD: Results of a randomized controlled trial. Nordic Journal of Psychiatry, *61*(5), 349–354.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders. Arlington. https://doi.org/10.1176/appi.books.9780890425596.744053

American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents. (2008). Children and trauma: Update for mental health professionals. American Psychological Association. Retrieved April 13, 2017, from http://www.apa.org/pi/families/resources/update.pdf

Amirkhan, J. H., & Marckwordt, M. (2017). Past trauma and current stress and coping: Toward a general model. *Journal of Loss and Trauma*, *22* (1), 47–60. https://doi.org/10.1080/01612840.2016.1182410

Bahk, Y.C., Jang, S.K., Choi, K.H., & Lee, S.H. (2017). The relationship between childhood trauma and suicidal ideation: Role of maltreatment and potential mediators. *Psychiatry Investigation*, *14* (1), 37–43. https://doi.org/10.4306/pi.2017.14.1.37

Breslau, N. (2009). The epidemiology of trauma, PTSD, and other posttrauma disorders. *Trauma, Violence & Abuse*, *10* (3), 198–210. https://doi.org/10.1177/1524838009334448

Breslau, N., Troost, J. P., Bohnert, K., & Luo, Z. (2012). Influence of predispositions on post-traumatic stress disorder: does it vary by trauma severity? *Psychological Medicine*, *43* (2),1–10. https://doi.org/10.1017/S0033291712001195

Briere, J. (1996). *Trauma symptom checklist for children (TSCC)*. *Journal of Abnormal Psychology Assessment of family violence: A handbook for researchers and practitioners.* https://doi.org/10.1037/t06631-000

Briggs, E. C., Fairbank, J. A., Greeson, J. P., Layne, C. M., Steinberg, A. M., Amaya-Jackson, L. M., Pynoos, R. S. (2013). Links between child and adolescent trauma exposure and service use histories in a national clinic-referred sample. *Psychological Trauma: Theory, Research, Practice, and Policy*, *5* (2), 101–109. https://doi.org/10.1037/a0027312

Bucci, M., Gutierrez Wang, L., Koita, K., Purewal, S., Silverio Marques, S., Burke Harris, N. (2015). Center for youth wellness ACE-Questionnaire user guide. *Center for Youth Wellness*.

Carrion, V. G., & Steiner, H. (2000). Trauma and dissociation in delinquent adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *39*(3), 353-359. DOI: http://dx.doi.org/10.1097/00004583-200003000-00018

Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. *Children and Youth Services Review*, *34*, 748-757. https://doi.org/10.1016/j.childyouth.2012.01.003

Chung, J. Y., Frank, L., Subramanian, A., Galen, S., Leonhard, S., & Green, B. L. (2012). A qualitative evaluation of barriers to care for trauma-related mental health problems among low-income

minorities in primary care. *The Journal of Nervous and Mental Disease*, *200*(5), 438–443. http://doi.org/10.1097/NMD.0b013e31825322b3

Cohen, J. A., & Mannarino, A. P. (2008). Disseminating and implementing trauma focused CBT in community settings. *Journal of Violence & Abuse*, 9(4), 214–226.

Cohen, J.A., Mannarino, A., Berliner, L., & Deblinger, E. (2000). TF-CBT: An empirical update. *Journal of Interpersonal Violence*, *15* (11), 1202–1223.

Cook, J. M., Thompson, R., & Schnurr, P. P. (2015). Perceived characteristics of intervention scale: Development and psychometric properties. *Assessment*, *22*(6), 704-714.

Donelly, C.L. (2003). Pharmacologic treatment approaches for children and adolescents with posttraumatic stress disorder. *Child and Adolescent Psychiatric Clinics of North America*, *2*(2), 251-269. http://dx.doi.org/10.1016/S1056-4993(02)00102-5

Duan, W., Guo, P., & Gan, P. (2015). Relationships among trait resilience, virtues, post-traumatic stress disorder, and posttraumatic growth. *PLoS ONE*, *10*(5), 1–13. https://doi.org/10.1371/journal.pone.0125707

Dyregrov, A., & Yule, W., (2006) A review of PTSD in children. *Journal of Child and Adolescent Mental Health*, *11*(4),176–184.

Elderton, A., Berry, A., & Chan, C. (2015). A systematic review of posttraumatic growth in survivors of interpersonal violence in adulthood. *Trauma, Violence, & Abuse, 18*(2), 223–236. https://doi.org/10.1177/1524838015611672

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/https://doi.org/10.1016/S0749-3797(98)00017-8

Finkelhor, D. (2017). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse & Neglect*. https://doi.org/https://doi.org/10.1016/j.chiabu.2017.07.016

Ford, J., Racusin, R., Rogers, K., Ellis, C., Schiffman, J., Ribbe, D., & Edwards, J. (2002). Traumatic events screening inventory for children (TESI-C) version 8.4. *National Center for PTSD and Dartmouth Child Psychiatry Research Group, Dartmouth VT*.

Giaconia, R.M., Reinherz, H.Z., Hauf, A.C., Paradis, A.D., Wasserman, M.S., Langhammer, D.M. (2000). Comorbidity of substance use and post-traumatic stress disorders in a community sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. *70*, 253–262.

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health*, *2*(8), e356–e366. https://doi.org/https://doi.org/10.1016/S2468-2667(17)30118-4

International Society for Traumatic Stress. Psychopharmacotherapy for Children and Adolescents. Retrieved July 27, 2018, from https://www.istss.org/ISTSS_Main/media/Documents/ISTSS_g71.pdf

International Society for Traumatic Stress Studies. Self-care for providers. Retrieved July 27, 2018, from https://www.istss.org/treating-trauma/self-care-for-providers.aspx

Johnson, D. R. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy, 14*, 7-13.

Kilmer, R., Gil-Rivas, V., & Griese, B. (2014). Posttraumatic growth in children and youth: Clinical implications of an emerging research literature. *American Journal of Orthopsychiatry*, *84*, 506–518. https://doi.org/10.1037/ort0000016

Kira, I. A. (2010). Etiology and treatment of post cumulative traumatic stress disorders in different cultures. *Assessment and Treatment*, 16(4), 128–14. https://doi.org/10.1177/1534765610365914

Kirmayer, L. J., Kienzler, H., Afana, A. H., & Pedersen, D. (2010). Trauma and disasters in social and cultural context. In D. Bhugra, & C. Morgan (Eds.), *Principles of social psychiatry 2nd ed.*, (pp. 155–177). New York, NY: Wiley-Blackwell.

Kisiel, C., Fehrenbach, T., Liang, L.J., Stolbach, B., McClelland, G., Griffin, G., Spinazzola, J. (2014). Examining child sexual abuse in relation to complex patterns of trauma exposure: Findings from the national child traumatic stress network. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6, 29-S39. http://dx.doi.org/10.1037/a0037812

La Greca, A., Boyd, B., Jaycox, L.H., Kassam-Adams, N., Mannarino, A.P., Silverman, W. K., Tuna, F., Wong, M. (2008). Children & Trauma: Update for Mental Health Professionals. *American Psychological Association*. Retrieved July27, 2018, from https://www.apa.org/pi/families/resources/update.pdf

Leitch, L. (2017). Action steps using ACEs and trauma-informed care: a resilience model. *Health & Justice*, *5* (5). http://doi.org/10.1186/s40352-017-0050-5

Lewis-Fernández, R., Gorritz, M., Raggio, G. A., Peláez, C., Chen, H., & Guarnaccia, P. J. (2010). Association of trauma-related disorders and dissociation with four idioms of distress among Latino psychiatric outpatients. *Culture, Medicine, and Psychiatry*, 34 (2), 219-243.

Meyerson, D. A., Grant, K. E., Carter, J. S., & Kilmer, R. P. (2011). Posttraumatic growth among children and adolescents: A systematic review. Clinical Psychology Review, 31(6), 949–964. https://doi.org/10.1016/j.cpr.2011.06.003

Mulvihill, D. (2005). The health impact of childhood trauma: An interdisciplinary review. *Issues in Comprehensive Pediatric Nursing*, *28*(2),115-136.

Najavits, L. M., Gallop, R. J., & Weiss, R. D. (2006). Seeking safety therapy for adolescent girls with PTSD and substance use disorder: A Randomized Controlled Trial. *The Journal of Behavioral Health Services & Research*, *33*(4), 453–463. https://doi.org/10.1007/s11414-006-9034-2

National Child Traumatic Stress Network. The 12 core concepts: Concepts for understanding traumatic stress responses in children and families. Retrieved June 26, 2018, from https://www.nctsn.org/resources/12-core-concepts-concepts-understanding-traumatic-stress-responses-children-and-families

National Child Traumatic Stress Network. All Measure Reviews. Retrieved July 31, 2018, from

https://www.nctsn.org/treatments-and-practices/screening-and-assessments/measure-reviews/all-measure-reviews?

National Child Traumatic Stress Network. (2012). Impact newsletter. Retrieved July 31, 2018, from https://www.nctsn.org/resources/nctsn-impact-newsletter-spring-2012

Nickerson, A. B., Brock, S. E., & Reeves, M. A. (2006). School crisis teams within an incident command system. The California School Psychologist, *11*, 63-72.

Ozer, E., & Weiss, D. (2004). Who develops Posttraumatic Stress Disorder? *Current Directions in Psychological Science, 13*. https://doi.org/10.1111/j.0963-7214.2004.00300.x

Perrin, S., Smith, P., & Yule, W. (2000). Practitioner review: Assessment and treatment of PTSD in children and adolescents. Journal of Child Psychology and Psychiatry and Allied Disciplines, *41*(3), 277-289. DOI: 10.1111/1469-7610.00612

Peterson, S. (2018, March 29). All Measure Reviews. Retrieved July 26, 2018, from https://www.nctsn.org/treatments-and-practices/screening-and-assessments/measure-reviews/all-measure-reviews?

Pynoos, R. S., Steinberg, A. M., & Wraith, R. (1995). A developmental model of childhood traumatic stress. In D. Cicchetti & D. J. Cohen (Eds.), Wiley series on personality processes. Developmental psychopathology, Vol. 2. Risk, disorder, and adaptation (pp. 72-95). Oxford, England: John Wiley & Sons.

Read, J., Agar, K., Barker-Collo, S., Davies, E., & Moskowitz, A. (2001). Assessing suicidality in adults: Integrating childhood trauma as a major risk factor. *Professional Psychology: Research and Practice, 32*(4), 367-372. http://dx.doi.org/10.1037/0735-7028.32.4.367

Shapiro, F., Solomon, R. M. (2010). Eye Movement Desensitization and Reprocessing. *Corsini Encyclopedia of Psychology*. 1–3. 10.1002/9780470479216.corpsy0337

Sibinga, E.S., Kerrigan, D., Stewart, M., Johnson, K., Magyari, T., & Ellen, J.M. (2011). Mindfulness-based stress reduction for urban youth. *The Journal of Alternative and Complementary Medicine, 17*(3), 213-218. https://doi.org/10.1111/jan.12329

Steinberg, A.M., Brymer, M.J., Decker, K.B., Pynoos, R.S. (2004). The university of California at Los Angeles post-traumatic stress disorder reaction index. *Current Psychiatry Report, 6*, 96–100.

Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 1, *Trauma-Informed Care: A Sociocultural Perspective*. https://www.ncbi.nlm.nih.gov/books/NBK207195/

Tufnell, G. (2005). Eye movement desensitization and reprocessing in the treatment of pre adolescent children with post-traumatic symptoms. *Clinical Child Psychology and Psychiatry*, *10*(4), 587–600.

Wagner, A. C., Monson, C. M., & Hart, T. L. (2016). Understanding social factors in the context of trauma: Implications for measurement and intervention. *Journal of Aggression, Maltreatment & Trauma*, *25*(8), 831–853. https://doi.org/10.1080/10926771.2016.1152341

Woodhouse, S., Ayers, S., & Field, A. P. (2015). The relationship between adult attachment style and post-traumatic stress symptoms: A meta-analysis. *Journal of Anxiety Disorders*, *35*, 103–117. https://doi.org/10.1016/j.janxdis.2015.07.002