Essentials

of Trauma-Informed Assessment and Intervention in School and Community Settings

- Detailed coverage on how early adverse experience of trauma and toxic stress put children at risk for academic, social-emotional, behavioral, neuropsychological, and mental health problems
- Expert guidance on incorporating a trauma informed perspective into practice for assessment, consultation, and evidence based interventions
- Conveniently formatted for rapid reference

Kirby Wycoff
Bettina Franzese

Alan S. Kaufman & Nadeen L. Kaufman, *Series Editors*

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Kirby L. Wycoff, Psy.D., NCSP, is a Nationally Certified School Psychologist and Associate Professor and Co-Director of the School Psychology Program at Eastern University. Her research and clinical interests are centered around the needs of high-risk youth and their families. Dr. Wycoff is currently pursuing her Masters of Publlic Health from The Dartmouth Institute for Health Policy and Clinical Practice to continue to build her understanding of the impact of trauma and adversity on communities. She is also serving a two-year fellowship in Leadership and Education in Adolescent Health (LEAH) through the Children's Hospital of Philadelphia and PolicyLab. The LEAH Fellowship is a national fellowship funded through the Maternal and Child Health Bureau of the Health Resources and Service Administration of the U.S. Department of Health and Human Services. LEAH Fellowship Training programs have been awarded to the leading children's hospitals across the country, where its mission is to prepare professionals from a variety of health care disciplines to be leaders in clinical care, research, public health policy, and advocacy as it relates to adolescent health.

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SERIES PREFACE

In the *Essentials of Psychological Assessment* series, we have attempted to provide the reader with books that will deliver key practical information in the most efficient and accessible style. Many books in the series feature specific instruments in a variety of domains, such as cognition, personality, education, and neuropsychology. Other books, like *Essentials of Trauma-Informed Assessment and Intervention in School and Community Settings*, focus on crucial topics for professionals who are involved in any with assessment—topics such as specific reading disabilities, evidence-based interventions, or ADHD assessment. For the experienced professional, books in the series offer a concise yet thorough review of a test instrument or a specific area of expertise, including numerous tips for best practices. Students can turn to series books for a clear and concise overview of the important assessment tools, and key topics, in which they must become proficient to practice skillfully, efficiently, and ethically in their chosen fields.

Wherever feasible, visual cues highlighting key points are utilized alongside systematic, step-by-step guidelines. Chapters are focused and succinct. Topics are organized for an easy understanding of the essential material related to a particular test or topic. Theory and research are continually woven into the fabric of each book, but always to enhance the practical application of the material, rather than to sidetrack or overwhelm readers. With this series, we aim to challenge and assist readers interested in psychological assessment to aspire to the highest level of competency by arming them with the tools they need for knowledgeable, informed practice. We have long been advocates of "intelligent" testing—the notion that numbers are meaningless unless they are brought to life by the clinical acumen and expertise of examiners. Assessment must be used to make a difference in the child's or adult's life, or why bother to test? All books in the series—whether devoted to specific tests or general topics—are consistent with this credo. We want this series to help our readers, novice and veteran alike, to benefit from the intelligent assessment approaches of the authors of each book.

Essentials of Trauma-Informed Assessment and Intervention in School and Community Settings is a book about how to help young people do and be the best versions of themselves. While the superb authors talk a great deal in this book about the impact of adversity and trauma, it is critically important that they also call readers' attention to the fact that *risks* do not have to be *realities*. It is critically important to acknowledge that youth exposed to adversity hold within themselves an incredible capacity for growth and resiliency. Helping young people find their own stories of strength, and supporting their ability to grow in the face of adversity is not only possible, but necessary. As the authors emphasize, trauma-awareness must be followed by a focus on resilience if we are to truly empower and support all young people.

Alan S. Kaufman, PhD, and Nadeen L. Kaufman, EdD, Series Editors

Yale Child Study Center, Yale University School of Medicine

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Kirby L. Wycoff

I dedicate this book to my dear mother, Vera, who was always encouraging of my endeavors. And to my loving husband, Steven, and talented son, Evan, who continue to make me a very proud partner and mother to their own achievements and many accomplishments.

Bettina Franzese

Essentials of Trauma-Informed Assessment and Intervention in School and Community Settings

Section One

HISTORY: TRAUMA, ADVERSITY AND THE TRAUMA-INFORMED MOVEMENT

One

ADVERSE CHILDHOOD EXPERIENCES

Kirby L. Wycoff

INTRODUCTION

We are a nation in crisis. Our schools, our communities, and our families are under fire. Physically, emotionally, spiritually, we are increasingly feeling the impact of adversity and trauma on a scale of massive proportions.

Take Mateo for example. Mateo is 9 years old and now resides in a therapeutic foster care home. He was removed from his home after his parents were jailed for drug possession. During the time he lived with his parents, Mateo and his siblings were left alone and unsupervised for days at a time. Sometimes there was no food in the house and the utilities were often turned off. Mateo, the middle son, was often punished severely due to his father's perceptions of him being an oppositional and willful child. All of the children witnessed domestic violence and Mateo's mother was hospitalized on several occasions. Mateo's mother, when abusing drugs, became agitated and angry and told the children they were "stupid and worthless." The siblings were split up after they were removed from the home. Mateo does poorly in school, gets into physical altercations, and spends a good deal of time in the principal's office for behavioral problems. Mateo is alternatively very clingy towards his teacher but also aggressive towards her as well. Teachers cannot understand why Mateo is so angry and can blow-up over the slightest incident. Between the ages of 6–8 years he was diagnosed with learning disabilities, attention deficit hyperactivity disorder and oppositional defiant disorder. Mateo has now been suspended from school three times and school administrators and teachers are running out of options.

Consider Rosalyn. Rosalyn is 17 years old and while she is committed to her schooling and education, she was recently suspended for sleeping overnight in the

locker room on school grounds. Rosalyn was born to a drug addicted mother who had a significant history of mental illness. Rosalyn's mother has been hospitalized on multiple occasions for depressive symptoms, suicidality, and undedicated bipolar disorder. Her father was largely absent during her early childhood. Up until the fifth grade, Rosalyn lived with her mother and grandmother. Rosalyn's grandmother struggles with drug and alcohol abuse and becomes violent and aggressive when using substances. On multiple occasions Rosalyn has landed in the ER with head trauma and bruising as a result of her grandmother's violent outbursts. Roslyn lives in an area of the city that makes it unsafe for her to walk to and from school. She has to alter her route on a regular basis to avoid gang violence and gun activity. What should be a 5-minute, 3 block walk often takes her 45 minutes as she navigates her dangerous neighborhood to make it home safely. Rosalyn often eats breakfast and lunch at her school, and these might be the only meals she gets all day. Frequently, the last meal she will have before the weekend is Friday at lunch. She will not eat again until she is in school on Monday morning. Child Protective Services has been involved with the family for many years. The agency is under-resourced and despite multiple failed interventions, Rosalyn still resides in the home. Recently, Rosalyn has been sleeping in the girls' locker room because she felt safer than walking home in a dangerous neighborhood and residing with two unstable adults who are unable to meet her needs. Unfortunately, in doing this, Rosalyn was suspended for violating the schools security policy. She has now been out of school on a suspension for 23 days.

We are a nation in distress and Mateo and Rosalyn are just two of hundreds of thousands of children in this country who have experienced chronic, traumatic stressors. More than half of the school-aged children in the United States have experienced at least one Adverse Childhood Experience (ACE). Research indicates that anywhere between 3 and 10 million children per year witness violence in their homes and communities (American Psychological Association, 2008). Research shows that at the last count approximately 906,000 children were found to be victims of child abuse and neglect by Child Protective Services (American Psychological Association 2008). There has been considerable coverage and publicity about the lifelong effects of ACEs lasting well into adulthood and the negative mental and physical health outcomes. Subsequent chapters in Section 1 will discuss the ACE Study including the role of the Centers for Disease Control (CDC) and Kaiser Permanente as well as introduce a discussion on the impact of stress and adversity. The effects of trauma exposure are long lasting and often life changing. The need for trauma-informed assessments and interventions in school and community settings continues to grow exponentially in our country and beyond.

Children like Mateo and Rosalyn are in your communities, neighborhoods, classrooms, and schools, and on our caseloads. This book is designed to provide school, clinical, and related psychologists and mental health practitioners and their trainers with science-based information about the negative and toxic effects of ACEs (also referred to as chronic or developmental trauma) on children's functioning, adjustment, cognitive, social–emotional, behavioral, academic, and neuropsychological outcomes.

The Invisible Suitcase provides a meaningful metaphor for understanding the social, emotional, educational, and behavioral challenges of traumatized youth. The National Child Traumatic Stress Network uses this exercise in helping individuals understand children and youth in the foster care system as part of their Child Welfare Trauma Training Toolkit. We offer it as an opportunity to consider any traumatized child that we interact with in school and community settings. Instead of calling it the invisible suitcase, here we will refer to it as the "invisible backpack." Children who enter our school buildings and community centers may come with personal belongings and items. They may have pencils, notebooks, and pens as they gear up for their learning in the schools. They also, however, arrive with another piece of luggage. It is one that not even they are aware they have. This is their invisible backpack and it is full of the beliefs they have about themselves, the people who care for them, the people who educate them, and the world at large.

For children who have experienced trauma, particularly the abuse and neglect that leads to foster care, the invisible backpack is often filled with overwhelming negative beliefs and expectations. Beliefs not only about themselves. . .

- I am worthless.
- I am always in danger of being hurt or overwhelmed.
- I am powerless.

But also about you as a caregiver. . .

- You are unresponsive.
- You are unreliable.
- You are, or will be, threatening, dangerous, rejecting. (Child Welfare Trauma Training Toolkit: The Invisible Suitcase, March 2008, p.1)

As individuals who interact with children and youth who have been exposed to trauma, whether that is in school settings, community settings, outpatient, or inpatient settings in roles as direct care providers, foster parents, educators, and coaches or mentors, our ability to be sensitive to these negative beliefs is critical to the child's welfare. We must remember that these beliefs that these

children and teens have are not about us; and if we do not understand them and where they come from, we will not be able to effectively connect and work with these children. (NCTSN 2008). This book sets the stage for community and school professionals to better understand the invisible backpack and how to help trauma-impacted children and their families.

These ACEs, which are often chronic and occur within caregiving and family systems, can throw children off a normal developmental trajectory and may have negative effects on mental and physical wellbeing that can last well into adulthood (Felitti & Anda, 2009). Current research on brain areas and cognitive processes typically associated with academic achievement has focused on the realms of language functioning, comprehension, executive functions, conceptual reasoning, learning, long-term retrieval, phonemic awareness, information processing, and related brain areas that are associated with mental health and neurodevelopmental disorders. These relationships will be discussed as they relate to early chronic stressors.

Early chronic stressors and developmental trauma can have damaging effects on children's functioning in school, home, and their communities. Youth impacted by chronic stressors are frequently referred for academic, neuropsychological, psychoeducational and/or psychological evaluations. When assessing such children, the importance of going above and beyond typical evaluations by gathering additional data from formal and informal testing, family and developmental history, and child and caregiver interviews allows for more comprehensive, trauma-focused evaluations. These evaluations can lead to targeted treatments to help understand the strengths and challenges of so many of our nation's vulnerable, at-risk children and youth.

The purpose of this book is to provide the knowledge base and tools to conduct trauma-informed assessments, develop and provide evidence-based interventions, a means in which to consult with caregivers about best practices in working with these students, and provide expertise in helping schools consider a trauma-informed perspective on children's educational and mental health services.

This book is organized and developed with the practitioner in mind. The book contains three different sections that each represent an important aspect of understanding the topic of trauma, adversity, and youth. We suspect that for the experienced clinician, you might brush up on the history of the trauma-informed movement in Section 1, and then jump right into assessment tools, services, and interventions in Section 3. This book does not need to be read chronologically and we encourage you to make this Essentials Book work for you.

Section 1: History: Trauma, Adversity, and the Trauma-Informed Movement
- Chapter 1: Adverse Childhood Experiences
- Chapter 2: Impact on Children, Teens, Families, and Communities
- Chapter 3: Public Health and the Trauma-Informed Movement
- Chapter 4: Trauma-Informed Schools

Section 2: Complex Trauma and the Role of Functional Impairment
Section 3: Trauma-Informed Assessment Framework

As we read ahead in Chapter 1, we will take a closer look at the ACEs Study and the impact that this has on our understanding of adversity and stress in the lives of children, teens, and families.

ADVERSE CHILDHOOD EXPERIENCES

The Adverse Childhood Experiences Study (1998) is one of the largest, longitudinal studies of its kind to document the harmful impact of early adversity on later physical and mental health in adults. ACEs refers to a myriad of negative experiences, including child abuse, neglect, and parental substance abuse and other traumatic stressors that occur prior to the age of 18. In the 1990s two prominent researchers, Dr. Vincent Felitti and Dr. Robert Anda, joined forces to better understand the impact of early childhood adversity on later health behaviors.

In 1985, Dr. Vincent Felitti was the chief physician at Kaiser Permanente's Department of Preventative Medicine in San Diego, CA, where he was researching obesity in an adult health clinic. He noticed over time that many of his study participants dropped out of the research protocol and never completed the program (Stevens, 2012). The Preventative Medicine Department, which housed the obesity clinic, was opened in the 1980's. Over the years, Dr. Felitti had established one of the leading preventative health clinics in the world, primarily focused on reducing health costs. Over 50,000 people were screened for disease on an annual basis, and research was being conducted to establish paths of illness and methodology for preventing illness. The dropout data at the obesity clinic puzzled Dr. Felitti. He and his team decided to dig into the medical records of all of their clients to better understand why they had dropped out. He noted that these overweight clients (most who had to lose between 100 and 600 pounds) actually left the clinic at the very moment that they were losing weight. The team wondered why someone who started at 300 pounds–and who had already lost 100 pounds–would stop just when they were feeling successful (Stevens, 2013a,b).

This phenomenon was terribly frustrating to Dr. Felitti and he wanted to know more. He noted that the situation "was ruining my attempts to build a successful program" and he wanted to know why (Stevens, 2012, Para. 7). This unexplained phenomenon would become the foundation of a career-long journey and partnership between the CDC and Kaiser Permanente to understand the impact of early childhood adversity. Based on the early research by Felitti and his team, which included approximately 17,000 subjects, we know that early exposure to adversity directly relates to multiple chronic health issues in adulthood. We know that adverse experiences in childhood are quite common, even for middle-class individuals, and that these chronic health issues cost our country billions of dollars on an annual basis.

What Dr. Felitti found in those clients' medical records was that all of clients had been born at a normal weight and most were not obese in childhood. This was shocking. He assumed that clients would gain extra weight, slowly over time. This was not the case. Instead, he found that they gained weight all at once and stayed at their heavier weight. If they lost weight, they would quickly gain it back. "I had assumed that people who were 400, 500, 600 pounds would be getting heavier and heavier year after year. In 2,000 people, I did not see it once," says Felitti (Stevens, 2012, para. 10). To dig deeper, Dr. Felitti and his team conducted in-depth interviews with a number of the clients who dropped out of his research study. He did face-to-face interviews and for many weeks, he learned nothing new that helped him solve his puzzle. Until one day he stumbled upon something accidentally. Dr. Felitti was interviewing an obesity clinic patient and working through his standard interview protocol, which included questions like these: "How much did you weigh when you were born? What was your weight in the first grade? What was your weight upon entering High School?" (Stevens, 2012, para. 11). Stumbling on one part of the interview, Dr. Felitti asked a female patient "How much did you weigh when you were first sexually active?" (Stevens, 2012, para. 11). The patient gave the physician quite a shock when she responded with "40 pounds" (Stevens, 2012, para. 12). Felitti asked again, seeking clarity. He was certain he had misunderstood. The patient went on to clarify that indeed, she was 40 pounds and 4 years old when she first became sexually active. Her father was her perpetrator.

Dr. Felitti recalled thinking that this was one of the first and only times in his 20-year career that he had worked with or even met a client with a history of incest (Stevens, 2012). As a physician, Felitti was trained on the medical side of the physical human body, but not necessarily on the mental health side. He recalled not knowing how to handle the information that this client had shared (Stevens, 2012). Felitti also recalled feeling distraught when he had another client

just a few days later report the exact same experience. He wondered how he had missed this critically important piece of information in his medical training. More concerning, he wondered if perhaps this was just not something that professionals or patients were talking about. Felitti wondered if he had unintentionally biased his participants in the way he worded his interview questions. Perhaps it was his flawed research methodology and design that created the shocking outcomes. Perhaps there was something about the way he was doing the interviews that was misleading or biased. He revisited his design protocol and asked colleagues to interview the remaining participants (Stevens, 2012). Unfortunately, it was not bias that was revealing these startling trends. In fact, of the 286 people interviewed by the team, most had reported being sexually abused as children. One particular respondent revealed another piece of the puzzle. This patient reported that she had not been born overweight, but was raped at 23 years of age. In the year following her attack, she gained over 100 pounds. Stevens (2012) noted in her now widespread article on this topic that Felitti reported the following in reference to the 23 year old client: "As she was thanking me for asking the question, she looked down at the carpet and muttered 'Overweight is overlooked and that's what I needed to be'" (Stevens, 2013a,b, para. 18).

Felitti was struck by a fact that had eluded so many others who were attempting to address the obesity epidemic. As Felitti reflected, for many of these people the weight was not the problem, it was the solution (Stevens, 2013a,b). For many of these participants, food had become a way to manage an intense emotional experience. Instead of processing the deep and complex feelings that occur as a result of trauma, mindlessly eating created a numbing experience. In many ways, the weight became a protective factor. Instead of becoming incredibly vulnerable and addressing the shame and guilt of the traumatic experience, eating became a distraction. Similar to the use of drugs, it was both a solution and distractor; a self-medication of sorts in which food provided a mechanism for coping. For some, being overweight in-and-of-itself works as an invisibility cloak in a society that is seemingly obsessed with being thin and attractive. Being overweight lets individuals fade into the margins of a society if they choose to do so. To the 23-year-old woman discussed above, becoming overweight after her rape was a safeguard against being sexually assaulted again. Another participant, who was also a sexual abuse survivor, recalls that every time she lost weight and men would comment on how attractive she was, she became paralyzed with fear; not surprisingly, she would again gain weight (Stevens, 2012). Obesity served as a protective factor to something more painful and scary. Losing weight caused significant anxiety and discomfort and with this line of thinking in mind, it was no wonder that so many of Felitti's participants dropped out of the study, right at the time

that they were "successfully" losing weight. Multiple subsequent researchers have documented the impact of early adversity on physical health and obesity. In a sample of 471, the prevalence of obesity (BMI>/= 85%) was greater (45.2%) among participants who had experienced four or more childhood adversities, compared to those that had no childhood adversity (Burke, et al., 2011). This critical aspect of obesity had largely been ignored by mental health professionals, physicians, and public health policymakers. Felitti's discovery led him down an entirely new path of inquiry—understanding the impact of adversity on later mental and physical health outcomes (Stevens, 2012).

In many ways this new information turned the public health and medical fields entirely upside down. For a long time researchers had been looking at the behavior as the problem, with rates of addiction and obesity skyrocketing across the country. Felitti's work suggested a different line of inquiry might be worth pursuing. With Felitti's discovery, the field began to turn their attention to the underlying causes of these behaviors. It would appear that the addictive behaviors of overeating (or doing drugs, or drinking alcohol, or smoking cigarettes) were coping mechanisms for unresolved early traumatic experiences (Stevens, 2012).

Felitti was invigorated by this new finding and took his data to a conference in Georgia in 1990 to spread the word. At the North American Association for the Study of Obesity, a conference largely attended by psychologists, psychiatrists, and obesity researchers, Felitti was sure his data would have an impact (Stevens, 2013a,b). It did not. Many in the audience criticized the work and noted that his findings were not generalizable. They criticized his sample size for being too small and generally discounted his findings. However, one attendee at the conference took note. Dr. David Williamson, who also happened to be an epidemiologist for the United States Centers for Disease Control and Prevention, approached Felitti with an idea. He told Felitti that with a larger sample size from the general population (instead of just those from an obesity clinic), folks might be more inclined to hear what he had to say. Williamson introduced Dr. Felitti to Dr. Robert Anda, a medical epidemiologist. Dr. Anda was a physician, who had become interested in public health and epidemiology. Broadly speaking, epidemiology is the study of disease from a population perspective. "Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems" (Last, 2001, p.1). It is the study of the health in an overall population and it involves connecting research-driven data and outcomes to community-based practice (Cates, 1982; Greenwood, 1935).

At the time that Felitti and Anda met, Anda was researching the relationship between depression and coronary heart disease at the CDC. He had found in