Evidence-Based Practice

A GUIDE TO EVIDENCE-BASED TRAUMA-FOCUSED PRACTICES

HELPING SCHOOLS RESPOND TO CRISES

SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

This report was produced with the support of the Saginaw County Community Mental Health Authority

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This report is one of a series on evidence-based practices that addresses a specific subpopulation served by the Saginaw County Community Mental Health Authority. It is designed to acquaint the reader with mental health services and supports applicable to schools responding to critical incidents that can be provided in educational, home, community, and treatment office settings. Both evidence-based and promising interventions are included. The material is derived from a review conducted of relevant literature in the fields of mental health and education.

The electronic version of this document has hyperlinks to web sites and between sections (denoted by blue underlined text) embedded within it to enable the reader to access additional information expediently. Web sites for specific programs and interventions described in the report are included where available.

It should be noted that this report is a snapshot in time and depicts practices currently available. As this area of study develops, and new evidence accumulates, revisions and updates will be needed.

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INTRODUCTION

Children of all ages, from all socioeconomic strata, racial and ethnic groups, and geographic regions can be exposed to traumatic events[2] that impact their functioning in school. The literature recommends that school personnel be aware of the events and experiences that can place students at risk for psychological trauma such as physical or sexual abuse, neglect, the death or loss of a loved one, life-threatening illnesses of caregivers, witnessing domestic violence, life-threatening health situations and/or painful medical procedures, witnessing police activity, the incarceration of a close relative, refugee or war-zone experiences, community violence, and disasters.

Traumatic stress impedes developmental progression and negatively impacts children as well as adults. For example, research has found that child abuse and neglect can negatively affect neurodevelopment (i.e., physical and biological growth of the brain, nervous, and endocrine systems) and psychosocial development (i.e., personality formation, including morals, values, social conduct, capacity for relationships with other individuals, and respect for social institutions and mores).

In recent years schools have confronted a number of traumatic incidents including murders of students, serious injuries and fatalities from traffic accidents during field trips, suicides, consequences of terrorist or criminal activities, major arson attacks, meningitis deaths, explosions, drownings, sports-related injuries and deaths, rapes, bullying, deaths from drug use, gang violence, and life-threatening natural disasters (e.g., earthquakes, hurricanes, ice storms, tornados, and floods). Data indicate that one out of every four children attending school has been exposed to a traumatic event significant enough to affect learning and/or behavior. According to the U.S. Department of Justice, one percent of students twelve to eighteen years of age (i.e., two hundred twenty five thousand children) have been victims of serious violent crimes either at school or as they traveled to and from school.

Safety and a sense of security are necessary components of effective learning environments that promote student achievement. Research has clearly demonstrated that exposure to trauma can affect attention, concentration, the ability to absorb new information, abstract reasoning, and long term memory for verbal information. Experiencing or witnessing trauma can negatively impact academic performance and be manifested in lower GPAs, decrements in reading abilities, higher rates of school absences[3], and increases in suspensions, expulsions, and drop-out rates. Trauma can disrupt the classroom environment thereby affecting students as well as teachers.

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[2] Childhood traumatic experiences generally fall into one of two categories: acute traumatic events or chronic traumatic situations. An acute traumatic event occurs at a particular time and place, and is usually short-lived. Acute traumatic events include school shootings, gang-related violence in the community, terrorist attacks, natural disasters (e.g., earthquakes, floods, or hurricanes), serious accidents (e.g., car or motorcycle crashes), sudden or violent loss of a loved one, and physical or sexual assault (e.g., being beaten, shot, or raped). Exposure to trauma can occur repeatedly over long periods of time which produces some of the same reactions associated with acute traumatic events and may also result in a range of other responses (e.g., loss of trust in others, guilt, shame, a decreased sense of personal safety, and hopelessness about the future). Chronic traumatic situations include physical abuse, sexual abuse, domestic violence, wars, torture, neglect, and emotional abuse.

[3] Children who experience persistent bullying at school may suffer physical injuries, serious symptoms of traumatic stress, and may avoid school to preserve a sense of personal safety.

Reactions to trauma may appear immediately subsequent to a traumatic event, or days or weeks afterward. Many children and adolescents who have been exposed to traumatic events experience fear of the event recurring and diminishment in trust in adults. Other reactions vary in accordance with age/developmental level.

AGE-ASSOCIATED REACTIONS OF CHILDREN EXPOSED TO TRAUMATIC OR STRESSFUL EVENTS	
0-5 years	Crying, excessive clinging, regressive behaviors (e.g., thumb sucking, bedwetting, loss of bladder/bowel control, inability to dress or eat without assistance), sleep terrors, nightmares, irritability, confusion, sadness, eating problems, re-enactment via play, and fears of darkness, animals, being left alone, and crowds or strangers. Children in this age range tend to be strongly affected by their parents' reactions to a traumatic event and the impact of the event on their mothers or other primary caregivers, rather than a trauma per se.
6–11 years	Regressive behaviors (bedwetting, excessive clinging, irrational fears), sleep terrors, nightmares, sleep problems, irritability, aggressiveness, disobedience, depression, somatic complaints (e.g., stomach aches and headaches),, visual or hearing problems, school problems (e.g., school refusal, behavior problems, poor school performance, fighting, concentration problems, distractibility), withdrawal, lack of interest, peer problems, increased conflict with siblings.
12-17 years	Withdrawal, isolation, somatic complaints (e.g., nausea, headaches, chills), depression/sadness, agitation or decreased energy level, antisocial behavior, poor school performance, sleep and/or eating disturbances, irresponsibility, risky behavior, alcohol and other drug use, diminished bids for autonomy, decreased interest in social activities, conflict with parents, concentration problems.

(Center for School Mental Health Assistance, Crisis Intervention: A Guide for School-Based Clinicians)

Some children and adolescents have been found to cope more effectively with adversity due increase resiliency. In other words, they have a greater capacity for successful adaptation despite facing challenging or threatening circumstances. Protective factors provide buffers that diminish the effect of risk factors and help build resilience.

PROTECTIVE FACTORS		
Child	**Family Characteristics**	**Social Support From Outside The Family**
Positive, easy temperament type	Living at home	Adult mentor for the child outside immediate family
Autonomy and independence as a toddler	Secure mother-infant attachment	Extra adult help for caretaker(s) of family
High hopes and expectations for the future	Warm relationship with a parent	Support for the child from friends
Internal locus of control as a teenager	Inductive, consistent discipline by parents	Support for the child from a mentor at school
Interpersonally engaging, likable	Perception that parents care	Support for the family from faith-based organizations
Sense of humor	Established routines in the home	Support for the family from work place
Empathy	Family cohesion	
Perceived competencies	Clear, open communication among family members	
Above average intelligence (IQ>100)	Spirituality/faith	
Good reading skills		
Gets along with others		
Problem-solving skills during school-age years		

Some children and adolescents are more vulnerable to the effects of trauma. Research has shown that children and adolescents who have previously experienced abuse or other trauma or

have a mental health problem are most impacted by traumatic events. Moreover, those who lack family support are at higher risk for a poor recovery.

It should be noted that even individuals who have multiple protective factors can also become overwhelmed by significant levels of trauma. Studies have found that individuals who experience multiple traumatic events or circumstances are at significantly higher risk for a range of health problems, including substance abuse, suicide attempts, heart disease, severe obesity, multiple (i.e., fifty or more) sexual partners, and sexually transmitted diseases.

RISK FACTORS		
Child	**Family Characteristics**	**Family/Experiential**
Fetal drug/alcohol effects	Poverty	Poor infant attachment to mother
Premature birth or complications	Large family; 4 or more children living in overcrowded space	Long term absence of caregiver in infancy
Difficult temperament	Siblings born within 2 years of the child	Witness to extreme conflict, violence
Shy temperament	Parental mental illness, especially maternal depression	Substantiated neglect
Neurological impairment	Parental substance abuse	Separation/divorce/single parent
Low IQ (IQ <80)	Parental criminal behavior	Negative parent-child relationship
Chronic medical disorder		Sexual abuse
Psychiatric disorder		Physical abuse
Repeated aggression		Removal from home
Substance abuse		Frequent family moves
Delinquency		Teen pregnancy
Significant levels of truancy and school retention challenges		
Poor academic performance		

Research indicates an association between stressful life events (e.g., parental death or divorce) and the onset of major depression in young children, especially if the events occur during early childhood. Trauma has been found to increase the risk for co-occurring psychiatric disorders. Research has demonstrated that PTSD[4] subsequent to exposure to a variety of traumatic events (e.g., family violence, child abuse, disasters, and community violence) is often accompanied by depression. Studies have also found a high prevalence of trauma exposure and PTSD among individuals with co-occurring mental health and substance use disorders.

Some children are at particular risk for high rates of exposure to traumatic events and require specific prevention and treatment efforts to ameliorate the adverse effects of trauma. These include children who have experienced:

- Abuse or neglect (Physical abuse has been found to be associated with insecure attachment, impaired social functioning with peers, posttraumatic stress disorder (PTSD), conduct disorder, attention-deficit/hyperactivity disorder (ADHD), and

[4] Research on posttraumatic stress disorder (PTSD) in children indicates there are a number of potentially traumatic events including sudden separation from a loved one and learning of a traumatic event occurring to a parent or a loved one (e.g., a parent being sent to prison). Studies of children exposed to trauma show they have almost double the rates of psychiatric disorders of those not exposed. Psychiatric disorders (e.g., anxiety, depression, and disruptive behavior disorders) are strongly interrelated with trauma and trauma symptoms. Moreover, depression and anxiety can serve as risk factors for and sequelae of trauma exposure. Depression and anxiety disorders are also common sequelae of trauma exposure, particularly for individuals who also display some posttraumatic stress symptoms (e.g., painful recall).

depression. Psychological abuse has been found to be associated with depression, conduct disorder, delinquency, and impaired social and cognitive functioning in children. Studies have found that adult survivors of child sexual abuse are at increased risk for psychiatric disorders including depression, anxiety, substance abuse, PTSD, eating disorders, and suicidality.)

- Out-of-home placement
- Exposure to domestic violence
- Poverty (Lower socioeconomic status is correlated with increased risk for experiencing undesirable life events. Racial, ethnic, and cultural groups that are overrepresented among low-income populations are thus at a higher risk for experiencing trauma.)
- The violent death of a parent, caregiver, sibling, or friend (Children residing in inner cities experience the greatest exposure to violence. Youngsters who have been exposed to community violence have been found to be more likely to exhibit aggressive behavior or depression within the following year.
- Placement in the juvenile justice system
- Catastrophic accidents or mass casualty events, including those associated with school violence, terrorism, or natural disasters
- Living in countries with major armed conflicts or civil disturbances
- Residential treatment or hospitalization for certain mental health or substance abuse problems, including suicide attempts
- Exposure to violence in schools and communities
- Chronic and persistent bullying, harassment, and victimization
- Secondary trauma exposure from parental and other caregivers experience of trauma who are struggling with their own recovery (e.g., mass disasters)

Without support, these children are more likely to perform poorly in school or drop out, experience difficulty obtaining or maintaining employment, engage in high risk behaviors, suffer from or perpetrate violence or abuse, and experience significant mental and physical health problems.

On the other hand, the majority of children and youth who have experienced a traumatic event and receive support from their families and communities are resilient and do not suffer long-term developmental consequences. Those who do not recover within a short time and develop posttraumatic stress disorder (PTSD) or other persistent problems require mental health intervention. Early intervention is considered critical and should be initiated at the scene of a traumatic event with help provided by parents, teachers, and mental health professionals to foster recovery.

UNDERSTANDING EVIDENCE-BASED PRACTICES

The term evidence-based practice refers to a clinical intervention that has a strong scientific foundation and produces consistently beneficial outcomes. An evidence-based practice is comprised of three components:

1. The highest level of scientific evidence
2. The clinical expertise of the practitioner
3. The choices, values and goals of the consumer

The strength of evidence for any given practice is referred to as the level of evidence. The highest level of evidence is based on a research methodology that is known as the randomized clinical or controlled trial (RCT). RCTs use sufficiently large number of participants (usually a minimum of thirty), or subjects, who are randomly assigned to a specific intervention (the experimental group), or to a group that receives a routine or another intervention (the control group). In some studies, the control group does not receive any intervention (e.g., they are put on a waiting list). Randomization reduces the potential for bias in the results. Outcomes from RCTs that are then replicated in typical clinical settings are assigned the highest level in the hierarchy of evidence.

In the most robust RCT investigators and participants are doubled blinded so that neither is aware of which subjects are in the experimental group and which are in the control group. In most studies examining interventions of a psychosocial nature, it is impossible to keep practitioners and consumers unaware of the intervention. However, it may be possible to keep interviewers and/or individuals who are conducting data analysis blind until data are collected and analyzed.

The next level of scientific evidence comes from RCTs that have not been replicated outside the controlled experimental situation. Less rigorous research designs are correlational research designs which entail observation of relationships to discern whether factors are associated or correlated, quasi-experimental studies which do not assign subjects to control and experimental groups on a random basis, and pilot studies. Pilot studies are evaluations or demonstrations that allow a comparison of the before and after the introduction of the intervention. They typically include findings from uncontrolled studies that can be used to refine the interventions and investigational methodologies in subsequent controlled studies.

Promising practices are those which show potential for positive results and or have significant evidence or expert consensus for their use. Emerging practices are innovative practices that deal with specific needs, but are not supported by the strongest scientific evidence. Expert consensus is another level of evidence that represents the incorporation of the opinions of practitioners who are deemed subject matter experts in their fields. Case reports or case studies constitute anecdotal evidence.

Meta-analyses use statistical techniques to combine the results of multiple research studies in order to determine the magnitude and consistency of the effect (i.e., the size or clinical significance) of a specific intervention detected across studies. It is important for a reviewer of a meta-analysis to ascertain whether the report includes studies with negative or insignificant results, and whether all of the studies are randomized. Omitting studies with negative or insignificant results and/or mixing differing levels of quality research can skew the results of a meta-analysis.

A guideline consists of a set of intervention strategies designed to assist practitioners in the process of clinical decision-making by synthesizing research and expert consensus into a practical form.

Guidelines have been written for a number of mental illnesses and are available from a variety sources including professional associations, such as the American Psychiatric Association, as well as the Agency for Healthcare Research and Quality, among others.

An algorithm is a series of sequential steps that are to be precisely followed without deviation in the administration of an intervention. It is usually constructed as a flow chart that functions as a decision guide with recommendations regarding what changes are to occur based upon the consumer's response to the intervention. Thus, the results of each step determine the next step. The Children's Medication Algorithm Project (CMAP) for attention deficit/hyperactivity disorder (ADHD) and major depressive disorder (MDD) in children and adolescents is one example. Another is the Texas Implementation of Medication Algorithm (TIMA) for the treatment of schizophrenia, bipolar disorder, and major depression in adults. The Michigan Implementation of Medication Algorithms (MIMA) is based on TIMA.

The use of guidelines and algorithms for medication has been shown to improve the quality of care and outcomes for consumers. They are designed to reduce practice variation and polypharmacy, increase predictability of costs, as well as provide a benchmark for monitoring care and evaluating interventions. It is also thought that their use reduces liability exposure as well. In sum, they are tools designed to help practitioners make clinical decisions to optimize outcomes but are not a substitute for clinical judgment.

The different research designs found in the literature and need to confer significance to their findings has led to use of a grading system known as Sackett's rules of evidence that is based on five levels of evidence:

Level I: Large randomized trials, producing results with high probability of certainty. These include studies with positive effects that show statistical significance and studies demonstrating no effect that are large enough to avoid missing a clinically significant effect.

Level II: Small randomized trials, producing uncertain results. These are studies which have a positive trend that is not statistically significant to demonstrate efficacy or studies showing a negative effect that are not sufficiently large to rule out the possibility of a clinically significant effect.

Level III: Non-randomized prospective studies of concurrent treatment and control groups, i.e., cohort comparisons between contemporaneous subjects who did and did not receive the intervention.

Level IV: Non-randomized historical cohort comparisons between subjects who did receive the intervention and earlier subjects who did not.

Level V: Case series without controls. The clinical course of a group of consumers is described, but no control of confounding variables is undertaken. This is a descriptive study which can generate hypotheses for future research but does not demonstrate efficacy.

Effectiveness refers to whether an intervention works in typical clinical settings. One of the biggest challenges is moving an efficacious intervention into routine settings to generate effective results. Efficacy studies typically include individuals who are not representative of populations in typical settings. Moreover, highly trained and supervised specialists adhering to strict protocols that require frequent monitoring of the participants often conduct them. Thus, many interventions work better in clinical research then in everyday practice settings. This so-called efficacy-effective gap is now a matter of national concern along with the drive to make evidence-based practices widely available.

Fidelity refers to the level of adherence to the original model as specified in written materials (e.g., a manual). The degree of fidelity to the model affects outcomes. Research has demonstrated that the level adherence to the model strongly affects the ability to achieve the desired outcomes. However, it

is sometimes necessary to adapt a practice to fit actual practice settings so that complete adherence to the original model is not maintained. This is referred to as adoption. This occurs because, as previously noted, controlled trials typically use individuals who are not representative of populations in typical settings. In order to be most effective, interventions need to be tailored to individuals with respect to gender, age, ethnicity, and culture.

The extent to which a practice can be explained in a manual, appraised for fidelity to the model, and adopted in everyday service settings is the gold standard of evidence-based practices. A manual needs to clearly articulate the goals and standardized techniques of the intervention to allow for comparison of practice with the original model. When used with a fidelity scale, a manual can reduce drift from the original model.

Empirical literature should be reviewed with critical appraisal. The methodological features of a study need to be scrutinized when evaluating its significance. The design of a study, whether it is experimental or quasi-experimental, and choice of outcome measures are of critical importance. In addition, criteria for inclusion and exclusion should also be analyzed since many studies do not take into consideration differential effects on ethnocultural groups. The length of follow-up is important to assess, as it can be an indicator of enduring effects of an intervention. Finally, a fidelity instrument allows for comparison with the original model in subsequent studies.

EVALUATING INTERVENTIONS

Step 1 Is the intervention backed by strong levels of effectiveness?

Quality of studies needed		Quality of evidence needed:		
To establish strong evidence: • Randomized controlled trials that are well designed and implemented	+	Trials showing effectiveness in • Two or more settings • Including a setting that is similar to that of the specific setting in which the intervention is to be conducted	=	Strong Evidence

Step 2 If the intervention is not backed by strong evidence, is it backed by possible evidence of effectiveness?

Types of studies that can comprise possible evidence:	Types of studies that do not comprise possible evidence:
• Randomized controlled trials whose quality/quantity are good but fall short of strong evidence and/or • Comparison-group studies in which the intervention and comparison groups are very *closely matched with respect to* characteristics	• Pre-post studies • Comparison-group studies in which the intervention and comparison groups are not closely matched • Meta-analyses that include the results of such lower quality

Step 3 If the answers to both questions above are no, one may conclude that the intervention is not supported by meaningful evidence.

(Adapted from United States Department of Education, 2003)

SCHOOL-BASED MENTAL HEALTH SERVICES

Schools play critical roles in communities that are much broader than the provision of classroom-based education. Schools address the emotional and behavioral needs of children and their families both within the context of promoting and facilitating academic achievement and in response to behavioral problems exhibited by students (e.g., conduct, attendance, and attention difficulties). Schools have become key settings for the provision of mental health services and typically some of the first institutions to reopen in communities that have experienced traumatic events.

Schools can provide early interventions during the acute crisis response phase to promote the psychological recovery of students and staff after a range of traumatic events (e.g., natural disasters and terrorism) and also address longer term mental health needs of students who have experienced trauma. For example, after the September 11, 2001 attacks on the World Trade Center and the Pentagon, schools provided support services to students in New York City. And, subsequent the bombing of the Murrah Federal Building in Oklahoma City, the Oklahoma City Public School District screened thousands of students and provided psychological support services to many students and school staff.

Schools are logical venues for the provision of trauma-informed programs. Over the last few decades, mental health programs in schools have proliferated. Many students in special education have mental health interventions written into their Individualized Education Programs (IEPs). A number of schools have school-based health centers (SBHCs) that incorporate mental health programs, and many schools offer services from community mental health providers on campus. The Surgeon General's *National Action Agenda for Children's Mental Health* and President's *New Freedom Commission on Report Mental Health* both call for increases in school mental-health programs.

School settings offer significant opportunities to promote mental health and prevent problems among all economic, geographic, racial, and cultural groups of children by nature of their access to a public education. One advantage to school-based interventions is that they teach children social and emotional skills while supporting academic achievement. Early intervention efforts have demonstrated effectiveness in contributing to the overall mental well-being of children as well as reducing delinquency, substance abuse, high risk sexual behaviors, and school failure. In addition, the provision of health services in the familiar settings of schools can reduce barriers that curtail access to mental health treatment including stigma, lack of transportation, parental participation (especially for parents residing within walking distance of neighborhood schools), as well as ongoing opportunities for the assessment of student progress.

A number of models for integrating mental health and education have been developed including:

❶ **School-supported mental health models:**

- Mental health professionals (e.g., social workers, guidance counselors, and psychologists) are employed directly by a school system
- Separate mental health units established within a school system
- School nurses function as a major portal of entry for students with mental health issues

❷ **Community connections models:**

- A mental health agency or professional delivers direct services in a school on a part-time or fulltime contractual basis

- Mental health professionals are available within a school-based health center (SBHC) or in after-school programs
- A formal linkage to an off-site mental health professional and/or managed care organization is established

❸ **Comprehensive, integrated models:**

- An integrated comprehensive mental health program focuses on prevention strategies, the school environment, screening, referral, special education, family and community issues and delivers direct mental health services
- SBHCs (school-based health centers) provide integrated, comprehensive health and mental health services within a school environment

Four primary methods for the selection of programs that target specific subsets of students are currently used:

❶ **Counselor or teacher referral:** This method requires orienting teachers and counselors to the kinds of problems a program addresses. However, this approach may overlook some students in need of services and supports because behavior problems are more readily noticed than withdrawal or anxiety. Brief one-on-one meetings with students to verify the appropriateness of a program selected are recommended.

❷ **Parental recommendation:** This approach requires describing a program to parents and asking them to designate their children or consent to an assessment. However, withdrawal or anxiety may not be noticed as readily as behavioral problems which can lead to the omission of some children in need of help. Brief one-on-one meetings the students to verify need and interest are recommended.

❸ **Targeted school-based screening:** Students who have been affected by a traumatic event can be assessed with a screening tool to determine the level of their potential need for a trauma-focused intervention program. Those with scores indicative of distress can be invited to participate. Parental consent for such assessment is usually required, and confidentiality of the screening results needs to be protected. It is recommended that assessments for referral take place at least a few (usually about three) months post-trauma, as the majority of students are likely to be distressed in the immediate aftermath, while many students' symptoms abate within this period without intervention.

❹ **General school-based screening:** All students in a school can be screened (with parental consent). This approach is potentially less stigmatizing and may reveal high rates of trauma exposure undetected by parents, teachers, and counselors. For example, some students may be affected by a natural disaster, while others may be affected by exposure to violence in the community, and some from both types of experiences. One-on-one meetings with each student whose assessment indicates high levels of distress is recommended in order to verify need (i.e., rule out false positives). More students may be detected who are in need with this approach rather than via school staff referral or parental recommendation.

COPING WITH CRISES

According to the National Center for Posttraumatic Stress Disorder early intervention to help children and adolescents who have suffered trauma due to violence or a disaster is critical. The Center recommends creating a safe haven for children and protecting them from further harm and additional exposure to traumatic stimuli, onlookers, and media. Children should be directed away from the site, severely injured survivors, and continuing danger. In addition, children who are in acute distress[5] should be identified and accompanied until initial stabilization occurs. A supportive and compassionate verbal or non-verbal reassuring exchange (e.g., a hug, if appropriate) should be used to help them feel safe. Adults are advised to give themselves time to come to terms with the event prior to offering reassurance to children.

The creation of a caring, warm, and trusting environment for students following a crisis is emphasized in the trauma literature. In addition, it is recommended that students be allowed to talk about what they felt and experienced during the traumatic event prior to returning to regular school routines. Younger children, who are unable to fully express their feelings verbally benefit from participating in creative activities (e.g., including drawing, painting, or writing stories). Young adolescents benefit from group discussions in which they are encouraged to talk about their feelings, as well as writing plays or stories about their experiences. It is recommended that older adolescents be engaged in group discussions and issues of guilt ("I could have taken some action to change the outcome of the crisis") be addressed.

The literature advises holding school sessions with entire classes, smaller groups of students, or individual students to let them know their fears and concerns are normal reactions and that they be given reassurance that the event was not their fault. Many school districts have teams that include mental health professionals which conduct such sessions subsequent to a traumatic event. It should be noted that forced discussion of a traumatic is contraindicated as it may cause re-traumatization. Thus, the preferences of children who do not wish to participate in class discussions should be respected.

Sensitivity to cultural differences among children is also advised as for example, in some cultures it is unacceptable to express negative emotions. Also, children who are reluctant to make eye contact may not be depressed, but rather exhibiting behavior appropriate to their cultures. It is recommended that meetings for parents be held to discuss the traumatic event, their children's responses, and ways they can be of assistance their children. Parental responses have been found to strongly influence their children's ability to recover, particularly mothers of young children; maternal depression or anxiety may require intervention to facilitate parental capacity to effectively help their offspring.

A phased-based approach for readiness and crisis management is recommended for school settings. The phases and activities of such an approach are depicted in the paragraphs that follow.

PREPARATORY PHASE:

This phase entails the establishment of crisis response services as well as a school and community recovery infrastructure comprised of different groups that work together for the recovery of the entire community and assists with the transition to intermediate and long-term services.

[5] Acute distress includes panic marked by trembling, agitation, rambling speech, becoming mute, or erratic behavior, and intense grief, the signs of which include loud crying, rage, or immobility.

IMMEDIATE SERVICES PHASE:

This phase focuses on re-establishing the socio-emotional stability of the school environment, encouraging students to return to school, providing a nurturing and supportive environment that emphasizes inclusiveness, and reaching out to students and staff who may feel isolated and alone. Active outreach services are considered critical. Psychological first aid can be offered as an intervention wherein fears and concerns are acknowledged and developing coping strategies are focused on. In addition, changes in the school environment (e.g., additional school resource officers, increased numbers of helping adults on campus, guarded gates, and limited entry) can help students and staff members feel safe and convey that safety and security are of primary concern. Support from the community may also be of benefit (e.g., special lunches provided by faith-based and community organizations, assembly addresses by city leadership or community heroes such as the first responders including law enforcement and emergency personnel, and visits by local sports figures).

Assessment at this stage consists of gathering information about student and staff exposure to trauma; eye witnessing death or injury or having close relationships with victims increases the risk for psychological effects and the need for mental health treatment. Consultation and support from the mental health system can help school and community leaders understand normal reactions that can be expected. Organizing services in the immediate services phase also involves planning for intermediate and long-term services.

In the immediate aftermath of a traumatic event (and ensuing weeks) it is important to identify children and adolescents in need of more intensive support and therapy. A triage method of risk screening and exposure can facilitate the identification of individuals at risk for psychological difficulties taking into account factors including:

- Direct exposure (victims/witnesses/perpetrators/suspects)
- On-site (students, faculty, staff, parents)
- Off-campus (students/staff absent on day of incident)
- Out-of-vicinity (e.g., friends at other nearby schools)
- Familiarity with victims
- Previous trauma or loss, especially during the past year
- Worry about safety of family member or significant other
- Family response and difficulties
- Individual psychopathology (history of previous problems or exposure to violence)
- Acute stress reactions (anxiety. fear, panic)
- Dissociative symptoms (detachment, derealization, depersonalization)
- Uncontrollable intense grief
- Marked sleep difficulties or loss of appetite
- Extreme cognitive impairment (confusion, difficulties with concentration and decision-making, marked intrusive thoughts)
- Distinct somatic complaints

INTERMEDIATE SERVICES PHASE:

Psychological trauma and stress subside subsequent to most incidents of mass trauma during the ensuing six to eight weeks. Clinical screening at the beginning of the intermediate services phase can be used to assess the recovery needs of students and staff. Ongoing attention to stress levels after the disaster has passed is recommended to determine ongoing needs. Key protective factors that mitigate trauma subsequent to the occurrence of critical incidents that can be instituted include:

- Setting and communicating high expectations
- Providing opportunities for meaningful participation
- Increasing prosocial bonding
- Setting clear, consistent boundaries
- Teaching life skills
- Providing care and support

It is recommended that outreach for the provision of services and supports focus on areas of communities where individuals and families who are at risk for difficulties are likely to live and congregate such as faith-based organizations, physician's offices, heath and mental health clinics, police and fire stations (as well as schools).

LONG-TERM SERVICES PHASE:

This phase consists of the provision of school and community-based mental health services for individuals who continue to experience trauma-related symptoms after the immediate services period. The provision of information as well as tangible and emotional supports has been found to be significant for the recovery of victims/survivors. Teachers, administrators, family, clergy, and other community supports can offer significant protection from adversity. However, these same protective resources can be victims of disaster and violence and sometimes suffer from the same ill effects and thus may require coping assistance.

During the intermediate and long-term phases of recovery schools are advised to maintain routines and social activities because these keep students, teachers, and parents informed about the needs of the school, provide natural places where experiences can be shared, and preserve the sense of belonging and unity needed in the aftermath of school-related trauma. The involvement of law enforcement, emergency service personnel, faith-based organizations, community service organizations, and others during the long-term phase of recovery can help to enhance levels of safety and well-being. In addition, student advisory groups can help to identify and discuss school problems with help from community groups through mentoring.

CRISIS PREPARATION AND COPING				
	Preparatory	Immediate	Intermediate	Long-Term
Time Frame	Prior to occurrence	From date of occurrence until 60 days afterward	From 61st through 1st year anniversary	After 1st year anniversary
Infrastructure	Establish school crisis response and recovery teams and protocols; establish and/or maintain partnerships in community	Establish and maintain three working groups	Continue community and provider working groups	Groups gradually phase into community relationships
Assessment	Assess current mental health needs and develop appropriate capacity to meet those needs; address range of mental health needs into the school's safety plan	Triage, with focus on at-risk groups	Provide screening, outreach services and follow-up of students at high risk for PTSD, depression and anxiety disorders	Re-assessment, with focus on delayed reactions and continued outreach to students who continue to be symptomatic, with special attention to anniversary and other emotionally significant events
Focus of Services	Range of intervention services from public mental health education to prevention, early intervention and tertiary services	Provide a sense of support and emotional safety; utilize a public health approach	Support recovery; focus on building strengths, assets and coping skills; provide treatment without stigma for those with ongoing needs	Return to normalcy; continued support, assistance and treatment for those with ongoing needs *(Adapted from Wong, et al.)*

It should be noted that there is some indication that long-term services (beyond the first anniversary of an event) on school campuses can function as traumatic reminders of an event thereby prolonging and/or rekindling distress during resumption of classes. This suggests that long-term mental health services for students, staff, and family members should be provided in community settings away from the school. On the other hand, however, many people may find it difficult to access off-campus support services.

PSYCHOLOGICAL FIRST AID (PFA)

Psychological First Aid is an evidence-informed approach to decreasing initial distress and foster adaptive coping of children, adolescents, and adults during the immediate aftermath of a disaster or terrorism event that can be delivered in a variety of settings. PFA includes providing basic necessities, optimizing parental adjustment, providing social support and reassurance, and giving age-appropriate information. It is comprised of the following components:

- **Contact and engagement** by responding to contacts initiated by individuals who have been affected by a traumatic event, or initiating contacts in a non-intrusive, compassionate, and helpful manner.
- **Safety and comfort** to enhance immediate and ongoing safety, and provide physical and emotional comfort. This includes meeting basic physical needs (e.g., physical protection, establishing a sense of security, providing physical necessities) as well as psychological needs (e.g., consolation, emotional and behavioral support, ventilation, and fostering constructive behavior).
- **Stabilization** to calm and orient survivors who are emotionally overwhelmed or distraught.
- **Information gathering regarding current needs and concerns** in order to identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions each person's needs.
- **Practical assistance** to offer practical help to the survivor in addressing immediate needs and concerns.
- **Connection with social supports** to foster brief or ongoing contacts with primary support persons (e.g., reuniting victims with friends or family or other sources of support, including family members, and friends) and utilization of community resources.
- **Information on coping** and stress reactions to reduce distress and promote adaptive functioning.
- **Linkage with collaborative services** entails informing survivors about available services and facilitating ongoing care (e.g., triage and referral for individuals in acute need and referrals to subacute and ongoing supports).

Studies have found that early, brief and focused intervention can reduce the social and emotional distress of children and adults after traumatic events. The National Center for PTSD offers a Psychological First Aid manual that can be downloaded free of charge from http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/PFA_2ndEditionwithappendices.pdf.

Psychological First Aid for Students and Teachers: Listen, Protect, Connect—Model & Teach (LPC—Model & Teach) is a five-step crisis response strategy designed to reduce the initial distress of students or adults and to help students return to school, remain in school and resume learning. A manual for implementing this evidence-informed model designed specifically for students and teachers can be downloaded from http://www.ready.gov/kids/_downloads/PFA_SchoolCrisis.pdf.

Group Crisis Intervention is a school-based psychological first aid intervention that is designed to help students cope during the aftermath of a crisis. GCI is offered to homogeneous groups of students (i.e., class membership) and entails guided group discussions in a supportive environment. GCI includes an introduction and sessions on providing facts, dispelling rumors, sharing stories, sharing reactions, providing empowerment, and offering a closing. Students with severe reactions to the crisis should receive more intensive interventions.

CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

Critical Incident Stress Management (CISM) is a comprehensive crisis intervention system that consists of multiple crisis intervention components spanning the entire temporal spectrum of a crisis from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. It is designed to assist individuals who have been affected by traumatic events cope with stress effectively. CISM is not meant to replace psychotherapy or impede the natural recovery of human resiliency. Rather, it focuses on the facilitation of a triage process for persons without psychiatric disorders and organizations experiencing a critical incident to enable them to return to previous levels of functioning. CISM includes pre-incident training and post-incident services that can be applied to individuals, large or small groups, families, organizations, and entire communities. The literature on CISM clearly states that none of the CISM components are meant to be administered as a solitary means of addressing critical incidents stress.

CORE COMPONENTS OF CISM				
Intervention	Timing	Activation	Goals	Format
1. Pre-crisis preparation	Pre-crisis phase	Anticipation of crisis	Set expectations. Improve coping and stress management	Group Organization
2. Demobilization & Staff Consultation (rescuers); Group Info, briefing for civilians, schools, businesses	Post-crisis or shift disengagement	Event driven	To inform, consult. Allow psychological decompression and stress management	Large Group Organization
3.Defusing	Post-crisis.(within 12 hrs)	Usually symptom driven	Symptom mitigation Possible closure Triage	Small group
4. Critical Incident Stress Debriefing (CISD)	Post-crisis. (1 to 7 days)	Usually symptom driven Can be event driven	Facilitate psychological closure Mitigation Triage	Small group
5. Individual crisis intervention (1:1)	Any time. Anywhere	Symptom driven	Symptom mitigation. Return to function, if possible Referral, if needed	Individual
6. Family CISM; Org. consultation	Any time	Either symptom driven or event driven	Foster support, communications. Symptom mitigation Closure, if possible. Referral, if needed	Organizations
7. Follow-up; Referral	Any time	Usually symptom driven	Assess mental status Access higher level of care	Individual Family

(*Everly and Mitchell*)

CISM helps participants relive traumatic events in a safe environment, begin to identify intense emotional reactions, provides education about stress management, identifies individuals who

may be at-risk and in need of additional support, and offers support to reduce the effects of a stressful event.

❶ Pre-crisis preparation includes stress management education, stress resistance, and crisis mitigation training for both individuals and organizations.
❷ Disaster or large-scale incident as well as, school and community support programs including demobilizations, informational briefings, town meetings and staff advisement.
❸ Defusing is a three-phase, structured small group discussion provided within hours of a crisis for assessment, triage, and acute symptom mitigation.
❹ **Critical Incident Stress Debriefing (CISD)** refers to the Mitchell Model seven-phase, structured group discussion, usually provided one to ten days post crisis, and is designed to mitigate acute symptoms, assess the need for follow-up, and, if possible, provide a sense of post-crisis psychological closure:

1. **Introduction:** consists of discussion of confidentiality, right to withdraw, establishment of boundaries and ground rules.
2. **Fact Phase:** consists of elucidation of known facts about the incident and participants' roles or involvement, control of rumors and discussion individual experiences.
3. **Thought Phase:** consists of helping participants reflect upon immediate thoughts as they experienced or learned about the critical incident.
4. **Reaction Phase:** consists of having participants identifying personally most traumatic aspect of the event, permitting voluntary discussion of emotions, and providing validation and support.
5. **Symptom Phase:** consists of returning participants to cognitive processing of event, identifying possible symptoms, and sharing symptoms and reactions.
6. **Teaching Phase:** consists of relating symptoms to reactions, normalizing reactions to the traumatic event, emphasizing that symptoms should gradually abate and that exposure via thought and feeling (in a safe environment) will facilitate the process, eliciting examples of coping and positive reactions to event (e.g., "Is there anything positive that you think has come of this?").
7. **Closure/Re-Entry:** consists of a final opportunity to summarize the event and review predominant reactions, clarify issues, answer questions, invite participants to articulate what they intend to do to cope, and identify supports (peer, family, community).

❺ One-on-one crisis intervention/counseling or psychological support throughout the full range of the crisis spectrum.
❻ Family crisis intervention and organizational consultation.
❼ Follow-up and referral mechanisms for assessment and treatment, if necessary.

A review of the literature on CISM reveals disparate findings. CISM programs have been empirically validated through qualitative analyses, controlled investigations, and meta-analyses. However, while some studies indicate that CISM has no effect on preventing psychiatric sequelae following a traumatic event, particularly post-traumatic stress disorder, several meta-analyses and RCTs indicate that CISM is ineffective in preventing PTSD. But, some studies report possible paradoxical worsening of stress-related symptoms indicative of possible iatrogenic effects. Some researchers suggest that the use of CISM be curtailed or be employed only with extreme caution and that it should never be a mandated intervention.

ACUTE TRAUMATIC STRESS MANAGEMENT (ATSM)

Acute traumatic stress management for educators is a school-based intervention that offers a road map for educators to use in dealing with the psychological consequences of a traumatic event. It is designed is to stimulate adaptive coping mechanisms and stabilize more severe reactions among students. It is comprised of ten stages:

1. Assessment of danger/safety for self and others
2. Consideration of the physical and perceptual impact of the event on the person
3. Evaluate the person's level of responsiveness (i.e., level of alertness and responsiveness)
4. Address the person's acute medical needs
5. Observation and identification of individuals evidencing signs of traumatic stress
6. Establishment of a connection with the individual (i.e., develop rapport and move the individual away from the stressor subsequent to medical evaluation)
7. Grounding (i.e., discuss the facts, assure safety, allow the person to tell their story, and discuss behavioral and physiological responses)
8. Provision of support conveying a desire to understand the person's feelings in an empathic manner)
9. Normalization of the response (i.e., offer validation and education regarding normal persons' attempts to cope with an abnormal event)
10. Preparation for the future (i.e., review the event, bring the person to the present, describe events in the future, and provide referrals.

SCHOOL-BASED INTERVENTIONS

It is recommended that mental health services be available to students, staff, and families after a school-related traumatic event. However, the literature notes that teachers, while serving a crucial front line role, should not be required to provide mental health treatment. Rather, community agencies should work in partnership with school administrators and staff to make mental health services be available for those in need through all phases of recovery.

Mental health services have been found to be more effective when provided in a location on school campuses rather than via referral to offsite community agencies[6]. A number of programs have been developed to help children and adolescents deal with traumatic events, many of which were designed specifically for use in schools. Most are designed to decrease emotional and behavioral problems associated with trauma exposure and foster resilience. Although many of the programs have not yet been evaluated, several have been shown to yield positive results, and many draw on evidence-based techniques. Some of the interventions target the entire school population, while others use a screening or referral process to identify students who might benefit from treatment. All typically require some level of parental consent and student consent for participation.

It has been noted in the literature that information regarding evidence-based trauma-informed interventions has not been well disseminated to schools. Considerable resources and staffing are required for distributing informational materials to parents, obtaining permission to screen children and/or implement a program, and communicating with parents throughout the program. Moreover, successful implementation of such programs hinges on access to program developers and others with expertise in implementing them.

[6] A lack of available personnel who are adequately trained in trauma-specific mental health services, both in schools and community agencies, have been cited as access barriers,

COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS (CBITS)

Cognitive Behavioral Intervention for Trauma in Schools is a cognitive-behavioral therapy group intervention that is designed to decrease symptoms of posttraumatic stress disorder (PTSD) and depression caused by exposure to violence in children aged ten to fourteen who have experienced substantial exposure to violence. CBITS also seeks to build resilience by improving the ability to handle future stressors and trauma as well as increase peer and parent support. This SAMHSA promising program has been implemented in inner-city schools and other settings with multicultural populations and as been found effective in school settings for children exposed to community violence and disasters.

CBITS consists of ten once weekly group sessions with five to eight students per group, one to three individual sessions with each child, two parent sessions, and one teacher session to address symptoms of PTSD, anxiety, and depression. Intervention includes cognitive-behavioral techniques (e.g., decreasing maladaptive thinking and relaxation training) as well as trauma-focused processing work using imagination, writing, and narratives. During each session, a new set of skills to is taught using didactic presentation, age-appropriate examples, and games. The skills are then used by participants to address their problems via homework assignments collaboratively developed by each child and the clinician. The content of each session is as follows:

Session 1:	Introduction of group members, confidentiality, and group procedures; explanation of treatment using stories; discussion of reasons for participation (kinds of stress or trauma)
Session 2:	Education about common reactions to stress or trauma; relaxation training to combat anxiety
Individual Session:	Between sessions 2 and 6
Session 3:	Thoughts and feelings (introduction to cognitive therapy); “fear thermometer”; linkage between thoughts and feelings; combating negative thoughts
Session 4:	Combating negative thoughts
Session 5:	Avoidance and coping (introduction to real life exposure); construction of fear hierarchy; alternative coping strategies
Sessions 6 and 7:	Exposure to stress or trauma memory through imagination, drawing, and/ or writing
Session 8:	Introduction to social problem solving
Session 9:	Practice with social problem solving and hot seat
Session 10:	Relapse prevention and graduation ceremony

Evaluations of CBITS indicate significant reductions in symptoms of PTSD, depression, and increased ability to cope with the effects of violence with post intervention maintenance of treatment gains in children and their parents. A manual which details step-by-step plans and provides scripts for implementing the program is available free of charge. Training, consultation, fidelity monitoring, and ongoing supervision of trainees and also available. Information on CBITS can be found at http://www.rand.org.

MULTIMODALITY TRAUMA TREATMENT (MMTT)

MMTT is a skills oriented, cognitive-behavioral treatment for children aged nine to eighteen (in grades four through high school) who have been exposed to single incident traumatic stressors (e.g., disaster, violence, murder, suicide, fire, and accidents). It targets posttraumatic stress disorder and attendant symptoms of depression, anxiety, anger, and external locus of control. MMTT was designed as a peer mediating group intervention for use in urban and rural schools

and been shown to be readily adaptable for group or individual modalities in mental health treatment settings.

The program consists of fourteen group sessions of six to eight participants per group delivered during one class period per week. An individual pullout session is conducted mid-protocol to introduce narrative exposure in a controlled manner. An individual assessment session is also conducted prior to group work to allow for any needed treatment adjustments to optimize the balance between individual and group trauma processing.

MMT is comprised of the following sessions/components:

Session 1:	Psychoeducation
Session 2:	Anxiety Management
Session 3:	Anxiety Management and Cognitive Training (Thinking, Feeling, Doing and Stress Thermometer)
Session 4:	Cognitive Training (Traumatic Reminders)
Session 5a:	Anger Coping
Session 5b:	Grief Management
Session 6:	Individual Pull-out Session (Narrative Exposure)
Session 7:	Setting up the Stimulus Hierarchy (group)
Session 8:	Group Narrative Exposure
Session 9:	Group Narrative Exposure (Cognitive and Affective Processing)
Session 10:	Group Narrative Exposure (Worst Moment)
Session 11:	Worst Moment Cognitive and Affective Processing
Session 12-13:	Relapse Prevention and Generalization
Session 14:	Graduation Ceremony

Outcome studies have shown that MMTT leads to reductions in PTSD, depression, anxiety, and anger in elementary, middle, and high school students. Materials on MMTT are available in English and French. Manuals, which are available at no charge, and information on training can found at www.ccfh.nc.org or can be obtained by contacting Ernestine Briggs-King, PhD, Director, Trauma Evaluation and Treatment Center for Child and Family Health, NC, at brigg014@mc.duke.edu or Robert Murphy, PhD, Executive Director, Center for Child and Family Health at NCRobert.Murphy@duke.edu.

SCHOOL INTERVENTION PROJECT (SIP) OF THE SOUTHWEST MICHIGAN CHILDREN'S TRAUMA ASSESSMENT CENTER (CTAC)

SIP is a manualized inclusive classroom-based program that focuses on establishing and maintaining safety, improving relational engagement, and building self-regulation skills that addresses the needs of children who have experienced trauma as well as those without known histories of trauma. The program is provided throughout the school year by teachers.

SIP is currently being implemented in Head Start, elementary, and middle schools and can be modified for high schools and other alternative school settings. It has been implemented in the Kalamazoo, Michigan Public Schools. Qualitative data, gathered through reflective writing and exit interviews, has revealed positive reports of decreased behavioral problems and increased student problem-solving throughout school settings. Limited quantitative data is also being analyzed. The program has been found to be effective for Caucasian, African American, and students from other minority groups.

Training for teachers consists of a two-day workshop that focuses on complex trauma and neurodevelopmental considerations, review of SIP materials, activities that address common classroom behavior, and strategies for prevention and intervention. Information on the program

can be obtained from Mary Blashill at BlashillM@certauth.cc.wmich.edu or Jim Henry at james.henry@wmich.edu of the Southwest Michigan Children's Trauma Assessment Center, University of Western Michigan (http://www.wmich.edu/hhs/unifiedclinics/ctac/).

BETTER TODAYS, BETTER TOMORROWS FOR CHILDREN'S MENTAL HEALTH (B2T2)

B2T2 is an education program for school faculty, staff and volunteers and various community groups (e.g., faith-based organizations, public safety and scouting groups) There is also a parent module. The program provides a general overview of the signs and symptoms of trauma/traumatic stress, mental illnesses, suicidality in youth, and barriers to treatment. It aims to raise awareness, encourage early intervention and treatment, and reduce stigma.

Participants indicate that the program improves their knowledge of how to seek treatment and reduces the stigma of traumatic symptoms and mental illnesses. Participation has been found to lead to referrals of children for mental health treatment. The model is recognized as a promising practice by the National Child Traumatic Stress Network and is currently under review by several other organizations as an evidence-based practice.

B2T2 consists of a one day, interactive training session conducted by staff of the Institute for Rural Health at Idaho State University. Interactive instruction through videoconference and a telehealth component on supplemental topics including suicide and depression in school-aged children are also available. Training materials are available on-line. Information on the program and training materials are available from www.isu.edu/irh/bettertodays and Ann Kirkwood (kirkann@isu.edu) at the Institute for Rural Health at Idaho State University.

UCLA TRAUMA/GRIEF PROGRAM

The UCLA Trauma/Grief Program is a promising intervention designed to alleviate anxiety, depression, somatic complaints, complicated grief, posttraumatic stress disorder, and risk-taking, aggressive, and antisocial behaviors of youth aged eleven to eighteen who have experienced moderate to severe trauma from events such as bereavement, accidents, community violence, natural and man-made disasters, war, and terrorist events. It consists of ten to twenty four individual, group, parent, and family sessions delivered in schools or clinical settings.

The program uses cognitive behavior therapy (i.e., narrative reconstruction, psychoeducation, cognitive restructuring, developing coping skills and managing activity) to facilitate intermediate or long-term recovery. It is implemented least one to two months subsequent to the occurrence of a traumatic event and incorporates a two-step screening protocol administered in classrooms or to individual students.

The UCLA Trauma/Grief Program has been implemented in primary and secondary schools in various states and countries, school districts in communities with high levels of community violence, schools in New York City following the events of September 11, 2001, and secondary schools in post-war Bosnia. A randomized controlled study was conducted in the latter site which demonstrated significant reductions in PTSD and depression as well as improvements in academic performance and classroom behaviors

Training consists of a two-day workshop followed by ongoing supervision and consultation. Screening measures, an interview protocol, a manual, and a workbook for the program are available. Information can be obtained from Bill Saltzman of the UCLA Trauma Psychiatry Program at wsaltzman@sbcglobal.net.

UCLA POST-HURRICANE RECOVERY INTERVENTION

The UCLA Trauma/Grief Program has been adapted into the Post-Hurricane Recovery Intervention which is designed to relieve specific post-traumatic stress symptoms, generalized and separation anxiety, depression, inappropriate coping responses, and family conflict or lack of support related to the trauma in youth aged eight to eighteen who have experienced hurricane-related trauma including personal injury, a threat to one's life, witnessing of injury or destruction, or having a loved one threatened or injured, as well as relocation, loss of contact with friends, and family hardships. It focuses on increasing emotional awareness, emotion expression, and skills enhancement (e.g., communication, coping, and problem-solving). The program is intended for intermediate or long-term recovery and thus is used subsequent to the passage of at least one to two months subsequent to the occurrence of a traumatic event.

The Post-Hurricane Recovery Intervention consists of ten individual, fifty-minute sessions held once a week, and up to three optional joint parent-child sessions that can be adapted for group settings. It is delivered in school or clinical settings. It uses a two-step screening protocol administered in classrooms or to individual students.

Due to the recent introduction of this intervention, it has yet to be evaluated. Training consists of an initial two-day workshop followed by ongoing supervision and consultation. Screening materials, a manual, and handouts for the Intervention are available. Information can be obtained from Bill Saltzman (wsaltzman@sbcglobal.net) of the UCLA Trauma Psychiatry Program.

PEACEZONE (PZ)

PeaceZone is a manualized classroom-based social cognitive therapy program that is designed to increase the ability of elementary school students (in kindergarten through fifth grade) aged four to eleven to make positive decisions, avoid risk-taking behavior, and recover from trauma and loss. PZ also seeks to assist adults in reinforcing the program's core concepts with children at home and in school. The program integrates social skill building and conflict resolution as well as recovery from trauma, grief and loss and emphasizes self-control, self-respect, problem solving, and cooperation. It incorporates psychomotor expressive activities (e.g., visual arts, music, and dance) and community service. Students identified as in need of additional, individual support services are referred to counselors and other mental health staff.

PZ consists of six classroom units, each of which contains four classroom sessions that are approximately thirty minutes in length, for a total of twenty four sessions. It is designed to be delivered in traditional elementary-school classroom settings of approximately twenty five students. The entire program can be presented in six weeks, but should be continued and reinforced throughout the school year with supplemental booster activities. The six units cover the following themes: the Louis D. Brown Story, Pledge for Peace, Trying your best, Self-Control, Thinking and Problem Solving, and Cooperation. The last lesson of each unit links the topic to a community service activity that capitalizes on the healing through helping strategy. In addition, there is a School Climate Change Module. It is recommended that lead teachers at each grade level and a half-time school counselor support both classroom and school-wide activities and that the school community commits to the use of the common PZ language.

PeaceZone was created in 1998 by the Harvard Youth Violence Prevention Center, the Lesson One Company, and the Louis D. Brown Peace Institute and implemented in four Boston public elementary schools with Hispanic/Latino, African American, Caucasian, and Asian students. An evaluation conducted in 2004 by the Harvard School of Public Health showed reductions in self-reported victimization and self-reported mild to severe depression. In addition, data indicate that

the PZ is particularly helpful for children who have experienced losses from divorce, death, or exposure to violence.

Training consists of one day-long seminar for teachers and administrators that provides information about grief and loss, potential behavioral manifestations of symptoms of grief and trauma, and the potential impact on academic achievement of grief and trauma. Program materials include a teacher's manual and a student's manual for kindergarten and first grade, second and third grades and forth and fifth grades which are available from Research Press Publishers at rp@researchpress.com. Information on PZ can be obtained from Dr. Deborah Prothrow-Stith at dphpdesk@hsph.harvard.edu of the Harvard School of Public Health in Boston.

STRUCTURED PSYCHOTHERAPY FOR ADOLESCENTS RESPONDING TO CHRONIC STRESS (SPARCS)

SPARCS is a sixteen or twenty two-session one-hour group intervention of six to twelve months duration that is designed to address the needs of adolescents experiencing chronic trauma/stressors and problems in several areas of functioning (e.g., difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, struggles with a sense of purpose and meaning in life, and worldviews that make it difficult to envision a future). The program seeks to help teens cope more effectively in the present, enhance self-efficacy, connect with others, establish supportive relationships, cultivate awareness, and create meaning.

This promising practice can be conducted in a variety of settings including schools, outpatient clinics, group homes, boarding schools, residential treatment centers and facilities, and foster care programs. Sessions can be divided into two segments and conducted twice per week to accommodate class periods in school settings. It is recommended that SPARCS be implemented in settings where adolescents can remain in treatment long enough to complete the intervention.

SPARCS is predominantly cognitive-behavioral and draws upon Dialectical Behavior Therapy TARGET, and the UCLA Trauma/Grief Program. It is not an exposure based model, but traumas are discussed in the context of the manner in which they relate to current behavior and participants' understanding of their problems and difficulties in the present. Routine discussion and processing of personal experiences occur throughout group sessions. It is comprised of the following key components:

- Mindfulness
- Problem-Solving
- Meaning-Making
- Relationship building/Communication Skills
- Distress Tolerance
- Psychoeducation regarding stress and trauma

SPARCS has been found to be effective for ethnically diverse groups, including African Americans, Hispanics/Latinos, Native Americans, and refugees/immigrants in urban, suburban, and rural settings. It has also been found to be of benefit to adolescents who have been traumatized and pregnant and/or parents of young children. Outcome studies indicate that participation leads to reductions in physical confrontations between students in school including students who are members of gangs. In addition, reductions in PTSD symptoms, (e.g., re-experiencing, avoidance, and hyperarousal), conduct problems (e.g., difficulties with attention and hyperactivity), improvements in interpersonal coping, and increases in support seeking

behaviors have been found. Generalization of skills has been observed with participants applying affect regulation and communication skills to real-life situations. The Illinois Department of Children and Family Services found that adolescents in foster care receiving SPARCS were half as likely to run away, and one-fourth less likely to experience placement interruptions (due to arrests, hospitalizations, running away, etc.). While improvements in overall functioning have been found for both the sixteen and twenty two session versions, beneficial outcomes from the latter version have been more profound.

The developers of SPARCS have established a learning collaborative approach to implementing and promoting sustainability of the program. During the Pre-Training Phase, SPARCS trainers partner with agencies to identify available resources to support a new practice and consider potential challenges in order to facilitate successful implementation. During this phase clinicians, supervisors, and administrators develop in-house SPARCS teams, complete the SPARCS Planning Worksheet as a team, and discuss their findings during conference calls with trainers. Training sessions typically include two or three separate interactive learning sessions that may include clinicians from multiple sites to promote mutual learning. The first training session consists of a two-day session attended by at least one clinician and one administrator from a site and includes didactic presentations, demonstrations, role-plays, and mindfulness practice. Multi-site consultation calls with group leaders, supervisors, and administrators occur throughout the duration of the implementation phase. The second training session is held for one day four to six weeks after the start of a group. Training and implementation materials include a training/clinician guide and color activity handouts for group members. Information can be obtained from Victor Labruna, Ph.D. at vlabruna@nshs.edu or Mandy Habib, Psy.D. at mhabib@nshs.edu.

OVERSHADOWING THE THREAT OF TERRORISM (OTT)

OTT is a school-based psychoeducational intervention that is designed to prevent and decrease symptoms of posttraumatic stress, somatic complaints, functional impairment, and separation and generalized anxiety in children in the third to the tenth grades. A version for first and second graders is also available. The program focuses on helping children who have experienced the threat of or exposure to a traumatic stressor (e.g., terrorism, war, natural disaster, or a large scale accident) cope.

The program consists of eight weekly ninety-minute classroom sessions with about twenty children per group. All sessions include homework review, warm-up exercises relating to the session theme, exploration of feelings, psychoeducational materials, practical coping skills training, and a closure exercise followed by a new homework assignment. It can be provided through local public schools by teachers who are acquainted with the pupils and parents.

OTT has been used and evaluated in Israel and Palestine where participants displayed significant reductions in symptoms of PTSD, somatic complaints, and generalized and separation anxiety symptoms two months after the intervention. It has also been evaluated in two unpublished studies that demonstrated benefits for seventh though eighth grade students exposed to ongoing missile attacks and students in the second through sixth grades in the aftermath of one of the worst bus accidents in Israel.

Teachers undergo twenty to thirty two hours of training and receive three to five hours of supervision which is provided via the Internet. A teacher's manual and a student's manual are available. Information can be obtained from Rony Berger of the NATAL, Israel Trauma Center for the Victims of Trauma and War in Tel Aviv at riberger@netvision.net.il,

ENHANCING RESILIENCY AMONG STUDENTS EXPERIENCING STRESS (ERASE-S)

ERASE-S is a school-based psychoeducational intervention that is designed to prevent and decrease symptoms of posttraumatic stress, somatic complaints, functional impairment, separation and generalized anxiety in children in the third to the tenth grades. It is designed for addressing daily stressors and includes resiliency strategies (e.g., building self-esteem and dealing with communication and assertiveness). It is comprised of ten forty five-minute sessions. ERASE-S targets children who have exposed to stressful or traumatic conditions.

The program consists of twelve weekly ninety-minute classroom sessions with about twenty children per group. All sessions include homework review, warm-up exercises relating to the session theme, exploration of feelings, psychoeducational material, practical coping skills training, and a closure exercise followed by a new homework assignment. ERASE-S can be provided through local public schools by teachers who are acquainted with the students and their parents.

ERASE-S has been evaluated among seventh and eight grade Israeli and Palestinian students and is currently being applied in Sri Lanka with students in grades three to twelve, and Turkey with students in grades three to six. The training program for ERASE-S has been shown to improve perceived levels of professional self-efficacy, sense of self-mastery, and produce a more optimistic outlook regarding personal future among Sri Lankan aid volunteers after the 2004 tsunami.

Teachers undergo twenty to thirty two hours of training and receive three to five hours of supervision which can be provided via the Internet. A teacher's manual, psychoeducational booklet and student handouts for the program are available. Information can be obtained from Rony Berger of the NATAL, Israel Trauma Center for the Victims of Trauma and War in Tel Aviv at riberger@netvision.net.il.

RESILIENCY AND SKILLS BUILDING WORKSHOP SERIES

The Resiliency and Skills Building Workshop Series is a cognitive-behavioral classroom-based intervention that is designed to reduce acting out behaviors, enhance and develop anger management and stress reduction skills, and increase levels of resiliency among high school students experiencing low to moderate levels of psychological distress subsequent to the experience of a traumatic event. This program also aims to inform students of the mental health services available at their school and introduce them to therapists. It is not intended as a substitute for treatment of moderate to severe psychological symptoms.

The program consists five thirty five-minute sessions integrated into health class curricula and administered for five consecutive days in a classroom setting with twenty five to thirty five students. It is recommended that a team of two mental health professionals deliver these sessions. A curriculum for middle school aged children that consists of eight sessions held biweekly is under development.

The workshops have undergone two years of evaluation using data on Hispanic/Latino, African American, Asian, American Indian/Alaskan Native and biracial students. Outcome data indicate that participants display reductions in anxiety levels and suspension rates.

Available materials include a manual on resilience and skill building and one on managing anger and increasing interpersonal skills, as well as an accompanying packet of supplemental materials (homework, handouts, and checklists). Information can be obtained from www.aboutourkids.org.

CLASSROOM BASED INTERVENTION (CBI)

CBI is a promising, manualized, psychosocial, classroom-based, integration and recovery program for children, adolescents, and their adult caregivers who have been exposed to psychological trauma. CBI is designed to decrease potentially harmful traumatic stress reactions (e.g., fear and depression) and increase children's ability to solve problems, maintain prosocial attitudes, and sustain self-esteem and hope for the future.

The program is a five-week fifteen-session classroom, community, or camp based group intervention that consists of a series of highly structured expressive-behavioral activities designed to alleviate traumatic stress reactions (e.g., anxiety, fear, and depression) by allowing and guiding children in play, learning, and creative problem solving. CBI focuses on immediate short-term reduction of traumatic stress reactions as well as longer-term preventive effects (e.g., increasing children's ability to problem solve, engage in social perspective taking, sustain enhanced self-esteem, and positive self and social concepts).

CBI identifies existing coping resources of children and youth facing difficult circumstances, and works to sustain the utilization of those resources for psychosocial recovery over time. It integrates cognitive-behavioral therapy (CBT) techniques with cooperative play and creative-expressive exercises (e.g., drama, dance, and music) within a structured phased program:

Week 1, Sessions 1 − 3:	Focuses on information, safety, and control (including psychoeducation)
Week 2, Sessions 4 − 6:	Focuses on stabilization, awareness, and self-esteem
Weeks 3 & 4, Sessions 7 − 12:	Focuses on the trauma narrative, non-forced sharing of trauma stories through art and drama games.
Week 5, Sessions 13 − 15:	Focuses on reconnecting the child and group to their social context using resiliency-based themes and activities

CBI has been widely utilized nationally and internationally and appears to be especially effective for younger children aged six through twelve. Participants have been found to display reductions in emotional and behavioral symptoms (e.g., hyperactivity, emotional arousal symptoms, and disruptive behaviors), increases in prosocial behavior (e.g., taking other people's feelings into consideration, helping others, and caring for others), and improvements in reactions to positive or negative events (e.g., strengthening a belief in personal responsibility and sense of control in positive events and lessening the tendency for self-blame for negative events), as well as increasing hope and the belief in capabilities for goal achievement. CBI appears to be specifically effective in assisting female adolescents in strengthening their relations and communication with parents, siblings, and relatives, maintaining negotiation skills with their peers, developing social support, increasing self-reliance and optimism, increasing their use of relaxation strategies as a coping mechanism, and positive self-esteem and satisfaction with self. However, the impact has been found to be much greater on the boys than on the girls.

Information regarding CBI can be obtained the Center for Trauma Psychology (CTP) in Boston at http://www.traumacenter.org/.

PSYCHOSOCIAL STRUCTURED ACTIVITY (PSSA)

PSSA is a short-term (nine session) classroom-based resiliency building intervention based on Classroom Based Intervention (CBI) that is designed help children aged five though eighteen who have experienced a crisis cope through a series of structured play therapy activities. It aims to normalize students' reactions to fearful events, rebuild self-esteem, address reactions, and foster planning for the future, identification of resources and coping mechanisms, and utilization

of available resources. Children who are identified through the sessions as distressed and in need of additional support are referred for mental health services.

PSSA is administered in conjunction with a one-day workshop, called Journey of Hope, for faculty and parents to help them to process recent events, cope with current challenges, and address their own needs for self-care during times of stress. The program consists of nine sixty-minute sessions held three times a week for three weeks in classroom or summer camp settings with no more than twenty students. Each session is comprised of four components:

1. A beginning circle
2. A central, interactive activity such as storytelling, dancing, music, drama, or drawing
3. A cooperative game
4. An ending circle in which the lesson of the session is reinforced

Two leaders are required to conduct the program. Training consists of a three-day workshop for professionals who have clinical expertise and experience working with children (e.g., counselors, social workers, and psychologists). Program materials include a teacher's manual and an activity kit, CD player, music, toys and art supplies, a twelve foot silk parachute, and informational packets with tip sheets for parents, teachers, administrators, and teens, as well as cooperative games useful for summer camps and schools that are unable to implement a more structured psychosocial program. Information can be obtained from www.savethechildren.org.

THE JOURNEY TO RESILIENCY (JTR): COPING WITH ONGOING STRESS

JTR is a school-based psychoeducational group intervention designed to alleviate the symptoms of posttraumatic stress (e.g., re-experiencing, avoidance, numbing, hyper-arousal symptoms, somatic complaints, functional impairment, and generalized anxiety) and improve the coping skills of adolescents in grades six through twelve who have experienced the threat of or exposure to traumatic stressors (e.g., terrorism, war, and natural disasters). Children are selected for participation with several screening instruments administered by a psychologist; a PTSD diagnosis s not required for participation.

The program consists of six two-hour group sessions of six to ten children per group conducted by school counselors within school settings. All sessions include homework review, warm-up exercises relating to the session's theme, exploration of feelings, psychoeducational material, practical coping skills training, and a closure exercise followed by a new homework assignment. Each session focuses on specific issues of exposure, dealing with triggers, affect regulation, and cognitive processing of traumatic experiences.

JTR has been used and evaluated in Israel. In a pilot study, two groups of eighteen participants in the program displayed significant reductions of posttraumatic symptoms, somatic complaints, and generalized and separation anxiety. Guidance counselors undergo twenty four hours of training, including four two-hour supervisory sessions. A guidance counselor manual and student handouts are available. Information can be obtained from Rony Berger (riberger@netvision.net.il) of the NATAL, Israel Trauma Center for the Victims of Trauma and War in Tel Aviv.

SAFE HARBOR PROGRAM

Safe Harbor is a school-based victim assistance and violence prevention program that is designed to help students aged six to twenty one, their parents, and schools cope with violence, victimization, and trauma. The program utilizes a safe harbor room in a school as a low stigma, readily accessible entry point to appeal to children/youth experiencing distress in response to

violence. It offers victim assistance, counseling, and concrete alternatives to violence at the individual and school levels.

Safe Harbor focuses on leadership, empowerment, and the development of social, emotional, and interpersonal skills. It is designed to help youth understand their own victimization; recognize the links between family, community and school violence; identify trauma, and provide support to break the cycle of violence. The individual level focuses on modifying beliefs, attitudes and norms, and development of positive behaviors that support non-violence. The interpersonal level focuses on enhancing relationships with peers and family who can functions as buffers from the effects of exposure to violence. The social context level focuses on changing parts of the environment and climate that contribute to violent behavior in order to prevent violence. The program is comprised of the following key components:

- A trauma education/violence prevention curriculum called PEARLS (People Empowered About Real Life Situations) which is comprised of ten lessons that address issues related to violence and victimization with modules on specific types of crime.
- Individual counseling and individual follow-up for students in the curriculum classes is provided as needed to support youth who have been victimized. Sessions focus on helping youth explore the impact of violence in their lives and helping them work through specific conflicts.
- Parental involvement and staff trainings are provided to enhance students' relationships with the adults in their lives.
- Structured group activities are provided to reinforce the curriculum lessons and strengthen peer relationships.
- A school wide antiviolence campaign is conducted to build a cohesive culture of nonviolence in the school and provide youth with meaningful opportunities for leadership and the promotion of social responsibility.

Safe Harbor has been implemented across the country with students from multiple ethnic/racial groups including recent immigrants and refugees as well as those from multiple religious backgrounds and youth from the LGBT (Lesbian, Gay, Bisexual, and Transgender) community. Studies demonstrate that participation leads to increases in the use of conflict-resolution and problem-solving strategies, self-confidence in the ability to control anger and resolve conflicts nonviolently, positive social control, and participation in productive activities. Reductions in fighting, anger, and bullying behaviors have also been found. In addition, participants have been found to be more strongly opposed to gang violence and schools have reported attenuation of the presence of gangs and increased safety. The program has been found to be most effective when youth participate in several components of the program.

Training regarding the use of Safe Harbor ranges from six hours to three days depending on experience of the clinician. Available materials include an implementation manual, the *PEARLS Curriculum*, and the *Facilitator's Guide to the PEARLS Curriculum*. Information regarding the program can be obtained from http://www.safehorizon.org/.

THREE DIMENSIONAL GRIEF

Three Dimensional Grief is a manualized group intervention process that is designed to facilitate the mourning and grieving process for school-aged children who have experienced permanent loss from the death of a friend, parent, caregiver, or other significant family member. The program incorporates developmental, psychodynamic, child-centered play therapy, and gestalt

elements. It can be used for recent losses or longer term recovery. Three Dimensional Grief consists of forty five to ninety-minute weekly group sessions of six to eight children per group. Children are referred to Three Dimensional Grief by teachers and counselors.

The program has been implemented in public, charter, and parochial schools in Washington, D.C. and has been found to be effective for African American students and students from families that are economically challenged. The program can be given for eight sessions or can be adapted to last the entire school year.

It is recommended that sessions be led only trained mental health clinicians with grief and group work experience. Training consists of one to two days, with at least one half day of clinical review and another half day of active practicing of the program. This is followed by one additional day of training and monthly consultations. Available materials include a manual, references, and resource lists. Information can be obtained from Susan Ley at sley@wendtcenter.org and Dottie Ward-Wimmer at dottie@wendtcenter.org of the Wendt Center for Loss and Healing (www.wendtcenter.org) in Washington, D.C.

HEALING AFTER TRAUMA SKILLS (HATS)

HATS is an evidence-informed, manualized, cognitive-behavioral intervention for classrooms, groups, or individuals that is designed to relieve trauma-related symptoms (e.g., re-experiencing trauma, anxiety, fear, numbing, avoidance, clinging behavior, mood changes, and arousal). It is targeted to children in kindergarten, elementary, and early middle school (aged four to twelve) who have experienced a natural or man-made trauma or disaster. It is not intended for children who are with traumatic bereavement.

The program consists of twelve exercises and three additional, optional exercises of between thirty and ninety minutes duration that can also be divided into shorter segments. The exercises also include take-home family exercises. It is recommended that HATS be provided subsequent to the passage of at least a subsequent to the occurrence of a traumatic event.

HATS has been implemented in many schools throughout the country and world where it has been translated into other languages. However, evaluation has only been qualitative; more rigorous evaluation is in progress. It is recommended that teachers or mental health professionals facilitate this program. Training consists of reviewing and following the HATS manual which is available for download free of charge from www.nctsnet.org/nctsn_assets/pdfs/edu_materials/HATS2ndEdition.pdf. In-depth training can also be provided upon request. More information can be obtained from Robin H. Gurwitch, Ph.D. (robingurwitch@ouhsc.edu) at the University of Oklahoma Health Sciences Center and the Terrorism and Disaster Center of the National Child Traumatic Stress Network.

LIFE SKILLS/LIFE STORY

Life Skills/Life Story is a manualized dual module group or individual intervention. The first module focuses on building resilience and the second addresses resolving problems such as depression, dissociation, and symptoms of posttraumatic stress disorder. Life Skills targets emotional and social competency building, emotional regulation skills, social skill development, positive self-definition, and goal setting. Life Story addresses emotional processing of traumas in the context of developing a positive life narrative and future plan.

The program is for girls and young women aged twelve to twenty one who have experienced complex, multiple, and/or sustained/repeated trauma related to sexual or physical abuse, community violence, domestic violence, or sexual assault. Life Skills/Life Story is not a single incident crisis intervention; it is designed for recovery from sustained problems in functioning

related to chronic symptoms and impaired development resulting from sustained trauma. It can be used to foster recovery from an acute trauma as well as past trauma.

Life Skills and Life Story can be conducted in either individual or group sessions (with four participants per group and one therapist, or six to eight participants per group and two therapists). Life Skills consists of ten sessions and Life Story consists of six sessions, all held once a week, each of which can stand alone or be used in conjunction. Life Skills/Life Story was developed for use in community mental health programs but has been implemented in a variety of settings, including residential school settings, after school programs, and during school lunch periods. It is currently being implemented in schools and hospital settings.

Life Skills/Life Story has been successfully conducted with ethnically diverse populations, including African Americans and Hispanics/Latinos. The limited outcome studies conducted on the program indicate that high school and middle school aged girls experience reductions in PTSD symptoms, depression, dissociation, and improvements in conduct, interpersonal relations, emotion regulation capacities, and social skills.

Training includes one day of workshops, weekly supervision by phone, and monthly in-person group supervision for the clinician's first group. A manual, worksheets, and treatment materials are provided at training workshops. Information on the program can be obtained from Marylene Cloitre, PhD, Director of the Institute for Trauma and Stress of New York University's Child Study Center at marylene.cloitre@MED.NYU.EDU.

MAILE PROJECT

The Maile Project is a manualized psychoeducational individual or group program that was developed for students with unremitting symptoms of posttraumatic stress disorder following Hurricane Iniki in Hawaii. It has also been adapted as a school-based counseling intervention to address terrorism-related exposure and associated symptoms. The program is focuses on resilience and supporting recovery processes in elementary and middle school children (in the second through the seventh grades) and adolescents (in the eighth through the twelfth grades) who have experienced a disaster and have symptoms of PTSD.

The Maile Project focuses on restoring a sense of safety, grieving losses, renewing attachments, adaptively expressing disaster related anger, and achieving closure regarding a disaster. It provides a structured method to help children review their trauma associated experiences while receiving supports to achieve mastery. While originally conceptualized as a package that includes screening to identify children who continue to experience post trauma difficulties followed by intervention, it can be used separately rather than as part of an integrated screen-and-treat approach.

The program consists of four individual or group sessions of four to eight children per group held weekly for the length of a classroom period (forty to eighty minutes). It can be provided by school counselors, clinical psychologists, or social workers who have experience in working with children in schools. The four sessions are comprised of the following themes:

- Safety and Helplessness
- Loss
- Mobilizing Competence and Issues of Anger
- Ending and Going Forward

During each session children/adolescents identify challenges, express feelings regarding their challenges, contemplate the significance of those challenges, and construct future oriented ways of integrating them into the present. The sessions incorporate a combination of play,

expressive art, and discussion. The group version of the program engages children in cooperative play and discussion.

A randomized three-cohort study the program indicated that participants displayed reductions in trauma-related problems in Hawaiian, part-Hawaiian, Caucasian, Filipino, and Japanese children on the island of Kauai who underwent either group or individual versions of the program two years subsequent to the occurrence of Hurricane Iniki.

School counselors or clinicians attend three days of training regarding post-disaster trauma psychology and one and a half days of didactic training specific to the program's treatment manuals. Group supervision is provided weekly to ensure consistent delivery of the protocol. Two treatments manuals are available. One is for the second through seventh grades and the other is for the eighth through the twelfth grades. Each manual covers individual and group formats, provides session-by-session protocols that outline each session's content, and includes a specific repertoire of activities designed to elicit material relevant to each session. A standard play-therapy kit that contains art and play materials is also available. Information can be obtained from Claude M. Chemtob at claude.chemtob@mssm.edu.

FRIENDS AND NEW PLACES

Friends and New Places is a cognitive contextual drama-based model for school-aged children (in kindergarten through twelfth grade that addresses cognitive processes regarding a traumatic event in the context of various environments (e.g., family, school, and community). It targets students experiencing traumatic changes in their lives. The program aims to reframe the manner in which children think about their experiences in a new environment in school and at home.

The program consists of six sessions with six to twenty children per session, of approximately sixty minutes in duration held once weekly. Each session consists of a theme (e.g., adjusting to new situations, dealing with anxieties, and coping with depression), acting out scenes around the topic/theme, and pointing out improvements or solutions regarding dealing with various situations thereby allowing students to be active and draw analogies between their activities, feelings, and reactions to experiences. Facilitators of the program check in weekly with teachers to ascertain how students are functioning and also make at least one formal contact with parents. The sessions are co-led by a psychologist or social worker and a school counselor.

Friends and New Places has existed for some time but was redeveloped specifically for Hurricane Katrina and has yet to be formally evaluated. One full day of training is required to familiarize facilitators with the model. Information can be obtained from Jenni Jennings (jjennings@dallasisd.org) of the Youth and Family Services of the Dallas Independent School District).

RAINBOWS

Rainbows is a grief support organization that provides prevention and intervention curricula for children and youth who have experienced divorce, separation, or death of parents, other types of losses, or painful transitions. Rainbows curricula provide grief support, foster emotional recovery, enhance self-esteem, and teach coping mechanisms.

Rainbows is comprised of a pre-school edition (called *SunBeams* which is for three to four year old children), an elementary edition (called *Rainbows* for children aged five to fourteen), and an adolescent edition (called *Spectrum*) There is also a program for college-age students and adults called *Kaleidoscope* and another called *Prism* for single parents and stepparents. Rainbows curricula have been used successfully by children and adults of diverse races and

religious denominations throughout the United States and sixteen other countries. It has demonstrated high participant and parent satisfaction.

Rainbows Elementary Edition consists of twelve group sessions held with three to five participants in two sets of six sessions with a Celebrate Me Day after each set. The length of each session depends on the age group and the curricula used and ranges from twenty five minutes to two hours. Each student uses an age specific journal, or activity book, which are private and confidential. Each session consists of discussion, sharing, activities, and reflection, focused on an aim and rationale. The twelve sessions cover the following themes: (1) self, (2) feelings, (3 and 4) divorce, death, and loss, (5) anger and hurt, (6) fears and worries, (7) family, (8) belonging, (9) stepfamily, (10) acceptance, (11) coping tools, and (12) reaching out to others. The Celebrate Me Days covers self esteem, guilt, trust, coping tools, and forgiveness, and can be conducted in conjunction with the other Rainbows groups in schools, faith-based organizations, and community agencies. SunBeams and Spectrum follow formats similar to that of the Rainbows Elementary Edition.

Two training levels are provided. Local Coordinators and Facilitators training consists of volunteer adults selected by sites who are trained by Rainbows to offer support, understanding, and guidance through their own listening skills and the Rainbows materials. Training takes six to nine hours. Rainbows can be facilitated by clinicians and non-clinicians. Registered Directors Certification training is targeted to individuals who are responsible for the implementation, quality, and growth of Rainbows in a geographic region and require the capability to market, train, and follow up with registered sites. This training requires attendance at a six-day certification institute. Materials include instructor manuals, journals, games, and activities for the different age-group programs (SunBeams, Rainbows, Spectrum, Kaleidoscope or Prism). Rainbows Registered Directors work with potential sites to complete an implementation process to become a Registered Rainbows Site. Information can be obtained from www.rainbows.org.

SILVER LININGS COMMUNITY CRISIS RESPONSE PROGRAM

Silver Linings is a promising, manualized, first-response, classroom, or youth group program designed to assist youth experiencing emotional difficulties due to loss or change caused by crisis situations (e.g., a natural disaster, death of a classmate or teacher or administrator, school closings, or violence in the school or community). The program aims to provide a safe place for students to express and explore feelings (e.g., anger, sadness, and guilt) with peers and adults while participating in physical activities and receiving instruction regarding effective coping strategies (i.e., positive reappraisal). The program is available for children aged five to eight, nine to twelve, and adolescents. Pre-school and adult versions are under development. It can be facilitated by persons who work regularly with children (e.g., coaches, teachers, counselors, and youth group leaders).

The program consists of six thirty to forty five-minute group sessions that can be held over a period of two to six weeks with at least one day between each session. Each of the six sessions has a theme/focus. These are feelings, changes, angry and fear, endings and beginnings, weathering the storms, and goal-setting. An option to use the creative activities for developing expandable large group displays where children can post drawings and other creative elements depicting what they have experienced in public settings is available.

Silver Linings has been found to be effective for a variety of settings and crisis situations, (e.g., classrooms, community centers, and short term rescue shelters). However, the program has not yet been formally evaluated but pre- and post-program data on participants and evaluations by facilitators is being collected. The three editions of Silver Linings include instructor manuals, participant booklets, and a coloring story booklet titled *Ferdinand the Eagle*, which focuses on rebuilding and generating hope. More information can be obtained from www.rainbows.org.

WORKING WITH FAMILIES

While responsibility for children's mental health care is shared across multiple systems, including schools, primary health care, juvenile justice, child welfare, and substance abuse and mental health treatment, the primary system is the family. Parents and other caregivers are a child's first and foremost teachers. Family members and caregivers should thus be viewed as equal partners in selecting, implementing, evaluating, and sustaining programs.

Programs that address issues of parents and other caregivers have been found to increase the potential for positive outcomes. And, parents and other caregivers are more likely to be involved if services are provided in easily accessible settings and if they are culturally and linguistically appropriate. Services and supports effectively incorporate families when they are made accessible to family members in terms of location, time, and language, and convey respect for the knowledge and experience that family members contribute to the decision-making process. Successful strategies include meeting families in environments that fit within their normal routines (e.g., home, work, primary care, and school), integrating cultural strengths, and accommodating any financial constraints. Programs have been found to be most effective when tailored to the cultural, community, and developmental norms of program participants.

Family-focused, evidence-based programs implemented with fidelity have been demonstrated to have a profound positive effect on parenting behavior and the developmental trajectories of children whose life courses are threatened by multiple risk factors. Higher levels of parental support have been shown to significantly predict more positive outcomes. Parental PTSD is associated with PTSD in children; effective treatment of parental PTSD and other psychiatric problems contributes to more positive child outcomes. Parental emotional distress significantly predicts poor child outcomes; parents who receive CBT interventions learn positive parenting skills that lead to reductions in behavioral problems in children who have experienced trauma.

CHILD-PARENT PSYCHOTHERAPY (CPP)

CPP is a manualized, fifty-session (on average), dyadic, attachment-based intervention for young children aged zero to six who have been exposed to interpersonal violence (i.e., the trauma of domestic violence and maltreatment). It integrates psychodynamic, attachment, developmental, trauma, social learning, and cognitive-behavioral principles and practices. CPP focuses on the manner in which the trauma experienced has affected the parent-child relationship. Discussions of cultural values and culture-related experiences are incorporated into CPP (e.g.,' connections to culture and cultural beliefs, spirituality, intergenerational transmission of trauma, historical trauma, immigration experiences, and parenting practices).

Treatment strategies address play, sensorimotor disorganization and disruption of biological rhythms, fearfulness, aggression, and reckless, self-endangering and accident-prone behaviors, as well as punitive and critical parenting, the relationship with a perpetrator of violence and/or absent father, and separation issues related to the termination of treatment. The parent-child relationship is used to improve children's emotional, cognitive, and social functioning through an emphasis on safety, affect regulation, the joint construction of a trauma narrative, and engagement in developmentally appropriate goals and activities. Children and their mothers are seen in joint sessions. Individual collateral sessions with mothers are scheduled when indicated. Interventions focus on promoting affect regulation, altering maladaptive behaviors, supporting and encouraging developmentally appropriate interactions and activities, and guiding children and mothers in the creation of a joint trauma narrative that includes finding avenues for conflict resolution and restoration of hope and trust in their relationship.

CPP has been found to be effective for African Americans, Asians, Caucasians, Native Americans, and Hispanics/Latinos with a wide range of acculturation levels including recent immigrants, as well as parents experiencing chronic trauma, and children who have experienced multiple traumas from a wide variety of religions and socioeconomic statuses (particularly those with lower incomes residing in urban areas).

CPP is one of the few empirically validated treatments for children under the age of six that has been shown to be effective for ethnic minorities. Outcome studies reveal that children display significant decreases in behavior problems, symptoms of traumatic stress, and mothers display reductions in avoidant symptomatology. Improvements in attachment have also been found. Moreover, treatment effects have been shown to continue post treatment. Program materials are available in English and Spanish. Information can be obtained from Chandra Ghosh Ippen, Ph.D. of the Child Trauma Research Project of the University of California in San Francisco at chandra.ghosh@ucsf.edu.

CHILD-PARENT PSYCHOTHERAPY FOR FAMILY VIOLENCE (CPP-FV)

CPP-FV is a manualized intervention that incorporates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning therapeutic principles into a dyadic treatment approach that is designed to restore parent-child relationships as well as children's mental health and developmental progression impaired by the experience of domestic violence. It targets infants, toddlers, and preschoolers who have witnessed potentially traumatizing levels of domestic violence and/or who display symptoms of violence-related trauma including PTSD, aggression, defiance, noncompliance, reckless behaviors, excessive tantrums, multiple fears, inconsolability, separation anxiety, difficulties sleeping, and social and emotional withdrawal.

CPP-FV consists of weekly one-hour sessions for twelve months provided in home or office based settings. Six intervention modalities that focus on parent-child interactions aimed at restoring a sense of mastery, security, and growth and promoting congruence between bodily sensations, feelings, and thinking on the part of both children and their parents, as well as their relationship, are incorporated into the program:

1. Use of play, physical contact, and language to promote healthy exploration, contain overwhelming affect, clarify feelings, and correct misperceptions
2. Unstructured developmental guidance
3. Modeling of appropriate protective behaviors
4. Interpretation
5. Emotional support and empathetic communication
6. Crisis intervention, case management, and concrete assistance with problems of daily living

CPP-FV has been found to be beneficial for multiethnic families and those with socioeconomic challenges. Outcome studies indicate significant improvement for children's symptoms of traumatic stress and behavior problems as well as significant reductions in maternal avoidance. It has been in use for over twenty years with immigrant families from over thirty five countries.

A one-year training program is available for clinicians who possess at least a master's degree in psychology or social work, as well as pre and postdoctoral psychology interns, and psychiatry residents. Training includes intensive supervision, weekly case conferences, three to five days of didactic training, and follow-up consultation based on video recordings of treatment sessions. A fidelity measure has been developed by the Child Trauma Research Project (CTRP) of the University of California-San Francisco that is currently being validated. Information can be obtained from Alicia Lieberman, PhD (alicial@itsa.ucsf.edu), or Patricia Van Horn, PhD (pjv@itsa.ucsf.edu) at the University of San California - San Francisco.

PARENT-CHILD INTERACTION THERAPY (PCIT)

PCIT is a parent management training program for families of children between the ages of two and six who are experiencing emotional, behavioral or developmental difficulties and family problems. The program uses play therapy and in vivo teaching to give feedback regarding mother-child interactions. It is a short-term, manualized intervention that is comprised of two phases, Child-Directed Interaction (CDI), and Parent-Directed Interaction (PDI). The focus of the CDI phase is on enhancing parent-child attachment. This is the foundation for PDI, which focuses on using a structured and consistent approach to discipline. CDI is based on attachment theory. Parents are taught skills to promote positive, nurturing interaction in order to provide a secure attachment for the child. PDI is based on social learning theory and addresses ineffective/maladaptive parent-child interactions that can create and maintain behavioral problems.

The program consists of ten to sixteen one-hour sessions conducted on a weekly basis consisting of:

- A pretreatment initial assessment of child and family functioning
- Joint development of therapy goals by the clinician and parents
- Feedback, teaching, and coaching of parents in the CDI skills
- Teaching and coaching parents in the PDI skills
- Direct consultation and coaching for the child's teacher
- Teaching generalization skills
- Post treatment assessment
- Booster sessions over a twelve month period to maintain positive skills

Each phase of treatment entails a didactic session for parents during which interactional skills and their rationales are taught via modeling and role plays. Then, parents and their children attend weekly coaching sessions together. They are given homework to practice skills between sessions on a daily basis for five to ten minutes per day. During CDI, parents are taught to use PRIDE (praise, reflection, imitation, description, enthusiasm) skills while avoiding questions, commands, and criticism when playing with their children. During PDI, parents are taught to impart clear, developmentally appropriate, direct commands and confer consistent consequences for both compliance and noncompliance. Praise is used for compliance and time-outs are used for noncompliance.

Research indicates PCIT is effective in reducing children's behavior problems at home and school, and results in improved parental interactional styles. Parents report gains in confidence in their parenting abilities and reductions in personal distress. The beneficial effects of PCIT have been shown to generalize to other family members (i.e., siblings who have not undergone treatment). Studies that have included culturally diverse families have also found these positive outcomes. PCIT has been shown to be most effective if it is used continuously in the home and other significant environments.

A comprehensive treatment manual, test outline of the program, and implementation recommendations are available. However, there are several training models and these are of varying levels of intensity. Information on PCIT can be found at http://www.pcit.org/.

ABUSE FOCUSED-COGNITIVE BEHAVIORAL THERAPY (AF-CBT)

AF-CBT is designed for parents who engage in physically abusive behavior and their school-aged children who display significant externalizing behavior problems (e.g., aggression, ineffective coping skills, adjustment problems, and inadequate social competence), internalizing symptoms, and developmental deficits in relationship skills. It targets caregivers who exhibit

negative child perceptions, heightened anger or hostility, harsh/punitive/ineffective parenting practices, and families that engage in verbally or physically coercive interactions.

KEY COMPONENTS OF AF-CBT	
Child-Directed Components	• Socialization to brief conceptual models of stress and cognitive-behavioral therapy • Understanding the child's exposure to family hostility and violence, and cognitive processing of the circumstances and sequelae of the referral incident, in part, to modify aggression supporting beliefs/distortions and other misattributions about the incident • Psychoeducation about child abuse laws, child safety/welfare, and common abuse-related reactions • Affect-focused interventions such as training in affect identification, expression, and management skills (e.g., abuse-specific triggers, anxiety/stress management, anger-control) • Coping skills discussions (healthy vs. unhealthy coping) and training to address everyday problems • Development of social support plans and skills training to enhance social competence
Caregiver / Parent-Directed Components	• Socialization to brief conceptual models of stress and cognitive-behavioral therapy, focusing on contributors to violent or coercive behaviors • Understanding the parent's views on hostility and violence, including an examination of the role of child-related developmental expectations and general attributions that may promote coercive interactions • Affect-focused interventions such as identifying and managing reactions to abuse-specific triggers, heightened anger or anxiety, and depression, to promote self-control • Training in alternative disciplinary strategies that minimize the use of physical force through instruction in several behavior management principles and techniques to promote effective discipline (e.g., attention/reinforcement, response-cost, time-out)
Parent-Child and Family-System Components	Parent-child or family-system interventions may be applied before, during, and/or after these individual services: • Discussion of no-violence agreement and development of safety plans • Family assessment using multiple methods (rating scales, observations) and identification of family treatment goals • Clarification sessions to clarify attributions of responsibility for the abuse, focus treatment on the needs of the victims/family, and develop safety and relapse prevention plans, as needed • Communication skills training to encourage constructive interactions • Non-aggressive problem-solving skills training to minimize coercion, with home practice applications identified to establish family routines • Community and social system involvement, as needed

The program consists of twelve to twenty four sessions conducted in home or office based settings. It includes parallel individual and family sessions as well an option for group treatment. AF-CBT incorporates therapeutic principles and procedures from learning/behavioral, family systems, and cognitive therapies as well as developmental victimology that target individual child and parent characteristics related to the experience of abuse and larger family context in which coercion, physical force, and aggression occurs. It emphasizes teaching specific intrapersonal (e.g., cognitive and affective) and interpersonal (e.g., behavioral) skills designed to promote the expression of prosocial behavior and discourage the use of coercive/abusive behavior at both the individual and family levels. Treatment is organized into three phases:

Phase 1: Psychoeducation and Engagement
Phase 2: Individual and Family Skills Training
Phase 3: Family Applications

Instruments may be used to evaluate parenting practices, family functioning, and children's social skills, behavioral and emotional problems that may contribute to the risks for and/or consequences of child physical abuse, and identify clinical targets for intervention.

Outcome studies indicate reductions in parental use of harsh or coercive discipline, force, and abusive behaviors, increases in the use of positive management practices, and improvements in parent-child relationships, family cohesion, reductions in family conflict, and successful case closures within the child protective service system across children and caregivers from various demographic backgrounds (e.g., age, gender, ethnicity, intellectual functioning, and family constellation). Reductions have been shown in the severity of children's behavior problems and increases in social behavior and improved peer interactions. While, explicit applications for specific cultural groups or settings have not been formally reported, the program is also used in Canada, Germany, Holland, and Israel

Training is available for mental health professionals with at least some advanced training in psychotherapeutic skills/methods and experience working with caregivers who are physically abusive and their children. A pretraining assessment survey is administered to gain an understanding of therapist's practices and knowledge. Training generally consists of a minimum of six hours of didactic instruction. Additional training experiences (e.g., follow-up consultation and supervision for implementation with a small caseload) in accordance with level of experience and case difficulty which typically ranges from six to eighteen hours for three to six months are recommended. The *AF-CBT Implementation Guide*, *AF-CBT Session at a Glance*, *AF-CBT Session Guide* and *Handouts Information* packet can be obtained from www.pitt.edu/~kolko.

TRAUMA AFFECT REGULATION: GUIDELINES FOR EDUCATION AND THERAPY FOR ADOLESCENTS AND PRE-ADOLESCENTS (TARGET-A)

TARGET-A is a promising manualized four to twelve session intervention for children aged ten to eighteen and their parents who are experiencing traumatic stress (i.e., physical abuse, domestic violence, emotional abuse, or sexual abuse) that focuses on recovery from interpersonal trauma. It can be provided as part of individual, conjoint family, dyadic parent-child, group, and case management interventions in residential and school settings.

TARGET-A has been adapted for youth in the juvenile justice, school, child protection, and mental health systems and has been found effective for Hispanics/Latinos, African Americans, Southeast Asians, Eastern European immigrants, and Native Americans residing in urban and rural settings. It has also been found effective for single parents, families whose children have limited contact with their biological parents (e.g., in foster care and residential settings) and individuals with socioeconomic challenges. Program materials are available in Spanish, Hebrew, Dutch, and French. The program has been implemented in the United States, Canada, and Israel, Netherlands, France, and Puerto Rico

The key components of TARGET-A are self-regulation, affect regulation, autobiographical and working memory (i.e., information processing), interpersonal problem-solving, stress management, didactic and nonverbal experiential exercises, and summarization of a skill set by its acronym FREEDOM:

Focus: Focusing helps individuals attend to and think about what is currently occurring rather than reacting based on alarm signals tied to past trauma. This step teaches participants to use the SOS skill (Slow down, Orient, Self-check) to pay attention to body signals and the immediate

environment as well as use a simple scale to measure stress and control levels.

Recognize triggers: Recognizing trauma triggers enables individuals to anticipate and re-set alarm signals as they learn to distinguish between a real threat and a reminder. This step helps participants identify personal triggers, take control, and short circuit alarm reactions.

Emotion self-check: This skill is designed to identify alarm or reactive emotions (e.g., terror, rage, shame, hopelessness, and guilt) which are most apparent subsequent to trauma and function to maintain readiness to fend off further danger. Main emotions, including positive feelings (e.g., happiness, love, comfort, and compassion), and those that represent positive strivings (e.g., hope, interest, and confidence) are identified in order to achieve a balance to foster reflection, values, and hopes when the brain's alarm is activated.

Evaluate thoughts: Participants learn to evaluate a situation and their options with a focus on how they decide to behave, moving from reactive (i.e., catastrophic) thoughts to main thoughts to achieve a balance of positive as well as negative thinking and away from automatic survival reactions.

Define goals: This step teaches individuals how to begin to create main goals that reflect their deeper hopes and values and move away from reactive goals that are limited to coping with the immediate situation or escaping from the source of danger (which is needed in emergencies, but does not reflect main goals of engaging in current worthwhile activities and a meaningful life).

Options: This step helps individuals identify the positive intentions concealed by more extreme reactive options generated by the brain's alarm system to foster opportunities for a greater range of options that take into consideration individuals' own needs and goals as well as those of others.

Make a contribution: This entails empowering individuals to think clearly enough to feel in control of their alarm reactions and, as a result, be able to recognize contributions they are making not to their own and other people's lives.

Outcome studies indicate that participation in TARGET-A leads to reductions in depression, anxiety, post-traumatic stress, post-traumatic cognitions, and substance use (particularly sustaining self-efficacy for recovery), which are maintained for at least one year post intervention. Its use in juvenile justice detention facilities as a milieu and group intervention is associated with reduced disciplinary problems. The program is being adopted as an educational and treatment model in statewide trauma initiatives in Connecticut and Florida for use in juvenile justice detention centers, probation offices, and residential and community programs, and in inpatient, residential, child guidance clinics, and community outreach mental health and substance abuse treatment programs for youths and families.

Clinician manuals, participant guides, and handouts have been copyrighted by the University of Connecticut and must be purchased from the University or its licensees. Consultation by a certified TARGET trainer/consultant is required following initial training, and continued use of the materials. Consultation includes reviews of recorded intervention and supervision sessions. Information can be obtained from www.ptsdfreedom.org and a TARGET-A manual can be downloaded from http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/AdolHandoutsMahoneyFordFeb05.pdf.

COMMUNITY OUTREACH PROGRAM - ESPERANZA (COPE)

COPE is a promising manualized parent-child intervention that is designed to address behavioral and socio-emotional problems experienced by children and adolescents aged four to seventeen with ongoing or past trauma and unable to effectively participate in traditional school counseling. The program uses-cognitive-behavioral therapy and incorporates coping skills training, affective identification and processing, trauma narrative construction, and risk reduction. It also uses Parent-Child Interaction Therapy to improve family interactions and intensive case management and advocacy to locate services and supports for family members (e.g. substance abuse treatment for parents) and address families' basic needs.

The program targets children who are traditionally underserved, African Americans, Hispanics/Latinos, and recent immigrants, with socioeconomic challenges who display behavioral and socio-emotional problems, experience barriers to accessing and remaining in traditional mental health treatment residing in urban and rural areas.

COPE is comprised of twelve to twenty weekly or biweekly forty five to ninety-minute individual child and parent sessions as well as joint sessions conducted in a combination of school, community, and home settings. Follow-up booster sessions are also provided. Outreach and case management are essential components to the program.

Training consists of one full day, thorough reading of treatment manuals and related journal articles, and supervision for one to three hours of joint and/or individual sessions each week for six to ten cases. Ongoing consultation is also provided. Materials are available in Spanish and English. Information can be obtained from Dr. Michael de Arellano, Director of COPE (dearelma@musc.edu) at the National Crime Victims Research and Treatment Center Medical University of South Carolina in Charleston (www.musc.edu/ncvc).

REAL LIFE HEROES (RLH)

Real Life Heroes is designed for school-age children, early adolescents, and adult caregivers who have experienced trauma (e.g., neglect, physical and sexual abuse, abandonment, losses, placements, domestic/family violence, disasters, terrorism, war losses, and severe and chronic neglect) and display symptoms of anxiety, depression, PTSD, disruptive behaviors, sexualized behaviors, and functional impairments in multiple areas. It is also for children in, or at risk for, placement in foster family care, residential treatment, detention, psychiatric hospitalization, as well as families involved with adoption or post adoption programs. RLH specifically targets children who often lack safe, nurturing homes, and secure relationships with caring and committed adults. It can be provided in a wide range of settings including within home-based family interventions, mental health offices, residential treatment, and psychiatric hospitals.

RLH consists of six to twelve months of once weekly sessions of thirty to forty five minutes in duration for children, and thirty to forty five minutes for their parents/guardians. The number of sessions depends on safety, developmental level, extent and number of traumas, attachments, legal status, and stability of the child. The model can be used to prevent out-of-home placements, reunite families, or find alternate permanent homes for children who cannot return to their biological parents.

The RLH *Life Storybook*, an activity-based workbook constructed around the metaphor of heroes, provides a structured, phased-based approach to engaging children and their caregivers in rebuilding safety, hope, attachments, skills, and resources for trauma therapy. The curriculum integrates verbal and nonverbal modalities and helps children and adults transition from trauma narratives, to life stories highlighting mastery, helping others, and nurturing relationships. Creative arts activities are utilized to develop affect recognition and regulation

skills as well as replace shaming and dysfunctional beliefs with confidence and constructive beliefs. The life story framework is designed to promote redefinitions of children's identities from victims to heroes who help others.

The components of RLH include psychoeducation regarding traumatic stress, activities to foster attunement and trust with caring adults, development of social support, development of skills for trauma processing, desensitization to triggers, and sharing a coherent life story including a past, present, and future. The model engages adults to validate children by building on family strengths, fostering an understanding of traumatic stress, reducing shaming/blaming, and strengthening each child's cultural heritage. Critical elements include safety planning, affect recognition, affect modulation, self-soothing, trauma psychoeducation, resource building, countering dysfunctional beliefs, problem solving, and desensitization of traumatic events.

A practitioner's manual provides guidelines for integrating each child's family and cultural heritage into life story work from assessment through the conclusion of treatment. Activities and tools engage strengths within the child's family, community resources, and cultural heritage including faith, ties to religious organizations, and spirituality. A Heroes Library provides books geared to children of different ethnicities grouped by three reading levels adapted to enhance family and cultural strengths of children with minimal acculturation and can be used with refugees, immigrants, and children in a range of countries. The Life Storybook is available in English and Chinese. The practitioner's manual also has specific chapters that provide guidelines for adaptations for adolescents, preschool children, children with disabilities, and families with adopted children.

Case studies have shown reductions in symptoms of trauma, PTSD, and problematic behaviors, as well as increased attachment, trust, and affiliation. RLH has been found to be beneficial for children in foster family care as well as those who have returned from placement to parents, relatives, kinship foster homes, or adoptive families. However, the lack of a comparison group, small size of samples, and difficulty separating the shared variance between time and the intervention limit the scope of conclusions regarding the effectiveness of RLH on improved clinical outcomes.

Clinicians (typically master's prepared social workers) attend a two-day workshop and participate in consultation groups every other week. Childcare staff and foster parents are also involved in training as team members and caring adults and can participate in sessions or assist with homework. Training materials include a *Life Storybook* for both children and adult caregivers and a *Practitioner's Manual* that includes key objectives, an overview, step-by-step guidelines, checkpoints (i.e., essential elements), pitfalls, and troubleshooting tips, as well as tools and handouts for activities and trauma psychoeducation. A session summary/progress note and a bookmark (i.e., a reminder list) are provided to ensure that key components are sequentially incorporated into sessions. Information on RLH can be obtained from Richard Kagan, Ph.D. of the Parsons Child and Family Center in Albany, NY at kaganr@parsonscenter.org.

THERAPY

Students can develop a variety of mental health problems following a traumatic event. Two of the most common are post-traumatic stress disorder (PTSD) and depression. It is recommended that treatment for childhood PTSD consist of direct exploration of the trauma, stress management techniques, cognitive reframing techniques and inclusion of parents in treatment. Cognitive behavioral therapy (CBT) has been the most widely supported in controlled outcome studies of children who have been exposed to trauma. Examples include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), and a dyadic attachment therapy for young children known as Child Parent Psychotherapy (CPP). Such therapies have been shown to be effective for children with histories of sexual abuse, single incident trauma, and exposure to community violence as well as for symptoms of depression. In addition, CBT has been found to be beneficial for diverse populations.

Trauma-informed treatment for children needs to be tailored to the age and developmental level of the child. Intervention modalities for trauma-related difficulties are predicated on the age and developmental level of the child. For example, non-verbal techniques are recommended for younger children and verbal techniques, and combined modalities, are recommended for older children with assurance of safety and/or consideration of ways to re-establish safety. Moreover, cognitive distortions, when present, need to be understood and clarified as these may inappropriately attribute personal responsibility by a child for the event. It also critical to weave traumatic experiences and walled off memories into a personal narrative. The development of a personal narrative entails helping a child understand the traumatic experience within a frame of reference that makes sense and offers a sense of mastery and hopefulness.

Treatment often needs to be coupled with case management, referrals, and translation services, for disadvantaged minority populations. Psychoeducation for parents regarding their child's trauma symptoms is recommended to monitor the child's symptoms and after treatment has been completed for continued effect.

Most interventions that address trauma emphasize teaching key skills including: (1) emotion identification, processing and regulation; (2) anxiety management; (3) identification and alteration of maladaptive cognitions; and (4) interpersonal communication and social problem-solving.

CORE COMPONENTS OF TRAUMA-FOCUSED INTERVENTIONS
• Risk screening and triage
• Systematic assessment, case conceptualization, and treatment planning
• Psychoeducation
• Attention to traumatic stress reactions and experiences of children and families
• Trauma narration and organization
• Emotional regulation and anxiety management skills
• Facilitation of adaptive coping and maintenance of adaptive routines
• Enhancement of parenting skills and behavior management
• Promotion of adaptive developmental progression
• Attention to grief and loss
• Promotion of safety skills
• Relapse prevention
• Evaluation of treatment response and effectiveness
• Engagement of families and consumers in improving access to services
• **Culturally competent practices**

Studies have demonstrated that effective interventions need to be culturally appropriate, supported by families, individualized, coordinated, and monitored. A number of programs have been culturally adapted to promote relevancy and acceptance by racial and other underserved populations.

Research indicates that children and adolescents from minority backgrounds are at increased risk for trauma exposure and development of posttraumatic stress disorder (PTSD). African American, American Indian, and Latin American children are overrepresented in reported cases of child maltreatment and in foster care. Studies have shown that disasters pose particular mental health burdens for people from ethnic minority groups and developing countries, especially children, due to social, economic, and political marginalization, deprivation, and powerlessness. Consequently, children from minority groups fare worse in the aftermath of trauma, often experiencing more severe symptomatology for longer periods of time.

While culturally competent trauma treatment and practices are increasingly recognized as a necessity for quality care, a gap in available data on trauma exposure among children from diverse cultural groups exists. The scant research that is available tends to focus on ethnicity and race (e.g., immigrants, refugees, youth with disabilities, those who are homeless, lesbian, gay, bisexual and transgendered, and youth living in rural areas).

As previously noted, most children and adolescents recover almost completely from a traumatic experience within a few weeks, particularly if given support. Studies suggest that the provision of counseling/brief psychotherapy to children very soon subsequent to the occurrence of a traumatic event may alleviate some of the symptoms of PTSD and prevent worsening of co-occurring depression.

COGNITIVE-BEHAVIORAL THERAPY (CBT)

CBT for children generally includes exposure wherein a child directly discusses a traumatic event, anxiety management techniques such as relaxation and assertiveness training, and correction of inaccurate or distorted trauma related thoughts. Although there is some controversy regarding exposing children to events that are frightening to them, exposure based treatments appear to be most effective for the distress of trauma-related memories/reminders. Exposure is generally provided in a graduated fashion and paired with relaxation so participants learn to relax while recalling their experiences. Children are thus taught that they do need to fear their memories. CBT also entails challenging children's false beliefs (e.g., the world is totally unsafe). The majority of studies that have been conducted on CBT for children who have posttraumatic stress disorder (PTSD) have found that it is safe and effective.

CBT is often accompanied by psychoeducation with parental/caregiver involvement regarding symptoms of PTSD and its effects. This is based on research showing that more effective parental coping with trauma engenders effective provision of support for children who in turn cope better. Parents may need intervention in order to develop coping skills to provide effective support for their children.

CBT APPROACHES	
Exposure Therapy	Participants are gradually and repeatedly guided through a vivid and specific imaginal or in vivo recall of traumatic events (constructing a traumatic memoir) until emotional reactions decrease through habituation within the safe, controlled context of the therapeutic relationship and remission of PTSD symptoms occurs. Confrontation of all memories or reminders of trauma at once is a technique is referred to as **flooding**. Exposure techniques for children usually involve narrative procedures, in which children are asked to describe what happened to them in great detail (e.g., what they saw, heard, smelled, felt, the movements they recall, and how they felt and thought at the time). The session is initially distressing, but is sufficient enough to allow for habituation so distress levels diminish towards the end and more and more details are recalled. Standardized CBT including exposure techniques have been shown to be effective for children of different cultures.
Systematic Desensitization	Deep muscle relaxation techniques and diaphragmatic breathing techniques are taught prior to the onset of treatment and used during therapy whenever anxiety increases. A hierarchy of fear-inducing stimuli is established and relaxation techniques are used to overcome these situations. The least distressing situation and aspects of the traumatic experience are recalled first. If negative reactions are evoked, relaxation is induced, A hierarchy to recall is ascended in order to overcome and integrate the individual's worst fears.
Anxiety Management	Participants are taught specific anxiety-reduction skills: relaxation training, positive self-talk, and distraction techniques in order gain skills in managing anxiety when faced with provocative situations.
Stress Inoculation Therapy (SIT)	SIT incorporates psychoeducation and skill-building techniques (e.g., relaxation, thought stopping, breath retraining, problem-solving, and guided self dialogue). SIT has yielded encouraging results for female rape victims. Positive outcomes have been achieved by combining treatments (e.g., prolonged imaginal exposure, SIT, and supportive counseling).

Four critical components of CBT for the treatment of childhood PTSD have been identified: (1) education and goal-setting, with both child and parents involved; (2) coping skills development, which includes recognition of triggers for anxiety, with the child learning to quantify anxiety; (3) exposure, which involves the use of imaginative or in vivo exposure to facilitate emotional processing of traumatic memories; and (4) termination and relapse prevention, followed up with one or two booster sessions as needed.

CBT for trauma incorporates the following techniques:

- Learning skills for coping with anxiety (such as breath retraining or biofeedback)
- Using cognitive restructuring to change negative thoughts
- Managing anger
- Preparing for stress reactions (i.e., stress inoculation)
- Handling future trauma symptoms
- Addressing relapse prevention and other substance abuse issues
- Communicating and relating effectively with people (i.e., social skills)
- Addressing thought distortions that usually follow exposure to trauma

- Relaxation training and guided imagery

Additional information on CBT can be obtained from www.cognitivetherapy.com.

TRAUMA-FOCUSED COGNITIVE BEHAVIOR THERAPY (TF-CBT)

TF-CBT is an empirically supported intervention designed to help children and adolescents, aged three to eighteen, and their parents overcome the negative effects of traumatic life events (e.g., child sexual or physical abuse, loss of a loved one, and domestic, school, or community violence, or exposure to disasters, terrorist attacks, or war trauma). The program can be provided in individual, family, and group sessions. It targets symptoms of posttraumatic stress disorder, which often co-occur with depression and behavior problems, and issues commonly experienced by children who have been traumatized (e.g., poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior).

TCF-CBT is a SAMHSA model program that consists of twelve to sixteen once weekly sixty to ninety-minute sessions (held for thirty to forty-five minutes each with parents and children), three of which are held jointly. It incorporates learning principles, cognitive-behavioral therapy, and stress inoculation training to reduce children's negative emotional and behavioral responses, and modify their beliefs and attributions related to abusive experiences. TF-CBT also provides support and skills to help parents who were not involved with the abuse cope effectively with their own emotional distress and provide appropriate support to their children who suffered the abuse. The components of TF-CBT are as follows:

- **Psychoeducation** regarding child abuse, typical reactions of victims, normalization of reactions, safety skills, and healthy sexuality.
- **Stress management techniques** such as focused breathing, progressive muscle relaxation, emotional expression skills, thought stopping, thought replacement, and other cognitive therapy interventions.
- **Constructing the Trauma Narrative** which entails gradual exposure techniques including verbal, written and/or symbolic recounting (using dolls, puppets, etc.) of abusive event(s).
- **Cognitive processing** (or cognitive reframing) which consists of exploration and correction of inaccurate attributions about the cause of, responsibility for, and results of the abusive experience(s).
- **Parental participation** in parallel or conjoint treatment including psychoeducation, gradual exposure, anxiety management and correction of cognitive distortions. Parents are thus aware of the content covered with their child and prepared to reinforce or discuss this material with the child between treatment sessions and after treatment has ended. Parents are assisted to explore their own thoughts and feelings regarding their child's experience, resolve their own personal trauma related distress, and provide support to their children.
- **Parental instruction** in child behavior management strategies/effective parenting skills.
- **Family work** to enhance communication and create opportunities for therapeutic discussion about the abuse.

Studies have shown that participation leads to beneficial outcomes including significantly fewer behavior problems, reductions in posttraumatic stress disorder and depressive symptoms, negative attributions (such as self-blame) about the traumatic event, defiant and oppositional behaviors, anxiety, and improved social competences that have been demonstrated to be maintained well over a year after the termination of treatment. TF-CBT has also been found to

enhance accurate and helpful cognitions, children's personal safety skills, resolve parental distress regarding their child's experience, and prepare children to anticipate and cope with reminders of traumatic loss. The cost of implementing the program is estimated to be $1,001.00 to $5,000.00. A Web-based training course for TF-CBT can be found at http://tfcbt.musc.edu/. An implementation manual can be downloaded from http://www.nctsn.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf.

COPING CAT

Coping Cat is a manualized, short-term cognitive-behavioral intervention for the treatment of childhood anxiety. It includes the Coping Cat Workbook and Notebook with charts and other materials. The program consists of eight training sessions followed by eight practice or exposure sessions. The coping skills taught include:

- Recognition of anxious feelings and physical responses to anxiety
- Clarification of cognitions in anxiety-provoking situations and an assessment of unrealistic or negative expectations and/or attributions
- Formulation of a plan to help deal with the anxiety provoking situation(s), altering anxious self-talk to promote positive self-talk, and determining which actions might be beneficial
- Evaluating the success of the coping strategies implemented, and administering self-reinforcement as appropriate

The Coping Cat Program is comprised of the following elements:

- **Psychoeducation** to assist the child and family understand the manner in which abnormal levels of anxiety are learned, maintained and treated. Children maintain a diary and use learning techniques from the Coping Cat Workbook.
- **Somatic management techniques** which entails teaching relaxation techniques to calm the fight or flight response to external stimuli that are perceived as threatening or fearful.
- **Cognitive restructuring** to investigate, uncover and challenge anxiety-provoking thoughts in order learn new ways to deal with feared situations. The following techniques are incorporated into this component: identification of automatic thoughts (ATs), gathering evidence to dispute negative ATs, and keeping a diary to monitor daily thoughts. The **Fear Plan** is a four step acronym that incorporates the use of behavioral experiments that challenge ATs that create anxiety and fear in very young children.
  - **F** - "**F**eeling frightened?" Children note the physical symptoms they are experiencing in response to this question.
  - **E** - "**E**xpecting bad things to happen?" Children note their self-talk, and the consequences or outcomes they fear in response to this question.
  - **A** - "What **A**ctions and **A**ttitude will help?" Children generate a list of different cognitions and behaviors that can help in response to this question. They then select and implement a coping strategy.
  - **R** - "What are the **R**esults of my coping actions?" and "How can I **R**eward myself for trying to cope with this situation?" Children realistically evaluate their chosen solution, and reinforce themselves for coping in response to these questions.
- **Problem-solving** training to teach the child to identify real life problems, then list and evaluate actions for resolving a specific problem.

- **Graduated Exposure** involves gradual and systematic exposure to a feared stimulus or situation. It can involve **guided imagery** (a step-by-step visual imagery of confronting the feared situation) through **symbolism** (the use of pictures or props), **simulation** (role-playing a feared situation), or **in vivo** exposure.
- **Response prevention** includes interventions that obstruct escape from the feared object or situation. The participant is encouraged to confront anxiety provoking thoughts, situations or objects in order to demonstrate that their connections with danger are unrealistic.
- **Relapse prevention** entails follow-up to maintain treatment gains and can include maintaining a diary of ongoing progress and challenging stress-provoking thoughts.

The Coping Cat program has been found to be highly effective for children with anxiety. Moreover, benefits endure for years post intervention.

The C.A.T. Project is an adaptation for adolescents. Coping Koala, an Australian adaptation, is a cognitive-behavioral group intervention comprised of contingency management in combination with self-control techniques. The FRIENDS program is also an Australian adaptation that has been expanded into two parallel age groups, FRIENDS for Children 7–11 years, and FRIENDS for Youth 12–16 years, as an early intervention and prevention model.

TRAUMA SYSTEMS THERAPY (TST)

TST is a community-based program that is designed to enhance the ability of children and adolescents aged six to nineteen to regulate emotional and behavioral responses to significant ongoing socio-environmental stressors in schools, their neighborhoods, and families. It thus focuses on helping children and families in situations of ongoing stress in the social environment. Services are tailored to each child and family using a 3 X 3 matrix with stability of social environment on one axis and the child's ability to regulate emotions on the other. TST also addresses barriers to engaging families in treatment. A module titled *Ready set go* specifically addresses treatment barriers (e.g., language and transportation). This module (which functions as a treatment-engagement module) addresses building a treatment alliance across different cultural perspectives and identifying treatment goals that are consistent with families' views of priorities.

Interventions in TST incorporate strategies that operate through and in the social environment to promote change, and those that enhance individuals' capacity to self-regulate. The model entails selecting a series of interventions that correspond to the fit between a traumatized child's/adolescent's own emotional regulation capacities and the ability of that child's social environment and system of care to help them manage emotions or to protect them from threat.

Treatment is phase-based and has up to five phases: Surviving, Stabilizing, Enduring, Understanding, and Transcending. The phase is chosen based on the degree to which a child can regulate emotional/behavioral responses and whether the social environment is stable, distressed, or threatening. The overall framework is based on the System of Care approach. There are prescribed treatment modules within each phase:

- Home-based services (based on Multisystemic Therapy[7])
- Legal advocacy
- Emotional regulation skills training (based on Dialectic Behavior Therapy)

[7] A discussion of MST can be found in SCCMHA's *A Guide to Evidence-Based Mental Health Practices for Children, Adolescents and their Families*.

- Cognitive processing (on Trauma-Focused Cognitive Behavior Therapy)
- Psychopharmacology (when indicated)

The duration of treatment varies in accordance with level of severity and phases of treatment administered. Thus, children with acute symptomatology may require a longer duration of treatment (e.g., one year). The Surviving phase usually takes three months; a child starting at this phase (in acute crisis) may be in the program for eleven to twelve months with the duration of services reduced based on placement at assessment in later phases.

An interdisciplinary team is required to implement TST which includes community figures (e.g., teachers, spiritual leaders, community advocates, and case managers) who are engaged in treatment planning. Implementation is contingent on the availability of four types of services in the team: (1) skill-based psychotherapy, (2) home and community-based therapy, (3) legal advocacy, and (4) psychopharmacology.

Outcomes studies indicate that TST leads to reductions in traumatic stress symptoms as well as family and school related problems over the course of three months. TST has been adapted for multiethnic/cultural populations including refugees and immigrants, adolescents who abuse substances, and those who experience medical trauma. It has been found effective in pediatric settings, schools, and residential settings and is available in English and Spanish.

Training is available through individual agency contracts and consists of two days of basic training, a weekly conference call, and a one day follow-up training at six months. Information on this promising practice can be obtained from Glenn Saxe, MD at glenn.saxe@bmc.org or glenn.saxe@childrens.harvard.edu.

KIDNET: NARRATIVE EXPOSURE THERAPY (NET) FOR CHILDREN

KIDNET is a child adaptation of Narrative Exposure Therapy (NET) which is based on Testimony Therapy[8] and cognitive-behavioral exposure techniques. In NET individuals are asked to repeatedly talk about a traumatic event in detail and re-experience all of the emotions associated with the event. It is a standardized short-term (three to four session) approach for the treatment of adult survivors of wars and torture. Participants construct detailed chronological accounts of their own biographies. The autobiographies are recorded by therapists and corrected at each subsequent reading thereby transforming the typically fragmented reports of traumatic experiences into coherent narratives. During discussions of traumatic experiences, therapists ask about current emotional, physiological, cognitive, and behavioral reactions, and probe for relevant observations. Participants are encouraged to relive emotions while reporting events. Discussion of a traumatic event is not terminated until acceptance of the emotional reactions presented and reported by the participant takes place. During the final session, participants receive a written report of their biographies which are signed by both parties.

[8] In NET, witnesses to severe human rights violations are invited to testify their traumatic experiences in order to restore their autobiographic memories regarding those experiences and transform fragmentary memories into a coherent narrative structure (i.e., a testimony). It is designed to enable the processing of painful emotions and foster the construction of clear contingencies of dangerous and safe conditions to engender emotional recovery. In addition, documents (i.e., testimonies) that result from this therapy can be used for the prosecution of human rights violations or raising public awareness. Since the testimonies created by the survivors can be used to document human rights violations, NET helps people regain dignity and satisfies the survivors' needs for justice. It also offers an opportunity for advocacy on behalf of communities and people. Consequently there is usually a high level of willingness to take part in this form of therapy.

Narrative Exposure Therapy was initially developed for adults, but has been adapted for use with children. KIDNET is a short-term (four to six session) exposure treatment for children older than eight years of age and adolescents who have PTSD. It incorporates play and visual instruction to elaborate the experiences of participants via theater and illustrative material, such as the life-line exercise in which a rope is used to represent the child's lifeline, flowers are used to mark positive experiences along the lifeline, and stones are used to mark negative and traumatic experiences.

Children reconstruct their own lifelines at the onset and produce a painting of them. They are encouraged to name the events for which an item is placed (e.g., "when we had to leave home", "death of uncle") and therapists write the headlines. In subsequent sessions therapists use the paintings repeatedly for illustrative purposes. At the end of therapy children are encouraged to unwind some of the unused section of the rope to illuminate imagined future hopes and fears.

Outcome studies of KIDNET indicate that participation leads to reductions in posttraumatic symptoms and remission of clinically significant depression.

ATTACHMENT, SELF-REGULATION, AND COMPETENCE (ARC)

ARC is a guideline for individuals working with children aged five through seventeen who have experienced chronic trauma (e.g., sexual abuse, physical abuse, neglect, domestic violence, and community violence) and display symptoms of anxiety, depression, PTSD, bereavement/traumatic grief, sexualized behaviors, and multiple functional impairments. It incorporates systematic phase-oriented treatment approaches that are designed to build secure attachments, enhance self regulatory capabilities, and increase competencies across multiple domains.

Each area of focus (i.e., attachment, regulation, and competency) is based on trauma-informed interventions and techniques. Appropriate interventions are selected from a menu based upon each child's/adolescent's strengths and needs. Therapeutic procedures include psychoeducation, relationship strengthening, social skills development/enhancement, and parent-education training, as well as psychodynamic, cognitive, behavioral, relaxation, art/expressive, and movement techniques. The number of sessions, frequency, and duration of intervention varies in accordance with participants' needs. ARC can be used in office-based, school, or community settings (e.g., transitional housing for persons who are homeless and have experienced domestic violence).

Evaluations of ARC indicates that it provides an effective framework for enhancing the ability to regulate affect (as demonstrated by fewer suspensions and aggressive outbursts), the ability to regulate attention (as demonstrated by increased time spent on academic tasks), affiliation and group cohesion (as demonstrated by fewer peer conflicts), and compliance with rules and expectations. Thus far, ARC has been found to be effective for racial/ethnic groups except American Indian, Alaska Native, and Asian children. Information regarding ARC can be obtained from Kristine M. Jentoft-Kinniburgh, LICSW of the Trauma Center in Allston, MA at kjentoft@traumacenter.org.

TAP (ASSESSMENT BASED TREATMENT FOR TRAUMATIZED CHILDREN: TRAUMA ASSESSMENT PATHWAY)

TAP is designed for children aged two to eighteen who have experienced trauma. It consists of triage, the formulation of clinical hypotheses, and evidence-supported clinical interventions. Session length varies based upon the clinical intervention(s) selected. Participants are administered a core set of measures (e.g., the Trauma Symptom Checklist for Children and the

UCLA PTSD Index for DSM-IV). Domains assessed include family, culture, caretaker functioning, and posttraumatic stress symptoms.

TAP can be used with Hispanics/Latinos and other Spanish-speaking populations and can be adapted for use with other ethnic and cultural groups. Staff of the Chadwick Center (www.chadwickcenter.org) provide training which costs $1000.00 per day for up to fifteen participants. Three to six months of consultation is provided as needed subsequent to training on each component (i.e., assessment, triage, and treatment). It is recommended that supervisors receive training in order to discuss the model during supervisory meetings. Information can be obtained from www.taptraining.net. The TAP manual can be downloaded free of charge from http://www.chadwickcenter.org/Documents/Master%20TAP-6-08new.pdf.

DIALECTICAL BEHAVIOR THERAPY FOR ADOLESCENTS (DBT-A)

Dialectical Behavior Therapy (DBT)[9] has been adapted for adolescents aged thirteen to nineteen who are suicidal. It focuses on helping teens and their families master the challenges of the transition from adolescence to adulthood as well as ameliorate problematic behaviors that are sometimes used to deal with extreme emotional intensity. The intervention has been modified for use in outpatient as well as inpatient settings. The first phase of treatment has been shortened from one year to sixteen weeks. The number of skills has been reduced in order to teach them in sixteen weeks. Parents are included in the skills training group in order to enhance generalization and maintenance of skills. Family members are taught to use skills and improve the adolescent's home environment. A new skills training module, Walking the Middle Path, has been added to teach behavioral principles and validation as well as address the dialectical dilemmas inherent in parent-adolescent interactions.

Parents are required to attend a multi-family parents' group where they learn the DBT skills of mindfulness, distress tolerance, interpersonal effectiveness, emotion regulation and Walking the Middle Path. In addition, parents learn to understand and respond to specific adolescent behaviors, encourage the use of skills at home, and receive support from each other within a DBT framework. One of the group skills trainers provides parents with skills coaching for occasions of distress. Parents and/or other family members are included in individual sessions when indicated. The language on the skills handouts has been simplified to make them developmentally and culturally appropriate for adolescents.

In the DBT-A outpatient format the consumer attends twice-weekly psychotherapy for sixteen weeks. One of these weekly sessions is for multifamily group skills training, and the other is for individual therapy. The focus is on stabilization and control of the acute behavior that precipitated the intervention. The inpatient format of DBT-A is briefer, more intensive, and even more focused on the behavior that precipitated the hospital admission. Here therapy goals are limited to establishing a commitment to treatment and stabilization of life-threatening behavior.

Both the adolescent and multi-family skills training groups use the following skills modules:

- **Core Mindfulness Skills** entails focusing one's mind, directing attention, and understanding how one feels. This module is designed to diminish identity confusion and self-dysregulation. It includes teachings of Zen meditation to enhance emotional control.
- **Emotion Regulation Skills** are aimed at reducing emotional intensity, identifying emotions, reducing emotional vulnerability, and increasing positive events.

[9] A discussion of DBT can found in SCCMHA's *A Guide to Evidence-Based Practices for Adults with Mental Illness*.

- **Distress Tolerance** is designed to reduce impulsivity by teaching acceptance and tolerance of painful situations with self-soothing, distraction from pain, and by generating ideas about the positive and negative aspects of painful situations.
- **Interpersonal Effectiveness** is designed to maintain stable relationships, get one's needs met, enable interpersonal problem-solving through assertiveness training, and help the adolescent become more aware of their goals in interpersonal situations.
- **Walking the Middle Path** entails helping with adolescent-family issues. It focuses on teaching adolescents and their parents the concepts of dialectics, validation, and behavioral therapy. Emphasis is placed on the relationship between parents and teens.

COMPONENTS OF DBT-A
• **Adolescents and their parents address capability enhancement during a weekly two-hour multifamily skills training group. The group provides an opportunity for skills acquisition through instruction and modeling and provides opportunities for skills strengthening through behavioral rehearsal and reinforcement of new skills.**
• **Weekly individual psychotherapy sessions to address enhancing motivation by focusing on emotional dysregulation, cognitive errors, and contingencies that may compromise motivation. Consumers and therapists review weekly diary cards (documenting suicidal, self destructive behaviors, and those that interfere with treatment and quality of life) and engage in behavioral analysis of maladaptive events recorded on the diary cards. These sessions also provide an opportunity for skill strengthening and generalization.**
• **Phone consultations with the therapist are conducted during the first twelve weeks of treatment to discuss skills that may be useful to decrease suicidal behaviors, report positive behaviors and events, and resolve conflicts. The therapist is available to the consumer for telephone consultation (before the consumer engages in parasuicidal behavior) to facilitate generalization of skills. The consumer can also phone the therapist to report positive news or work on the consumer-therapist relationship if needed.**
• **Therapists attend weekly DBT therapist consultation groups to address their own skills and motivation.**
• **Various additional interventions (e.g., collateral family sessions, meetings with other treatment providers, and contacts with school personnel) are used to structure the environment and help ensure the consumer does not have to become more symptomatic or engage in more self-destructive behavior in order to get help.**
• **Consumer consultation groups for mutual assistance in utilizing skills to cope with life circumstances are held during the second twelve weeks of treatment.**

Research has demonstrated that use of this approach leads to reductions in suicidal behavior, premature treatment termination, psychiatric hospitalizations, substance abuse, anger, and interpersonal difficulties. Some research also indicates that teens are very receptive to the techniques used in DBT-A.

LOSS AND BEREAVEMENT PROGRAM FOR CHILDREN AND ADOLESCENTS (L&BP)

L&BP is a group intervention program designed to alleviate anxiety, heightened imagery, frightening dreams and misconceptions about death in children aged six through adolescence who have experienced the death of a parent, caregiver, or other significant family member or friend resulting in simple or complicated bereavement. It can be used for recent losses as well as longer term recovery.

The program consists of twelve sixty to ninety-minute once weekly group sessions and one or two joint sessions with each child's surviving parent or caregiver and the child conducted by mental health professionals. It employs intervention techniques designed to help children

understand death, and discuss and answer questions about death. L&BP follows J. W. Worden's four tasks of mourning: accepting the reality of the loss, experiencing the pain of grief, adjusting to living without the deceased, and emotionally relocating the deceased and moving on with life. School counselors refer students to the program.

L&BP has been found to be effective for Hispanics/Latinos and African Americans residing in with inner cities and has been used in New York City since 1991. Participation has been found to lead to improvements in school attendance and positive and students report satisfaction with the program. Information regarding L&BP can be obtained from the Jewish Board of Family and Children's Services at www.jbfcs.org.

INTEGRATIVE TREATMENT OF COMPLEX TRAUMA (ITCT)

ITCT is a developmentally adapted intervention model for children, adolescents, and young adults aged two to twenty one that addresses issues related to complex trauma (e.g., attachment disturbance, chronic negative relational schema, behavioral and affect dysregulation, interpersonal difficulties, and identity-related issues). It addresses trauma stemming from physical abuse, sexual abuse, emotional abuse, neglect, community violence, domestic violence, medical trauma, traumatic loss, and parental substance abuse.

The model incorporates protocols for empirically based interventions for complex trauma and is comprised of multiple treatment modalities including cognitive therapy, exposure therapy, play therapy, and relational treatment in individual, group, collateral and family therapy modalities. It also includes aspects of the Self Trauma model[10], Trauma-Focused Cognitive Behavioral Therapy, and traumatic grief therapy[11]. Therapeutic exposure and exploration of trauma are facilitated in a developmentally appropriate and safe context and focus on increasing affect regulation capacities, enhancing self-esteem, and increasing a sense of self-efficacy. The relationship with the therapist is deemed critical to the effectiveness of ITCT; safety and trust are necessary components.

ITCT has been found relevant for Hispanics/Latinos, African Americans, Caucasians, and Asian Americans of varying socioeconomic status residing in rural and urban areas. It addresses issues specific to individuals with socioeconomic challenges (e.g., transportation barriers) and various cultural experiences (e.g., faith and spirituality). ITCT has been adapted for use in office-based and school settings.

Treatment is based on needs identified through regular administration of standardized assessment protocols as well as developmental and cultural considerations. The average number of sessions ranges from sixteen to thirty six. Immediate trauma-related issues (e.g., anxiety, depression, and posttraumatic stress) are addressed earlier in treatment to increase the capacity to explore more chronic and complex trauma issues.

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[10] The trauma model, developed by Briere, is comprised of humanistic, psychodynamic, and cognitive-behavioral theories. The model includes respect, positive regard, and the assumption of growth. Safety, support, therapeutic feedback, and working through the trauma are key principles.

[11] Traumatic grief therapy incorporates strategies from interpersonal therapy for depression (which is discussed in SCCMHA's *A Guide to Evidenced-Based Practices for Adults with Mental Illness* and *A Guide to Evidence-Based Mental Health Practices for Children, Adolescents and their Families*) and cognitive behavior therapy for PTSD. It aims to crease the intensity of grief, facilitate the ability to enjoy fond memories of the deceased, and support re-engagement in daily activities and relationships with others. This manualized intervention is delivered in approximately sixteen sessions over the course of four months. Imaginal (re-experiencing the death scene) and in vivo exposure is used targeting situations the bereaved individual is avoiding. Interpersonal therapy methods are used to help with re-engage in relationships with others.

School-based program studies have demonstrated significant reductions in depression, posttraumatic stress, dissociation, and internalizing and externalizing symptoms. Office-based studies have shown significant decreases in symptoms of anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns. It should be noted that longer treatment is sometimes required and the model is less structured/manualized than other interventions for trauma. In addition, empirical/research support has not included comparison with control groups. Materials are available in English and Spanish and information on ITCT can be obtained from www.johnbriere.com.

TRAUMA AND GRIEF COMPONENT THERAPY (TGCT)

TGCT is a promising multi-component manualized treatment for children, adolescents, and young adults aged twelve to twenty who have been exposed to trauma and are experiencing traumatic bereavement. It can be implemented in schools, community mental health, and other service delivery settings. It is specifically tailored to adolescent issues surrounding trauma and loss. The program targets youth who have been impacted by community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist events. It focuses on identifying and remediating disturbances in developmental progression resulting from trauma or loss.

TGCT is assessment-driven; specific treatment modules are selected for implementation based on presenting problems, strengths, and needs. It is typically conducted over the course of ten to twenty four fifty-minute individual sessions but the length of treatment is variable and depends on the number of modules implemented. Participants with higher levels of distress are more likely require longer and more intensive intervention. Sessions can be reduced in length to accommodate school class periods or expanded to ninety minutes as needed.

The intervention consists of psychoeducational exercises, skill building exercises, and group or family based interventions that focus on individual differences in responses to trauma or traumatic loss arising from cultural, developmental, or exposure-based influences. Initial sessions address potential stigma related to mental health treatment and other barriers to participation. A grief component emphasizes sensitivity to cultural, developmental, or religious/spiritually connected differences in responses to death. The grief module provides psychoeducation, focuses on reducing traumatic grief, and promotes adaptive grieving and mourning. A family-focused intervention component is also included. TGCT is comprised of the following components:

- Initial assessment, case conceptualization, and treatment planning
- Psychoeducation
- Emotional regulation skills
- Addressing youths' and families' traumatic stress experiences and reactions
- Promoting adaptive coping (e.g., social support, problem-solving, contending with trauma and loss reminders)
- Addressing maladaptive beliefs relating to trauma and loss
- Promoting adaptive developmental progression
- Addressing grief and loss
- Maintaining adaptive routines
- Relapse prevention
- Ongoing monitoring, surveillance, and evaluation of treatment response
- Family/parent sessions are offered at key points in treatment

TGCT has been implemented and evaluated in both individual and group-based modalities. It has been found to benefit multiracial and cultural groups in a variety of rural, inner city, urban, and post war locales (e.g., war-exposed Bosnian adolescents, multi-racial, multi-ethnic middle and high school students exposed to community violence and school shootings in California, youths exposed to a massive earthquake in Armenia, and adolescents exposed to the September 11th 2001 terrorist attacks in New York City). Outcome studies indicate significant reductions in PTSD, depression, and complicated grief reactions, as well as improvements in school behavior.

A two-day training with ongoing supervision and consultation are required for implementation of this intervention. Available materials include a variety of assessment instruments specifically tailored to support initial assessment, monitoring, and evaluation of participants' responses to treatment, as well as an interview protocol, a manual, and a workbook for participants containing numerous handouts and exercises. Information can be obtained from Christopher Layne, Ph.D. (cmlayne@mednet.ucla.edu) or Bill Saltzman, Ph.D. (wsaltzman@sbcglobal.net) of the UCLA National Center for Child Traumatic Stress.

PHARMACOTHERAPY

Medication is not considered a first-line treatment for symptoms of trauma, especially for younger children but may be considered for the amelioration of severe and incapacitating symptoms of trauma (e.g., extreme hyperarousal and emotional reactivity) and the presence of comorbid psychiatric disorders. However, few randomized, controlled studies involving use of psychotropic medication for trauma symptoms in children have been conducted. Moreover, some medications used for the treatment of PTSD are not approved by the FDA for this purpose, nor are they approved for children and are thus used off-label. It is recommended that when medication is prescribed, it is used to address specific target symptoms that are monitored over time and is not sedating to children.

Medication can reduce the anxiety, depression, and insomnia that often accompany PTSD and, in some instances, may also relieve the distress and emotional numbness caused by traumatic memories. Several antidepressant drugs have yielded mostly positive results in clinical trials. Antidepressant drugs used to control PTSD symptoms include tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), and selective serotonin reuptake inhibitors (SSRIs). The latter are considered first-line medications for trauma symptoms as these also have anxiolytic properties, have been shown to be effective for all categories of PTSD, and are currently the most widely used and best studied.

Medications that specifically target hyperarousal and hyperactivity include the adrenergic agents, clonidine or guanfacine. Extreme mood lability and uncontrollable anger may respond to mood stabilizers (e.g., lithium, valproic acid, and carbamazepine). Clonazepam regulates anxiety and panic symptoms. Atypical neuroleptics (e.g., risperidone, olanzapine, quetiapine, aripiprazole, etc.) in low doses can also be helpful in addressing hyperarousal and symptoms of anger and mood lability.

In sum, medication alone is rarely, if ever, adequate to address significant symptoms of trauma. Moreover, no specific medication has shown to be a definitive treatment for PTSD, although pharmacotherapy is effective for providing immediate relief of traumatic symptoms. Medication is not recommended as a sole treatment for trauma, but rather as a means of stabilization so that psychotherapeutic interventions can be provided effectively.

OBJECTIVE MEASUREMENT OF TRAUMA

Studies indicate that mental health screening and surveys of trauma exposure are helpful in planning and implementing intermediate and long-term services for students and staff. However, it has yet to be determined when it is most optimal to institute such measures. In addition, there is concern that the use of assessment instruments too soon subsequent to the occurrence of a traumatic event may compound its effects on the victims/survivors. Thus, subtler methods of detection (e.g., teacher and parent referrals) have been suggested as more appropriate for determining mental health treatment needs. Nonetheless, screening conducted with appropriate trauma assessment instruments can be used to determine which individuals who have experienced trauma require more individualized or intensive services and supports. In addition, to risk screening, validated Instruments can be used for triage, monitoring, and/or program/intervention effectiveness evaluation. Examples of these include the following:

Traumatic Experiences Screening Inventory – Revised (TESI-R)
The TESI is a fifteen-item clinician-administered interview that assesses a child's experience of a variety of potential traumatic events (e.g., current and previous injuries, hospitalizations, domestic violence, community violence, disasters, accidents, physical abuse, and sexual abuse), PTSD, and additional information about the specifics of the event(s). The TESI-CRF-R is a revised twenty four-item version of the original TESI. It was revised to be more developmentally sensitive to the traumatic experiences that young children may experience. It is available in a child-report form (TESI-CRF-R) and a parent report form (TESI-PRF-R). The instrument is available from Chandra Ghosh Ippen at Chandra.ghosh@ucsf.edu.

Child Posttraumatic Stress Reaction Index (CPTS-RI)
The CPTS-RI (also known as the Reaction Index) is a twenty-item interviewer-administered scale for children between ages six and seventeen that assesses DSM-IV symptoms of PTSD as well as guilt, impulse control, somatic symptoms, and regressive behaviors. Items are rated on a five point frequency scale ranging from none to most of the time. The CPTS-RI yields total scores ranging from zero to eighty in accordance with the frequency of symptoms. Categories of degree of disorder, from doubtful to very severe, can be assigned based on the total scale score. A parent's versions is also available.

Trauma Symptom Checklist for Young Children (TSCYC)
The TSCYC is a ninety-item caretaker report instrument with separate norms for males and females in three age groups: three to four years of age, five to nine years of age, and ten to twelve years of age. Caretakers rate each symptom on a four-point scale in accordance with how frequently the symptom has occurred during the previous month. The TSCYC contains eight Clinical scales: Anxiety, Depression, Anger/Aggression, Posttraumatic Stress-Intrusion, Posttraumatic Stress-Avoidance, Posttraumatic Stress-Arousal, Dissociation, and Sexual Concerns, and a summary posttraumatic stress scale (Posttraumatic Stress-Total). These scales provide a detailed evaluation of posttraumatic stress and information regarding other symptoms experienced by many children who have been traumatized. The TSCYC is appropriate for English-speaking caretakers, including those with relatively low reading levels. The TSCYC materials consist of a Professional Manual, Item Booklet, Answer Sheet, and age and gender-specific Profile Forms. Once the TSCYC is administered to the caretaker, the Answer Sheet is hand-scored by an examiner using the Scoring Sheet and the PTSD Diagnosis Worksheet. The raw scores are then converted and plotted as T scores in accordance with the child's age and gender. The PTSD Diagnosis Worksheet helps ascertain the status of PTSD accordance with DSM-IV-TR™ criteria. The Professional Manual includes several examples

scoring and interpreting the TSCYC. Information regarding this instrument can be found at http://www3.parinc.com/products/product.aspx?Productid=TSCYC.

Life Stressor Checklist—Revised (LSC-R)
The Life Stressor Checklist-Revised is a self-report measure that assesses traumatic or stressful life events. It includes a focus on events relevant to women (e.g., abortion). The questionnaire takes account of thirty life events, including experiences with natural disasters, physical or sexual assault, death of a relative, and other events in a yes/no format. Respondents are asked to provide the age at which the event began, the age when the event ended, if they believe they were hurt, and whether they have feelings of helplessness for endorsed events. The affect on life and how upsetting event was at the time are rated on a five-point intensity scale (from 1 = not at all to 5 = extremely). Respondents are asked to identify the three events that currently have the greatest impact on them.

Clinician-Administered PTSD Scale (CAPS)
The CAPS is considered the gold standard in assessing PTSD. It is a thirty-item structured interview that corresponds to the DSM-IV criteria for PTSD that can be used to make a current (past month) diagnosis, lifetime diagnosis of PTSD, or assess symptoms over the past week. Questions also target the impact of symptoms on social and occupational functioning, improvement in symptoms since a previous CAPS administration, overall response validity, overall PTSD severity, and frequency and intensity of five associated symptoms (i.e., guilt over acts, survivor guilt, gaps in awareness, depersonalization, and derealization). Standardized questions and probes are provided for each item. The Life Events Checklist is used to identify traumatic stressors experienced as part of a trauma assessment (Criterion A). CAPS items are asked in reference to up to three traumatic stressors. The full interview takes from forty five to sixty minutes to administer, but not all parts (e.g., associated symptoms) need to be administered.

Life Events Checklist (LEC)
The Life Events Checklist is a measure of exposure to potentially traumatic events that is used concurrently with the CAPS to facilitate a diagnosis of PTSD. It contains forty six self-report items representing a wide range of possible life events. Respondents can endorse the occurrence of an event in the past year and how they would rate the event (i.e., good or bad). Respondents can also rate the degree to which the event impacted their lives (i.e., four point Likert rating scale).

Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)
The CAPS-CA is a thirty three-item clinician-administered PTSD scale for children and adolescents aged eight to eighteen. It is a modified version of the CAPS that contains items adapted to make them age appropriate and the addition of picture response options. It contains practice questions to help familiarize children with the assessment. The Life Events Checklist is used to identify traumatic events. Like the CAPS, the CAPS-CA measures the frequency and intensity of DSM-IV PTSD symptoms as well as the impact of those symptoms on aspects of functioning (e.g., overall distress, coping skills, and impairment). Items assess overall severity, validity of ratings, associated symptoms, and coping strategies in addition to current and lifetime diagnoses. Items are scored on five-point frequency (e.g., 0 = none of the time, 4 = most of the time) and five point intensity rating scales (from 0 = not a problem to 4 = a big problem, I have to stop what I am doing) for the past month.

My Worst Experiences Survey (MWES)
This measure asks children about their most stressful experiences and associated reactions. Part 1 assesses twenty one stressful events (e.g. abuse, disaster, and family problems) and asks children to select their worst event. They are then asked six more questions about that

event. In Part II, children are asked to rate the frequency and duration of 105 possible thoughts, feelings and behaviors they may be experiencing in response to the endorsed events. Items are rated on five point scales (from 1 = one time to 5 = all of the time). The MWES can be completed in twenty to thirty minutes for children/adolescents who read at a third-grade level or higher. Responses to Part II yield a Total Score, Inconsistent Responding Index, DSM-IV PTSD Criteria Scores, and Symptom Subscales for depression, hopelessness, somatic symptoms, oppositional conduct, hypervigilance, dissociation/dreams, and general maladjustment. Another version of the instrument, the My Worst School Experience Survey, focuses on stressful events that occur at school.

Child Post-Traumatic Stress Symptoms Scale (CPSS)
The CPSS is a twenty six-item self-report measure that assesses PTSD diagnostic criteria and symptom severity in children aged eight to eighteen. It includes two event items, PTSD symptom items, and seven functional impairment items. Symptom items are rated on a four-point frequency scale (from 0 = not at all to 3 = 5 or more times a week). Functional impairment items are scored as 0 = absent or 1 = present. The CPSS yields a total symptom severity scale score (ranging from 0 to 51) and a total severity-of-impairment score (ranging from 0 to 7). Scores can also be calculated for each of the three PTSD symptom clusters (i.e., B, C, and D).

Children's Impact of Traumatic Events Scale-Revised (CITES-2)
The CITES-2 is the most recent version of the CITES, a seventy eight-item clinician-administered scale that assesses the effects of sexual abuse on children between the ages of eight and sixteen. It is designed as a continuous assessment measure but can be used to determine diagnostic status. Items are rated on a three point Likert scale (i.e., not true, somewhat true, very true). The CITES-R is comprised of four main scales and eleven subscales: (1) PTSD (Intrusive Thoughts, Avoidance, Hyperarousal, and Sexual Anxiety); (2) Social Reactions (Negative Reactions from Others and Social Support); (3) Abuse Attributions (Self-Blame and Guilt, Empowerment, Personal Vulnerability, and Dangerous World); and (4) Eroticism. A twenty five-item CITES-Family Violence Form (CITES-FVF) that assesses the effects of family violence on a child is also available.

Childhood PTSD Interview
The Childhood PTSD Interview is a ninety five-item semi-structured interview that assesses DSM-IV PTSD diagnosis and associated symptoms. It includes a description of the event(s), sixty three symptom items (with three to six items for each DSM-IV symptom), and thirty two associated symptom items (with two to five for each of eleven associated symptoms). Each item is rated dichotomously as being present or absent (i.e., yes/no). The Childhood PTSD Interview yields a categorical score of PTSD diagnosis as well as a continuous severity score obtained by adding all endorsed items. The questions are written at the third-grade reading level, but the instrument has been used with younger children. There is also a Parent Form that assesses the same dimensions as the Child Form using language appropriate for adults in which a parent answers the questions with respect to their child's symptoms. The forms may also be used in a self-report format. Either interview can be administered by paraprofessionals.

When Bad Things Happen Scale (WBTH)
The WBTH scale is a ninety five-item self-report inventory. The questions contained in this instrument parallel the questions in the Childhood PTSD Interview and can be used as a complement to the interview. It includes sixty three DSM-IV symptom items (with three to six per symptom) and thirty two associated symptom items (with two to five questions per associated symptom). Items are rated on a three-point frequency scale (i.e., never, some, lots). The WBTH yields a categorical diagnosis of PTSD as well as a continuous severity score. A scoring system template is provided with the scale. It is written at a third-grade reading level and includes a parent report version.

Children's PTSD Inventory (CPTSDI)
The CPTSDI is a clinician-administered scale for children between six and eighteen years of age. Items are based on DSM-IV diagnostic criteria for PTSD. Examples of traumatic experiences are described and the child is asked they have ever experienced a scary event and, if so, whether they felt upset when it happened and/or felt they could do nothing to stop it from happening. If an event meets screening criteria, symptoms are assessed in reference to that event, including eleven items concerning re-experiencing symptoms, sixteen concerning numbing and avoidance, and seven concerning arousal. Questions related to the duration of symptoms are also asked. The instrument yields dimensional and categorical scores to indicate severity and presence of a diagnosis of PTSD. In addition, scores on five subscales (Situational Reactivity, Re-experiencing, Avoidance and Numbing, Increased Arousal, and Significant Impairment) are yielded. The CPTSDI is available in English and Spanish.

Trauma Symptom Checklist for Children (TSCC and TSCC-A)
The TSCC is a fifty four-item self-report scale for evaluating children who have experienced traumatic events (e.g., physical and sexual assault, victimization by peers, major losses, witnessing violence to others, and natural disasters) that can be administered on an individual or group basis. It consists of two validity scales (indicating over and underreporting of symptoms) and six clinical scales (Anxiety, Depression, Posttraumatic Stress, Sexual Concerns, Dissociation, and Anger). The child is presented with a list of thoughts, feelings, and behaviors and asked to mark how often each happens to them. Items are rated on a four point scale (from 0 = never to 3 = almost all the time). It is written at an eight year old reading level and has been normed for boys and girls between the ages of eight and sixteen. The TSCC is available in two versions: a full fifty four-item test that includes ten items related to sexual symptoms and preoccupation, and a forty four-item alternate version (TSCC-A) that makes no reference to sexual issues (and has no Sexual Concerns scale) and includes seven Critical Items. Information can be obtained from http://shop.acer.edu.au/acer-shop/group/TSC.

UCLA PTSD Index for DSM-IV
The UCLA PTSD index for DSM-IV, one of the most widely used instruments, consists of a series of self and parent-report instruments which are brief screening tools for exposure to traumatic events and for all DSM-IV PTSD symptoms in school-age children and adolescents who report traumatic stress experiences. The items of the UCLA PTSD indices are keyed to DSM-IV criteria and can provide preliminary PTSD diagnostic information. Self-reports for children, adolescents and parental report of PTSD symptoms are available. An example can be downloaded from http://thriveinitiative.org/files/forms/UCLA_PTSD_Index.pdf.

CHILDHOOD PTSD INSTRUMENTS						
Child Measures	Target Age Group	Format	# of items	Time to Admin. (min.)	Allows Multiple Trauma	Corresponds to DSM-IV Criteria
Traumatic Events Screening Inventory*(TESI)	4 and up	Interview	18/varies	10-30	Yes	Yes
Childhood PTSD Interview	n.s.	Interview	93/1	15-20	Yes	Yes
Children's Posttraumatic Stress Disorder Inventory (CPTSDI)	7-18	Interview	43/1	15-20	Yes	Yes
Clinician-Administered PTSD Scale for Children & Adolescents (CAPS-CA)	7-18	Interview	33/2	30-120	Yes	Yes
My Worst Experiences Survey	9-18	Self-Report	105	20-30	No	Yes
UCLA PTSD Index for DSM-IV	7-12 child, 13+ adol.	Self-Report	48	15-20	Yes	Yes
When Bad Things Happen Scale (WBTH)	8-13	Self-Report	95/1	10-20	No	Yes
Child PTSD Reaction Index*(CPTS-RI)	6-17	Interview	20	15-20	No	No
Child PTSD Symptom Scale (CPSS)	8-18	Self-Report	26	10-15	Yes	Yes
Children's Impact of Traumatic Events Scale-Revised (CITES-2)	6-18	Interview	78	30-45	Yes	Yes
CPTS-RI Revision 2 (PTSD Index for DSM-IV)	6-17	Interview	20	15-20	No	No
Parent Report of Child's Reaction to Stress	n.s.	Parent Report	79	30-45	Yes	No
Trauma Symptom Checklist for Children (TSCC)	6-17	Interview	54/1	10-20	Yes	No
Trauma Symptom Checklist for Young Children (TSCYC)	3-12	Caregiver-report	54/1	20-30	Yes	No
*n.s. - not specified						

(National Center for Posttraumatic Stress Disorder)

APPENDIX A: SELECTED REFERENCES

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APPENDIX B: SELECTED RESOURCES

American Academy of Child and Adolescent Psychiatry (AACAP): www.aacap.org
American Psychiatric Association: http://www.psych.org
American Psychological Association: http://www.apa.org
    Information on trauma: http://www.apa.org/topics/topictrauma.html
American Red Cross: http://www.redcross.org
Anxiety Disorders Association of America (ADAA): http://www.adaa.org
Federal Emergency Management Agency (FEMA) Information for Children & Adolescents: www.fema.gov/kids/
Center for Effective Collaboration and Practice, American Institutes for Research: http://www.air-dc.org/cecp/
Center for Mental Health in Schools: http://www.smhp.psych.ucla.edu/
Center for Mental Health Services (CMHS): http://www.mentalhealth.org/cmhs/emergencyservices/index.htm
Center for Mental Health Services, Knowledge Exchange Network: http://www.mentalhealth.org/index.htm
Center for the Study and Prevention of Violence (CSPV): http://www.colorado.edu/cspv/index.html
Centers for Disease Control and Prevention (CDC): http://www.cdc.gov
    Emergency Preparedness and Response: http://www.bt.cdcgov/
    Trauma and disaster mental health resources: http://www.bt.cdc.gov/mentalhealth/
    National Center for Injury Prevention and Control: http://www.cdc.gov/ncipc/
    Division of Violence Prevention (DVP): http://www.cdc.gov/ncipc/dvp/dvp.htm
ChildTrauma Academy: http://www.childtrauma.org/default.asp
Child & Family Disaster Research Training & Education Initiative (DRT): http://tdc.ouhsc.edu/drt.htm
Emergency Response and Crisis Management Technical Assistance Center: http://www.ercm.org
International Critical Incident Stress Foundation: www.icisf.org
International Society for Traumatic Stress Studies (ISTSS): http://www.istss.org
Michigan Division of Emergency Management: http://www.michigan.gov/emd
National Association of School Psychologists: http://www.naspweb.org/center.html
National Association of School Psychologists National Emergency Assistance Team: www.nasponline.org/NEAT
National Center for Children Exposed to Violence: www.nccev.org/violence/children_terrorism.htm
National Center for School Crisis and Bereavement: http://www.cincinnatichildrens.org/svc/alpha/s/school-crisis/default.htm
National Center for PTSD: http://www.ncptsd.org
Nation Center for Trauma-Informed Care (NCTIC): http://www.mentalhealth.samhsa.gov/nctic/default.asp
National Center for Victims of Crime: http://www.ncvc.org/ncvc/Main.aspx
National Child Traumatic Stress Network (NCTSN): www.NCTSN.org
National Clearinghouse for Educational Facilities: http://www.edfacilities.org/
National Education Association (NEA) Crisis Response: http://neahin.org/crisisguide/index.html
National Institute of Mental Health (NIMH): http://www.nimh.nih.gov
National Mental Health Association: www.nmha.org/reassurance/anniversary/index.cfm

National Mental Health Information Center: www.mentalhealth.samhsa.gov
National Organization for Victim Assistance (NOVA): http://www.trynova.org/
Office for Victims of Crime Resource Center: http://www.ncjrs.org
Partnership for Results: http://www.partnershipforresults.org
Promising Practices Network of the Rand Corporation: http://www.promisingpractices.net
Ready Campaign: http://www.ready.gov
Safe Kids: http://www.usa.safekids.org/
Substance Abuse and Mental Health Services Administration (SAMHSA):
http://www.samhsa.gov/trauma/index.aspx
U.S. Department of Education: : http://www.ed.gov
U.S. Department of Education Office of Safe and Drug-Free Schools (OSDFS):
http://www.ed.gov/about/offices/list/osdfs/index.html
U.S. Department of Education Emergency Management for Schools (REMS) Technical Assistance Center: http://rems.ed.gov/
U.S. Department of Homeland Security: http://www.dhs.gov
U.S. Department of Justice: http://www.usdoj.gov
U.S. Safe Schools: http://www.ussafeschools.org/