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Increasing the use of Trauma-Sensitive Lens for School Case Managers: A Training Assessment

Breanne Thomas
mcinnisbl1@gmail.com

Becky Scott
Baylor University, becky_scott@baylor.edu

David K. Pooler
Baylor University, david_pooler@baylor.edu

Introduction

Almost 70% of children and adolescents have experienced a potentially traumatic event by the time they are 16. Of the children and adolescents who have experienced a traumatic event, 50% experienced a second event. Furthermore, more than 20% of these children who had witnessed a traumatic event also had school problems, emotional difficulties, and physical problems (Copeland, Keeler, Angold & Costello, 2007). With many youth experiencing trauma, it is important to have a clear definition of trauma as well as an understanding of the different types of trauma. Trauma is defined as:

> an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; witnessing an event that involves death, injury, or a threat to the physical integrity of another person or learning about unexpected of violent death, serious harm, or threaten of death or injury experienced by a family member or other close associate (Little, Akin-Little, & Somerville, 2011, p. 449).

Because the definition of trauma is very inclusive, counting even exposure to a violent event as possible trauma, it is necessary to understand the different types of trauma. Acute trauma is exposure to a single event in a limited time. Examples of this type of trauma are a serious accident, community violence, natural disasters, sudden or violent loss of a loved one, or physical and sexual assault (Centpatico, 2012). Another type of trauma is chronic trauma, which refers to the experience of multiple frightening events. These events can be a continuation of one event, such as repeated domestic violence, or when an individual is exposed to two or more different and unrelated events, such as being in a fatal car accident and then being exposed to community violence (Centpatico, 2012). Finally there is complex trauma, such as ongoing sexual

or physical abuse. Complex trauma describes exposure to chronic trauma as well as the impact of such exposure. There are many effects that trauma exposure can have on a child, including attachment, biological, cognitive, and behavioral effects.

We wonder how school-based professionals are equipped to handle the complex challenges of assessing and working with students who have experienced trauma. In this manuscript we report results of a one-day training for school-based case managers and then discuss the importance and implications of equipping school-based professionals to use a trauma sensitive lens. We pretested case managers on their knowledge and comfort of working with traumatized students and tested their knowledge immediately after the training and then again at one month post- training. We begin with a review of the literature.

Review of the Literature

Trauma in Children and Adolescents

> For the victims of traumatic events, as well as those who work with them, the period after may be more realistically identified as a beginning rather than an ending, an often prolonged time and space of suffering, pain, and hardship-a hell on earth (Fournier, 2002, p. 113).

Sadly, studies have shown that many of these people living "a hell on earth" are children and adolescents in the United States. It appears most children and adolescents living in the United States have experienced at least one traumatic event. In fact, one study found that of 1,467 youth participants, only 29% had *not* experienced a traumatic event in the year prior to the study (Overstreet & Mathews, 2011). After experiencing trauma, the majority of youth experience distress in the first few weeks after the event. They may feel scared, avoid reminders

about the event, become distracted easily, lose interest in various social activities, or demonstrate regressive behavior (Alstic, 2012).

Many children who experience trauma are resilient and able to recover quickly. As time progresses, the symptoms of trauma begin to fade. On some occasions, children may actually grow and improve in their functioning through a process referred to as Post-Traumatic Growth (Little, Akin-Little & Somerville, 2011). However, for other children and teens, the consequences of a traumatic event are serious and long lasting (Alstic, 2012).

Symptoms of trauma are different in each child. Trauma exposure can affect many aspects of the child or adolescent's life, including: attachment with others, affect regulation, memory, behavior control, self-concept, and potential hypersensitivity to the world (Leeb, 2012). Youth who have been traumatized may experience depression, anxiety, or engage in disruptive behavior (Overstreet & Mathews, 2011). In addition, children who have been exposed to trauma and have not developed positive coping strategies may engage in high-risk or destructive coping behaviors more frequently than their counterparts (Leeb, 2012).

Deficits in executive functioning and attention regulation are forms of cognitive impairment associated with exposure to trauma (Overstreet & Mathews, 2011). When a child or adolescent is exposed to a traumatic event, it triggers the natural fight-or-flight response. If the child or adolescent remains in that fight-or-flight mode, physiological changes can occur including inhibited brain development and inhibited physical growth. This can lead to long-lasting effects in brain functioning as well as possible impairment (O'Neill, Guentte & Kichenham, 2010).

Impact of Trauma on School Performance

With all the potential effects trauma may have on children or adolescents, it is easy to see how some have trouble in school. Youth who have experienced trauma report higher incidences of emotional, behavioral, developmental, physical, and academic difficulties (Hansel et al., 2010). Traumatized children and adolescents often bring the consequences of the trauma with them into the classrooms. These externalized or internalized consequences impact their academic achievement and possibly the academic success of those around them. Youth exposed to trauma display a wide variety of reactions to what is happening around them including withdrawal, acting out, lower frustration tolerance, and noncompliance (Alisic, 2012; Tishelman, Haney, O'Brien & Blaustein, 2010).

When compared to their peers who have not experienced trauma, youth exposed to trauma frequently show greater avoidance of challenging tasks, demonstrate lower competence, flexibility, and creativity, and have more behavioral and social problems (O'Neill et al, 2010; Tishelman et al., 2010). Traumatized youth have difficulty relating to others and experience social isolation and alienation (O'Neill et al., 2010). Because students may demonstrate a vast array of consequences stemming from their traumatic experiences, their teachers may find it difficult to provide the necessary structure and order in the classroom while still being sensitive to the youth's situation and needs.

Unfortunately, many school personnel do not feel prepared to provide or help provide trauma intervention. Many teachers refer the youth to the school's psychologists and social workers to provide the services the youth needs. The teachers feel uncertain about providing the optimal support to the traumatized youth, especially when they have to look after and teach the rest of the class (Alisic, 2012; Dean et al., 2008; McAdams et al., 2009; Silva et al., 2003). Teachers and "clinicians within the school can play an integral role in bolstering resilience and

healthy coping skills in children exposed to… [trauma] in order to promote academic and social successes" (Thompson & Trice-Black, 2012, p. 234). As more schools recognize the number of traumatized students, it is imperative that school personnel are equipped to view students through a trauma sensitive lens.

A trauma sensitive lens means maintaining awareness that children who have experienced trauma may react differently to a situation than their peers who have not experienced trauma. By using a trauma sensitive lens, teachers, principals, social workers, and others are able to recognize signs of trauma that a student is displaying and recognize their triggers. They also are able to create a safe environment in which the student is able to learn and help restore safety in their life. A concrete example of this might be found in the school personnel's approach to a campus intruder or tornado drills. School personnel using a trauma sensitive approach recognize that even a rehearsal for such events could be alarming, at the least, and trigger traumatic memories for some students. Therefore, care is given to communicate with guardians and students ahead of time the purpose of the drill, the plan for the drill, and how to discuss these at home. Practicing with a trauma sensitive lens allows teachers, principals, social workers and others to acknowledge that the traumatizing situation could be occurring at school (Curtin, 2008).

Trauma Screens and Assessments in Schools

The growing trend is for schools to provide treatment or trauma interventions to the students who need it. A growing number of school-based interventions have shown positive emotional or behavioral outcomes (Nadeem et al., 2011). Schools have the unique opportunity to screen, complete assessments, and offer interventions as well as provide a referral for

intervention to their students. Many students attend school every day, which eliminates the possible barrier of transportation. Furthermore, services provided through schools help reduce the stigma of counseling and provide a familiar environment where the interventions take place (Hansel et al., 2010). Also, school-based programs provide opportunities for a long counseling relationship between the worker and the youth. Schools can provide traumatized youth the much-needed services more frequently and more easily than other agencies or organizations.

While some teachers and other school personnel may be aware of the external symptoms that a child or adolescent will display when they have been exposed to trauma, school staff has reduced clarity of what is happening in the student's life outside of school without an assessment (Tishelman et al., 2012). Without this initial assessment, teachers, school social workers, and other staff cannot be expected to realize the complexity of the student's life, including his or her history and the experiences he or she has had (Berkowistz, 2012). In fact, many professionals advocate that each student seen by a school-based mental health professional be assessed or screened for socioemotional problems *and trauma* (Tishelman et al., 2012). Outcomes can be enhanced when teachers, social workers, and other school staff incorporate a trauma informed perspective in their work (Ko et al., 2008). This can help improve quality of care for the children, enabling the students to effectively and successfully function in school and other areas of life. Unfortunately, most school-based mental health programs do not incorporate trauma assessment into their practice (Ko et al., 2008). For the schools that do an initial assessment for trauma, they rarely provide a routine screening for continuing symptoms related to trauma exposure (Greenson et al., 2010). Schools, including the mental health professionals working there, need to realize the importance of assessing for trauma and how a comprehensive trauma screening is

essential for making appropriate referrals or choosing an appropriate intervention for the student (Greenson et al., 2010).

There is no single pattern of problems that occur or symptoms displayed after a child or adolescent has been traumatized (Mohammadkhani, Nazari, Dogaheh, Mohammadi, & Azadar, 2007). It is, therefore, necessary for the school employees, including social workers or other mental health professionals, to work together to address the holistic needs of the student who has been traumatized. In addition to learning about trauma, they also need to be trained in why screening for trauma and assessing for potential trauma symptoms is important. Unfortunately, many therapists, social workers, and other professionals struggle with either incorporating a trauma screen or assessment into their practice, or effectively identifying potential traumatic events and symptoms, or both (Henry & Sloane, 2011).

However, there are effective tools that can be used to identify trauma or its symptoms. A trained practitioner can utilize the Trauma History Profile, Trauma Symptom Checklist for Children, Trauma Symptom Checklist for Young Children, the Children's Trauma Assessment Center (CTAC) assessment, Trauma History Screen, Brief Trauma Questionnaire, Traumatic Life Events Questionnaire, and the DSM 5, among many others, to effectively screen for potentially traumatic events and assess a student for symptoms of trauma (Greeson et al, 2010; Henry & Sloane, 2011; Leeb, 2012; Mohammadkhani et al., 2007). Once a student is screened or assessed for trauma, the mental health professional is able to determine the next appropriate steps to helping the child or adolescent become resilient from the trauma.

Practicing with a Trauma Sensitive Lens

With the amount of potentially traumatic events that students may experience, schools and other professionals working within the education systems have begun looking at the best

way to handle the trauma students bring to school with them. Schools are starting to use trauma screens and trauma assessments when working with students who have been exposed to traumatizing events. However, some professionals do not believe that screening and assessing for trauma is enough. For example, Susan Cole, director of the Trauma Learning Policy Initiative, suggested that without a school wide approach, the role trauma plays in learning is difficult to address (Harvard School of Law, 2012).

In fact, legislation in Washington, Montana, and Massachusetts has led to training for school personnel to enhance safety and improve environments as related to issues of trauma. In this type of learning environment, school personnel and mental health professionals have the opportunity to address the effects trauma has on each of the students' lives (Curtin, 2008). More specifically, in Massachusetts, all school personnel are trained to use a trauma sensitive lens.

Once a social worker, teacher, or other school personnel is able to recognize the presence of trauma in a student's life, the professional is able to help reduce the impact of trauma as a barrier and link the child to the help that they need (2008). Recent events such as the shooting at Sandy Hook Elementary School and Hurricane Sandy, have shown politicians, parents, and school districts alike the importance of using a trauma sensitive lens when working with students.

Purpose

We developed a training program for an agency that provides mental health services in schools on how to assess youth for trauma. The training was provided to case managers in one school-based social service agency that serves elementary, middle and high schools. We exposed the case managers to several trauma screens including the Trauma Symptom Checklist to identify traumatic events in a student's life in order to to assess for specific trauma symptoms

present in a child or adolescent's life. The goal was that the case managers would demonstrate an increase in knowledge about how students present with trauma in the school setting. Therefore a short 15 item survey was created to measure the effectiveness of the training.

Methodology

Research Design

We utilized a non-experimental pre-post test design to determine the efficacy of a one-day training on using a trauma sensitive lens in a school setting. Each case manager completed a pretest before the training, a posttest directly after the training, and a second posttest at one month after the training. The study had University IRB approval and institutional approval. We invited 25 case managers who provided direct services to children in one Texas County to participate in the study. Of the 25 case managers who were invited, 20 (80%) completed the brief survey.

Research Frame

Our study took place in an organization that provides services to children in their schools. This organization provides services to 17 schools in Texas. Students are offered services to help reduce specific barriers, such as trauma, that they have to overcome in order to achieve academic success. The partnership between this organization and schools benefits the students, families, and teachers by offering programs including drop-out prevention, tutoring, mentoring, and transition to college programs, as well as programs to help students who are trying to overcome physical or mental health challenges.

Measure and Analysis

We created a 15 item measure on a four point Lickert scale with anchors of 1 = *strongly disagree* to 4 = *strongly agree*. Example items are "I am familiar with the symptoms

traumatized children display" and "I know how to ask questions during an assessment that would help me screen for trauma". The complete survey is included in Appendix A. These items were created and initially piloted with a small group of professionals who would not attend the training. There was agreement that the items had face validity to evaluate a participant's knowledge of using a trauma sensitive lens. Because of the small number of respondents (n=20), we were not able to calculate the Chronbach's alpha for the scaled items. These 15 items were summed to create a score and we used SPSS 19 to analyze the pretest and two posttests scores. A repeated measures ANOVA was used to compare the scores of each test. For the small amount of missing data, we imputed the series mean. We also asked participants to define trauma in their own words.

Findings

Description of Sample

The participants in the study were all in the role of case manager. This role includes an overall focus on supporting the students in their academic success. Case managers provide direct services such as anger-management groups, absentee-prevention groups, resource referrals (e.g. for uniforms, family housing), as well as in-direct services such as grant-writing and supervision of mentors to the students. Most of the respondents (19) were female with the majority holding the Master of Social Work degree. The participants had been with the agency an average of 3.3 years with approximately half serving two years or less.

A repeated measures ANOVA with a Greenhouse-Geisser correction determined that there were statistically significant differences in the mean scores between the pretest and the posttest, the pretest and the post-test 30 days after the training, and the post test and the 30 day post test after the training ($F(1.473, 27.992) = 37.957$, $P = .000$). See Table 1. Post hoc tests

using the Bonferroni correction revealed that the trauma sensitive lens training elicited a large increase in score from the pretest to the posttest (42.65 to 54.15) which was statistically significant (p=.000) and a modest decrease in score from posttest to the 30 days posttest (54.15 to 48.80 p=.000). Even though the scores dropped from the posttest to the posttest 30 days later, the final measure score were still statistically significantly higher than the pretest scores (42.65 to 48.80) suggesting that at 30 days there was notable retention of the content. Therefore, we can conclude that the one-day training on using a trauma sensitive lens elicited a statistically significant increase in knowledge at posttest and 30 days after posttest.

Table 1

Score Means

	Mean	Std. Deviation	N
Pretest	42.65	4.79	20
After Training	54.15	5.23	20
One Month After Training	48.79	5.17	20

Additionally, we looked at each item to determine any unique responses. There were two questions in which the mean between the posttest and 30 day posttest increased (i.e. item 5 "I am knowledgeable about the impact trauma can have on a child of adolescent's behavior," and item 15 "This training increased my knowledge about trauma in school-aged children."

We also noted that definitions of trauma became more inclusive and stronger after the training. For example, one participant defined trauma on the pretest as "any event in a person's life that had a negative effect on that person." After the training, the participant wrote "an event in an individual's life that caused that person any significant mental, emotional, or physical

stress." Another participant initially defined trauma as "any crisis event that results in emotional mental or physical harm to the individual, often causing fear and/or anxiety about this event happening again." After the training, that same participant's definition changed to "trauma is any perceived or actual event that causes harm or threat of harm to one's physical, emotional or mental health and wellbeing – trauma may be caused by observing an event which occurred to someone else or in front of the individual."

Discussion

It is interesting to note that while the participants' knowledge increased from the training, their knowledge collectively decreased during the month between posttest one and posttest two. This suggests that while the training was effective at increasing the participants' knowledge, the participants were unable to retain everything they learned. However, as noted previously, there were two questions in which the case managers' knowledge increased during the month between the posttests (question 5 and question 15). It is possible that as the case managers worked with different students, they were able to identify and learn how trauma impacts the behavior of the students they worked with as well as learn the importance of using a trauma sensitive lens in their work. However, the overall decrease in scores between the immediate posttest and the 30 days after posttest suggest that multiple trainings or supervisory consultation focused on trauma may be needed for the case managers to retain all important information.

Strengths and Limitations of Study

There are a number of strengths as well as limitations of this study. The one-day training increased the case managers' knowledge regarding how trauma impacts the students attending schools, how the trauma manifests, and the importance of using a trauma sensitive lens when working with students. We hope this increase in knowledge is a proxy for more robust

assessments and ongoing interventions with children. In addition, this study provided direction for future trainings and educational opportunities for the case managers.

Because the sample size was small with no controls, the results of this study are not generalizable beyond the frame of the study. Additionally, we acknowledge the inability to report the Chronbach's alpha of the items as a limitation. We are also uncertain to what extent there was any response bias on the measures. Bias would be in the direction of respondents wanting to look good, so the increase in scores could be inflated. Higher scores may not actually translate into better outcomes for the children served and we did not measure any treatment or intervention outcomes. This was a preliminary study assessing the efficacy of training to increase awareness and knowledge within one agency.

The Need for Training

The current literature on trauma and children indicates that the prevalence of children experiencing trauma is significant enough that schools would benefit from considering how trauma might impact the learning environment. With 70 % of children experiencing a trauma (Copeland, Keeler, Angold & Costello, 2007) it is inevitable that each classroom will have a student in some stage of recovery from trauma. For those who work directly with mental, behavioral, and social assessment and intervention with students in schools, the need to use a trauma sensitive lens is paramount.

The results from this study indicate that preparing school-based mental health professionals to apply a trauma sensitive lens does not have to be an enormous undertaking. Based on a one-day training that was held on-site, the case managers gained information that they needed to shift their awareness to the potential presenting symptoms and needs of their students that have experienced trauma. Furthermore, without any additional training or

intervention, the majority of the knowledge they acquired was retained 30 days after the training – a strong indication that the professionals will continue to be able to recall and hopefully use the concepts.

Training Overview

The training is reproducible. A masters level social work intern researched, prepared, and delivered the training material, in consultation with (and under the supervision of) the agency supervisors, social work professionals, and professors. This no-cost training workshop was provided to the case managers at the agency during a professional development day. Additionally, because the case managers are required by the agency to accumulate a certain amount of professional development hours, the training did not cost the case managers extra time outside of their assigned duties.

The training occurred over a two hour period in which the participants explored the prevalence of childhood trauma, learned basic assessment approaches for trauma, and were presented various resources. We began the presentation with an overview of trauma, relevant definitions, effects, and examples. Because the participants all worked in schools, we also noted how the effects of trauma might present in student behavior or learning needs in a school setting. The training emphasized how using a trauma sensitive lens in a school helps children and adolescents who have experienced a traumatic event. Fifteen tips were provided to help create a trauma sensitive environment within the school where they worked. We finished the presentation by providing the participants with several resources to help screen and assess students who have experienced trauma.

The presenters reviewed in detail three different screenings that the school-based mental health worker could use. These screenings were the Trauma History Screen, the Life Events

Checklist, and Traumatic Events Screening Inventory for Children (TESI-C). We also listed nine trauma assessments that could be used after a positive trauma screen to gather additional information during intervention. The trainers noted that the use of these tools were only for the licensed clinicians in the audience and required additional training.

The social work intern used several public domain resources in developing the training. One of the most significant sources was *Helping Traumatized Children Learn,* a report that was compiled by Massachusetts Advocates for Children. This report is replete with information about the prevalence of trauma and its impact on academic and behavioral performances in school. While this report is aimed at developing a school-wide "flexible framework" for applying trauma sensitivity, it gives an action plan that can be partially incorporated by the school-based mental health practitioners, especially those that are trained social workers (Cole et al., 2005).

Additional resources used in developing the training came from the U.S. Department of Veteran's Affairs National Center for PTSD. The Center provides multiple resources on trauma and post trauma topics to the general public via their website. Some of the resources (i.e. assessment tools) that are intended for use by clinically licensed professionals can be obtained via an email in which they insure the request is from a licensed professional before sending the tools. In the training, the case managers were exposed to the Traumatic Events Screening Inventory for children and adolescents (Ippen et al., 2002). This is a screening tool for identifying specific trauma events that a student has been exposed to at any point. During the training the case managers were informed that they had to receive additional training for using clinical-level assessment tools but that understanding some of the general assessment questions can aid them in lines of questioning when conducting a general intake or a more thorough

psycho-social assessment. The case managers were asked to include assessment questioning regarding trauma exposure with each student with whom they conduct an intake – recognizing that most of the case managers in this agency provide referrals for clinical level intervention, rather than provide clinical level services themselves. Finally, the training also included information from all of the sources cited in the literature review of this manuscript.

Recommendations for Practice

This study provides preliminary evidence that short, focused training could have lasting impact on the lens that school-based professionals use when considering student needs and behavior. Therefore, despite the prevalence and impact of childhood trauma on students, a no-cost intervention of a training such as this could increase the sensitivity towards trauma that school-based case managers use when engaging students. Therefore, with reasonably small effort, school-based programs that provide case management could experience high yields such as improved accuracy in assessment for in-school services and out-of-school referrals and increased support for faculty when confronting student behaviors that may be related to trauma.

Furthermore, this type of training could be beneficial for schools that do not have case management staff. This particular training was not focused on providing intervention for students who exhibit symptoms of trauma. It focused on increasing case managers' awareness that the needs of the student may be trauma-related. This means that any staff or faculty that directly interact with students may be a candidate to increase their knowledge and use of a trauma-sensitive lens. Since the literature indicates that a trauma sensitive lens can improve the school experience for students, this allows for a school-wide paradigm that could have positive impact on student success irrespective of which type of professional is utilizing the lens (Curtin, 2008; Nadeem et al., 2011).

Conclusion

We provided a no-cost training on using a trauma sensitive lens to case managers at a school-based mental health agency. We assessed participants' knowledge before and after the training and found that participants' knowledge increased following the training and thirty days later, indicating that in-service training on using a trauma sensitive lens can be productive for school-based practitioners.

References

Alisic, E. (2012). Teachers' perspectives on providing support to children after trauma: A qualitative study. *School Psychology Quarterly*, *27*(1), 51–59. Doi:10.1037/a0028590

Berkowitz, S. J. (2012). Childhood trauma and adverse experiences and forensic child psychiatry: The Penn Center for youth and Family Trauma Response and Recovery. *Journal of Psychiatry & Law*, *40*, 5-22.

Cole, S. F., O'brien, J. G., Gadd, G., Ristuccia, J., Wallace, L., & Gregory, M. (2005). *Helping traumatized children learn; Supportive school environments for children traumatized by family violence*. Boston, MA: Massachusetts Advocates for Children.

Copeland, W. E., Keeler , G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *General Psychiatry*, *6*(5), 577-584.

Curtin, J. C. (2008). Creating trauma-sensitive schools: Reducing the impact of trauma as a barrier to student learning. *Traumatic Stress Points* , *22*(4), Retrieved from http://istss.org/source/stresspoints/index.cfm?fuseaction=Newsletter.showThisIssue&Issue_ID=80&Article_ID=1353

Fournier , R. R. (2002). A traumatic education workshop on posttraumatic stress. *Health & Social Work*, *27*(2), 113-124.

Greesom, J. K. P., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake, G. S., Ko, S. J., Gerrity, E. T., Steinberg, A. M., Howard, M.L., Pynoos, R.S., & Fairbank, J.A. (2011). Complex trauma and mental health in children and adolescents places in foster care: Findings from the National Child Traumatic Stress Network. *Child Welfare*, *90*(6), 91-108.

Hansel, T. C., Osofsky, H. J., Osofsky, J. D., Costa, R. N., Kronenberg, M. E., & Selby, M. L. (2010). Attention or process and clinical outcomes of implementing a rural school-based trauma treatment program. *Journal of traumatic stress*, *23*(6), 708-715. Doi: 10.1002/jts.20595

Harvard School of Law. (2012). *Education law clinic/trauma learning policy initiative*. Retrieved from http://www.law.harvard.edu/academics/clinical/clinics/education.html

Henry, J., & Sloane, M. A. (2012, February). *Brain-based/ trauma-informed comprehensive assessment for children & adolescents level 1*. West Michigan University Children's Trauma Assessment Center & Center For Behavioral Pediatrics, Kalamazoo, MI

Ippen, C. G., Ford, J., Racusin, R., Acker, M., Bosquet, M., Rogers, K.,…Edwards, J. (2002). Traumatic events screening inventory (TESI-PRR / TESI-SRR). Unpublished instrument. Retrieved from www.fordham.edu/childrenfirst

Ko, S. J., Kassam-Adams, N., Wilson, C., Ford, J. D., Berkowitz, S. J., Wong, M., Brymer, M. J., & Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional psychology: Research and practice*, *39*(4), 396-404.

Leeb, S. (2012, February). *Trauma informed care for school social workers and educators*. Centpactico, San Antonio, TX

Little, S. G., Akin-Little, A., & Somerville, M. P. (2011). Response to trauma in children: An examination of effective intervention and post-traumatic growth. *School Psychology International*, *32*(5), 448–463. Doi:10.1177/0143034311402916

Mohammadkhani, P., Nazari, M. A., Dogaheh, E. R., Mohammadi, M. R., & Azadmehr, H. (2007). Standardization of trauma symptoms checklist for children. *Psicologia: Teoria e Prática*, *9*(1), 75–85.

Nadeem, E., Jaycox, L. H., Kataoka, S. H., Langley, A. K., & Stein, B. D. (2011). Going to scale: Experiences implementing a school-based trauma intervention. *School Psychology Review*, *40*(4), 549–568.

O'Neill, L., Guenette, F., & Kichenham, A. (2012). 'am i safe here and do you like me?' understanding complex trauma and attachment disruption in the classroom. *British journal of special education*, *37*(4), 190-197. Doi: 10.1111/j.1467-8578.2010.00477.x

Overstreet, S., & Mathews, T. (2011). Challenges associated with exposure to chronic trauma: Using a public health framework to foster resilient outcome among youth. *Psychology in schools*, *48*(7), 738-753.

Tishelman, A. C., Haney, P., O'Brien, J. G., & Blaustein, M. E. (2010). A framework for school-based psychological evaluations: Utilizing a "trauma lens." *Journal of Child & Adolescent Trauma*, *3*(4), 279–302. Doi:10.1080/19361521.2010.523062

Thompson, E., & Trice-Black, S. (2012). School-based group interventions for children exposed to domestic violence. *Journal of Family Violence*, *27*(3), 233–241. Doi:10.1007/s10896-012-9416-6

Pretest / Posttest Instrument

1. Define trauma

Please read each question. Check the box that you believe most accurately describes you

Question	Strongly Disagree	Disagree	Agree	Strongly Agree
2. I am familiar with the symptoms traumatized children display				
3. I am familiar with the symptoms traumatized adolescents display				
4. I am knowledgeable about the impact trauma can have on a child of adolescent's academic success				
5. I am knowledgeable about the impact trauma can have on a child of adolescent's behavior				
6. I know that trauma can present symptoms that could be mistaken for symptoms of a different diagnosis				
7. I know that a traumatic experience can lead to an additional diagnosis				
8. I know how to ask questions during a assessment that would help me screen for trauma				
9. I know how to make behavioral observations when conducting an assessment that will help me screen for trauma				
10. I am knowledgeable about different types of trauma				
11. I understand that the symptoms of trauma may be similar or identical to symptoms of other diagnosis				
12. I understand why it is important for school social workers and other school personnel to screen of assess students for trauma				
13. I am knowledgeable about resources or tools that can help assess or screen students for trauma				
14. I am knowledgeable about the next steps to take once a child or adolescent has been identified as experiencing a traumatic event				
15. This training increased my knowledge about trauma in school-aged children				
16. This assessment tool will be useful when assessing the students with whom I work				

17. Other: