Best Practices in School-Based Services for Addressing Trauma

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May 18, 2018
Presentation at the Northeast PBIS Network Leadership Forum
Groton, CT

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Agenda

- Defining childhood trauma with implications for school-based prevention and intervention
- Addressing childhood trauma at the systems-level
- Review of screening for trauma exposure and response
- Responding to childhood trauma through Tier 2 and 3 trauma-specific interventions
- Providing recommendations for school-based providers

Defining Trauma

Trauma Exposure

Traumatic Experience

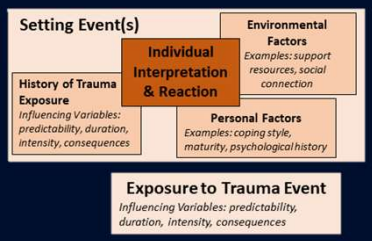
Adverse Experiences

Toxic Stress

Childhood trauma can be described as an event that poses a threat (adversity), which may be experienced by the child as harmful (physically or emotionally); the child's reaction to the traumatic experience may have enduring effects on functioning and well-being.

(SAMHSA, 2014)

Defining Trauma



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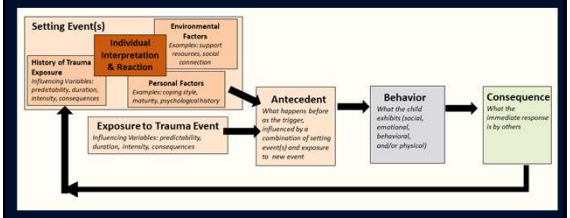
Defining Trauma



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Exposure to Traumatic Event ≠ **Maladaptive Interpretation and/or Response**

- An important aspect of trauma service delivery is determine who should receive intervention
- Avoiding re-traumatization
- Providing treatment to those with trauma exposure without an elevated response *can cause harm*

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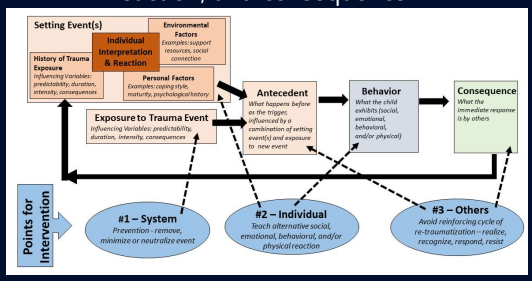
Childhood trauma cycle of exposure, reaction, and consequence



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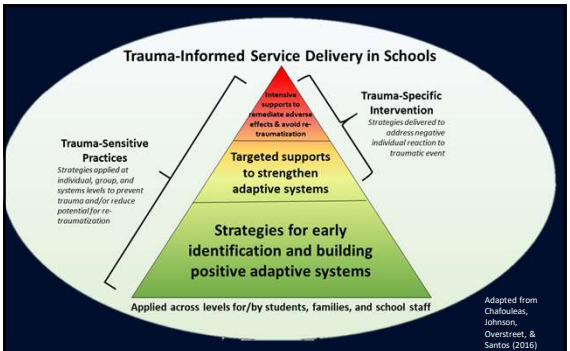
Trauma-Informed Service Delivery in Schools



Adapted from Chafouleas, Johnson, Overstreet, & Santos (2016)

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Impact of Trauma on the Systems Level

- Behavior
  - Greater discipline referrals (Eckenrode, Laird, & Dorris, 1993)
  - Greater number of suspensions (Lansford et al., 2002)
- Attendance
  - Greater number of absences (Fantuzzo et al., 2011; Hurt et al., 2001; Lansford, et al., 2002; Matthews et al., 2009; Shonk & Cicchetti, 2011; Wodarski, et al., 1990)
  - Associated with mobility/school transfers (Eckenrode et al., 1995)
  - Negatively associated with academic achievement

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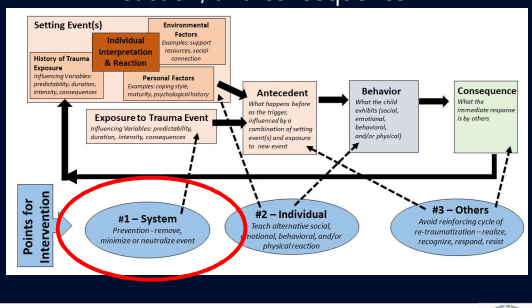
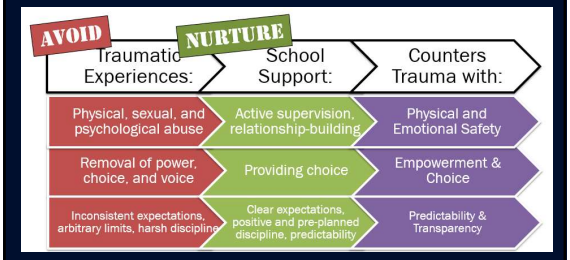
Childhood trauma cycle of exposure, reaction, and consequence

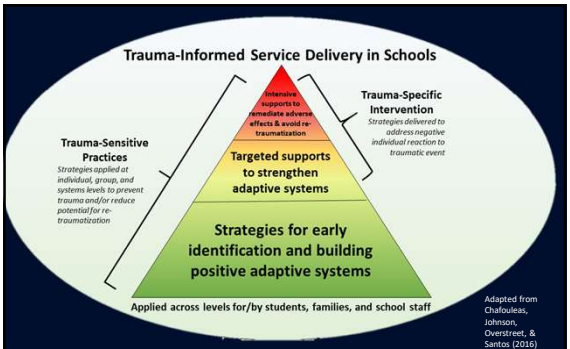


Trauma-Sensitive Strategies (School-Wide)



(EASTCONN, 2017; Wisconsin Dept. of Public Instruction, 2011; Wolpow, Johnson, Hertel, & Kincaid, 2016)

Trauma-Informed Service Delivery in Schools



Adapted from Chafouleas, Johnson, Overstreet, & Santos (2016)

Impact of trauma at the student-level

- Psychosocial (Perfect et al., 2016)
  - Teacher-reported behavioral symptomatology
  - Elevated internalizing symptoms
  - Greater externalizing symptoms
- Academic
  - Poorer academic achievement
  - Lower math and reading ability than controls (De Bellis et al., 2009; DeBellis et al., 2013; Eckenrode et al., 1993; Saigh et al., 1997)
  - More likely to be retained (Eckenrode et al., 1995; Shonk & Cichetti, 2001; Wodarski et al., 1990)

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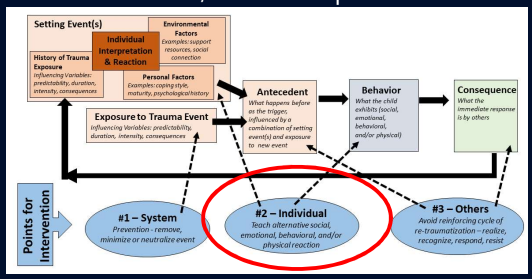
Childhood trauma cycle of exposure, reaction, and consequence



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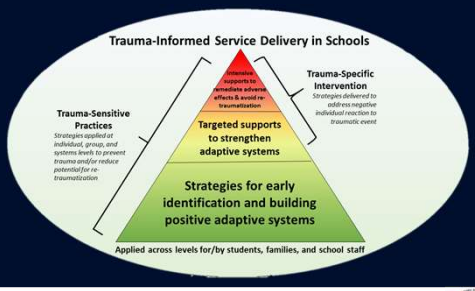
Moving from trauma-sensitive to trauma-specific interventions:



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Means of identification

?

There a trauma-specific interventions available but how should we decide who to provide these services?

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Should we screen?

- Cons
  - Can create stigma
  - Takes attention away from creating safe whole-school environments for all children (Cole et al., 2013)
  - Very little data available on how best to screen for trauma

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Canadian Collaboration for Immigrant and Refugee Health (CCIRH)

- "Routine administration of brief screening tools for PTSD has yet to demonstrate clear benefits and **could be harmful**."
- "**Do not conduct routine screening for exposure to traumatic events** because pushing for disclosure of traumatic events in well-functioning individuals **may result in more harm than good**."
- "**Brief screening instruments overestimate the rate of disease** because they focus on symptoms and do not measure functional impairment"

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Should we screen?

- Pros
  - Established association of trauma with negative outcomes
  - Can help identify resource allocation & scope of issue

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Support for Trauma Screening

- National Child Traumatic Stress Network's 7 Key Elements of Trauma-Informed Systems
  - "#1: Screen routinely for trauma exposure and symptoms. "
- Education Law Center
  - "**An annual screening** that assesses either directly or indirectly for trauma would be a **helpful primary way of obtaining information and moving towards being trauma-informed**. If the screen uncovers an experience of trauma, further assessment and referral to specialized services should take place."

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Considerations in Screening

- Consent
- Format (interview or survey)
- Who is the reporter?
- Available psychometrics
- Need to have a *clear* purpose for screening
- Plan for response


Child Trauma Screening Questionnaire

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Considerations in Screening

What are we measuring?

Exposure – Occurrence of an objective, observed experience expected to cause stress or harm

- May include ACE, child maltreatment, death of parent, natural disaster
- Can be single-event or chronic

Symptomatology – Subjective, individualized response

- Recurrent thoughts, avoidance or withdrawal, loss of appetite

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Trauma Screening Cautions

*Still very new

*Few studies have demonstrated ***efficacy*** and ***effectiveness***

*Important to identify purpose, format, method, and how data will be used

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Review of Trauma Screening Measures

Eklund, Rossen, Koriakin, & Chafouleas, in press

- Sought to conduct a systematic review of currently available trauma-related screening measures
- Identified 18 measures appropriate for school-based screening

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Methods- Inclusion Criteria

1. Trauma was chief component of measurement
2. Children, adolescents & youth as population of interest
3. Articles published since 2000
4. Identified for use as a screening measure
5. Any type of format or informant
6. Psychometric properties related to screening
7. Peer-reviewed articles published in English

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Effectiveness of Trauma Screening Measures

- Most measures over a decade old
- Most rely heavily on definition of PTSD as symptom of concern
- Out of the 18 measures:
  - 13 Self-report rating scales
  - 4 clinician-administered interview
  - 7 included parent rating scale
  - *No teacher ratings*
  - *No observational components*
- Length of time varied (5 minutes to an hour)
  4 of the measures were 48 items or more

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Efficacy of Trauma Screening Measures

- Reliability metrics offered for most measures
- Validity metrics were variable
  - Most included convergent validity data but not consistent on other validity indices
- Classification accuracy missing for most measures
- Issue with not reporting sensitivity/specificity
- Missing social validity data

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Implementation Considerations

- Psychometric evidence is lacking
  - Psychometrics of symptomatology items examined, but not exposure
  - Time consideration of false positives or false negatives – we don't know!
- Older measures need to be updated
- Newer measures need more studies examining efficacy
- 10 out of 18 measures exclusively measured trauma symptoms
- 1 measure assessed exposure to traumatic events

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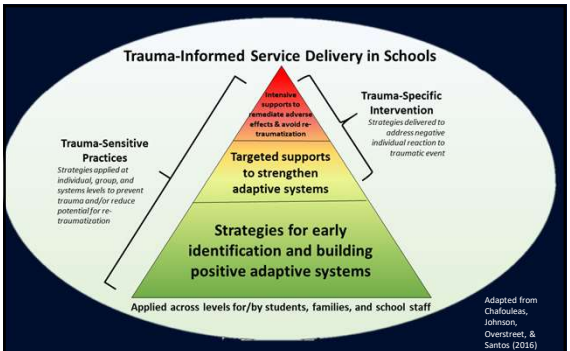

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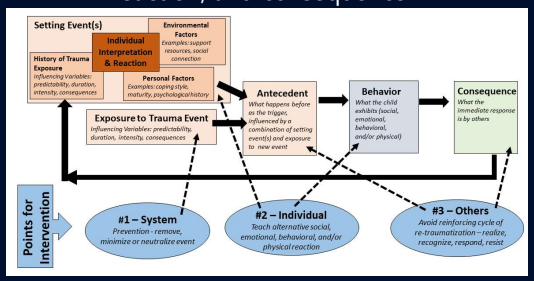
Childhood trauma cycle of exposure, reaction, and consequence



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Selecting trauma-specific interventions

- 3 systematic reviews focused on treating childhood trauma (Dorsey et al., 2017; Jaycox et al., 2006; Rolfsnes & Isdoe, 2011)
- Key findings and common themes:
  - Schools some of most common settings for intervention
  - Significant effects for treatment of PTSD symptomatology (.68, SD = 0.41)
  - Treatment significant across developmental levels; however, limited options for preschool
  - Effective across populations and different types of trauma
  - CBT-based treatments are some of the most effective interventions

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CBT-Based Treatments (Dorsey et al., 2017)

- Classified trauma-specific interventions from 1 (well-established treatments) to 5 (treatments with questionable efficacy)
- Well-established treatments
  - Group-based CBT
  - Individually delivered CBT with and without parent involvement
- Of the treatments categorized as well-established or probably efficacious, only one was not based in cognitive-behavioral therapy

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Common Elements of Effective CBT-Based Treatments (Dorsey et al., 2017)

- Psychoeducation
- Emotion regulation training
- Exposure
- Cognitive Processing
- Problem Solving

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Review of Trauma-Specific Interventions for School-Based Delivery

Selected from NCTSN Empirically Supported Treatments and Promising Practices (2016) and National Registry of Evidence-Based Programs and Practices (NREPP)

Criteria

1. Highest standard of evidence available- at least one study with a control condition
2. Interventions feasible for school-based implementation
3. CBT-based interventions
4. Studies that reported school-relevant outcomes

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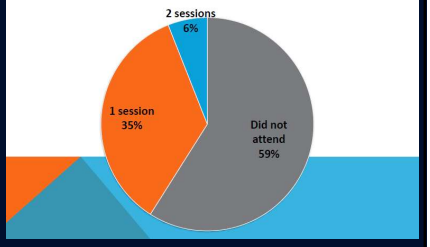
PAST FINDINGS: CBITS AND PARENTS

When 2 parent psychoeducation sessions offered, more than ½ don't attend any sessions



Kataoka, 2017

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Selected Interventions

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Bounce Back
- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)
- Trauma-Focused Coping in Schools (TFC)/Multimodality Trauma Treatment (MMTT)

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CBITS

- 10 hour long group sessions
- 1-3 individual sessions, 2-3 optional parent sessions
- Group of 6-8 students
- Includes psychoeducation and CBT-based techniques, child selects event on which to focus treatment

Strengths

- Strong evidence base
- Free online training
- Teacher information session included
- Culturally responsive

Limitations

- Parent sessions may not be feasible

Supporting Empirical Evidence

Decreased PTSD symptomatology, depression symptomatology, psychosocial dysfunction (Jaycox et al., 2009; Jaycox et al., 2010; Kataoka et al., 2003; Stein et al., 2003)

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Bounce Back

- 10 group sessions, 50-60 minutes each
- 2-3 one-on-one sessions; 1-3 optional parent sessions
- Includes components of TF-CBT and CBITS (psychoeducation, relaxation, cognitive coping, exposure)

Strengths

- Designed for use with young children
- Designed to address a variety of different traumatic experiences
- Free online training

Limitations

- Recently developed intervention, only one study
- No K students in study evaluating effectiveness (recommended for K-5)

Supporting Empirical Evidence

Decreased PTSD and anxiety symptomatology in treatment group compared to waitlist control (Langley et al., 2015)

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MATCH-ADTC

- Number of sessions varies based on modules used (average of 16 sessions)
- Individual sessions rather than group format
- Several modules use a CBT approach

Strengths

- Addresses comorbidities commonly associated with trauma exposure
- Flexible in nature

Limitations

- Studies conducted in clinic settings
- No participants with trauma exposure or PTSD in evaluation study
- Trauma-related outcomes not measured

Supporting Empirical Evidence

Modular condition associated with decreased internalizing, externalizing, and total problems when compared to usual care (Chorpita et al., 2013; Chorpita & Weisz, 2009; Weisz et al., 2012)

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TFC/MMTT

- 14 group sessions + 1 individual session
- CBT-based with social learning influences
- Strategies to cope with anxiety, anger, and grief

Strengths

- Designed to be adapted for developmental level
- Each session aligned with a specific goal/skill

Limitations

- Somewhat outdated studies

Supporting Empirical Evidence

Decreased PTSD, depression, anger, and change of locus of control, but effect sizes not reported (Amaya-Jackson et al., 2003; March et al., 1998)

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Summary of Findings by Age Range

Age Range	Preschool	Elementary	Middle	High
CBITS		X	X	X
Bounce Back		X		
MATCH		X	X	
TFC/MMTT		X	X	X

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Summary of Findings

- Evidence for impact on psychosocial outcomes
- Limited evidence to support impact on academic outcomes
  - Evaluated teacher-reported behavior problems
  - Despite evidence to show that trauma has significant effects on academic and school functioning

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Considerations for School Based Providers

1. Review available evidence for an intervention
   - consider appropriateness for the intended problem, desired outcomes, and population to be served
2. Evaluate fit for the intended service delivery setting as well as broader community
   - For example, immediate crisis at larger population versus individual experiencing chronic adversities
3. Understand appropriateness for the clinical competencies of the intended provider
   - For example, local culture and values in the community, settings available for service delivery and other resources to be leveraged

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Considerations for School Based Providers

4. Evaluate match between the presenting situation and various core components in trauma-specific interventions

Adapted from NCTSN (2016) *Empirically-Supported Treatments and Promising Practices*

Intervention Objectives Does the intervention target the desired outcomes as valued by client and related stakeholders and/or intended by provider?	☐ Risk screening ☐ Triage to different levels and types of intervention ☐ Systematic assessment, case conceptualization, and treatment planning to tailor intervention ☐ Progress monitoring of client responsiveness to treatment ☐ Evaluation of treatment effectiveness, as perceived by all stakeholders
Practice Elements Are the intervention components usable (acceptable, feasible, understood, supported) by client, provider, and others involved in delivery?	Provider-Focused ☐ Motivational interviewing to engage client ☐ Addressing barriers to service seeking ☐ Advocacy on behalf of client across systems of care Client-Focused ☐ Psychoeducation about trauma reminders and loss reminders ☐ Psychoeducation about posttraumatic stress and grief reactions ☐ Teaching emotional regulation skills ☐ Maintaining adaptive routines ☐ Parenting skills and behavior management ☐ Constructing a trauma narrative ☐ Teaching safety skills ☐ Teaching relapse prevention skills

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Questions, comments, thanks!

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