Helping Traumatized Children Learn

supportive school environments
for children traumatized by family violence

A Report and Policy Agenda

Massachusetts Advocates for Children: Trauma and Learning Policy Initiative

In collaboration with The Hale and Dorr Legal Services Center of Harvard Law School

and The Task Force on Children Affected by Domestic Violence

Helping Traumatized Children Learn marks a major milestone in child advocacy. Based on evidence from brain research, child development, and actual classrooms, here is a road map for parents, schools, administrators, and policy makers that shows concrete and feasible steps for making schools the life raft for children who otherwise may be misunderstood and abandoned by the community.

— Martha L. Minow, Professor of Law, Harvard Law School

Helping Traumatized Children Learn opens up the conversation on how to best help the students who have been victims or witnesses of violence. Removing their roadblocks can give them the opportunity to be active and enthusiastic learners.

— Massachusetts State Representative Alice Wolf

Helping Traumatized Children Learn is a useful and timely report. [It] lists practical steps that educators can take to recognize signs of trauma and help children who are affected by it. The report encourages state and local officials, educators, community leaders, parents, and experts in prevention and treatment to work together for the benefit of all children. The Massachusetts Department of Education will continue to work in partnership with others to achieve these important goals.

— David P. Driscoll, Massachusetts Commissioner of Education

I endorse the recommendations in *Helping Traumatized Children Learn* and invite the Commonwealth's leaders to join this powerful effort to help all children, including those who have been exposed to family violence, reach their highest potentials.

— Tom Scott, Executive Director
Massachusetts Association of School Superintendents

Helping Traumatized Children Learn thoroughly documents the impact of the trauma of family violence on children's ability to learn and succeed in school. The report makes a strong case for increased resources for schools and support for teachers who work with this vulnerable population. These resources are an important investment in the future of children and in the future of our communities. Let's hope that legislators and policy makers invest in these resources.

— Betsy McAlister Groves, Director, Child Witness to Violence Project, Boston Medical Center;
Associate Professor of Pediatrics, Boston University School of Medicine

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The Governor's Commission on Sexual and Domestic Violence has overwhelmingly endorsed the concepts, principles, and recommendations presented in *Helping Traumatized Children Learn*. . . . It is our sincere hope that, in the Commonwealth and beyond, educators, administrators, funding agencies, policy makers, school committees, and others will read this work and incorporate in their educational philosophies and schools the methods it recommends to address the impacts of violence on children.

—Marilee Kenney Hunt, Executive Director
Governor's Commission on Sexual and Domestic Violence

Helping Traumatized Children Learn is a much needed resource for educators, policy makers, clinicians, and parents. The authors have already contributed much to the advocacy for educational reform to ensure that the needs of traumatized children are met; this report is an impressive continuation of that process.

—Margaret E. Blaustein, Ph.D., Director of Training and Education
The Trauma Center, Justice Resource Institute

Helping Traumatized Children Learn is an immensely important contribution. These proposals for enhancing success at school have tremendous potential to help a child look forward toward the positive possibilities of the future.

—Amy C. Tishelman, Ph.D., Director of Research and Training
Child Protection Program, Children's Hospital, Boston

The Massachusetts Administrators for Special Education offers our Association's endorsement for *Helping Traumatized Children Learn* and applauds Massachusetts Advocates for Children's commitment to this most worthy need.

—Carla B. Jentz, Executive Director
Massachusetts Administrators for Special Education

Helping Traumatized Children Learn is a groundbreaking report that can show educators and communities exactly how to help children who have experienced family violence. The considerable impact of domestic violence on children's ability to learn has been ignored for too long. The education and policy agenda that Massachusetts Advocates for Children offers here is vitally important and can improve the lives of countless children who have been traumatized by family violence.

—Esta Soler, President, Family Violence Prevention Fund

Additional Endorsements:

Children's Law Center of Massachusetts, Children's League of Massachusetts, Federation for Children with Special Needs, Horizons for Homeless Children, Jane Doe Inc., Massachusetts Law Reform Institute, Massachusetts Society for the Prevention of Cruelty to Children, Treehouse Foundation

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Supportive school environments for children traumatized by family violence

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Task Force on Children Affected by Domestic Violence

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Massachusetts Advocates for Children

Mission:

Massachusetts Advocates for Children's (MAC) mission is to be an independent and effective voice for children who face significant barriers to equal educational and life opportunities. MAC works to overcome these barriers by changing conditions for many children, while also helping one child at a time. For over 30 years, MAC has responded to the needs of children who are vulnerable because of race, poverty, disability, or limited English.

Ron Eskin and Eileen Hagerty, *Board Co-chairs*
Jerry Mogul, *Executive Director*
Susan Cole, Julia Landau, and John Mudd, *Senior Project Directors*

The Hale and Dorr Legal Services Center of Harvard Law School

Educating law students for professional service while working to meet the legal needs of the community.

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Preface

Helping Traumatized Children Learn is the result of an extraordinary collaboration among educators, parents, mental health professionals, community groups, and attorneys determined to help children experiencing the traumatic effects of exposure to family violence succeed in school.

Years of case work, coalition building, and policy analysis lie behind this report, which stands in the proud tradition of other reports produced by Massachusetts Advocates for Children. These reports have led to significant improvements in the lives of children in the areas of special education, bilingual education, child nutrition, lead-poisoning prevention, and others.

Susan Cole, the leader of the collaboration and this report's principal author, is an attorney who had previously been a teacher. She melded her deep understanding of the classroom with her uncompromising standards of advocacy on behalf of children to produce this dynamic and interdisciplinary synthesis of theory, practice, and policy.

In 1998, as head of the Children's Law Support Project, Susan collaborated with Jacquelynne Bowman, who was then at Massachusetts Law Reform Institute, to form the Task Force on Children Affected by Domestic Violence. Clinical psychologist Dr. Jessica Greenwald O'Brien, attorney Ray Wallace, school psychologist Joel Ristuccia, and others soon joined to form the Schools Working Group of the Task Force, with Susan as its chair. The group addressed the need for trauma-sensitive approaches in schools and legislation to implement them. With Geron Gadd, a Harvard Divinity School student as staff researcher and writer, a strong early draft of *Helping Traumatized Children Learn* was created. It was enriched over the next several years through multiple discussions with parents, educators, psychology and language experts, and domestic violence experts.

The Schools Working Group wrote articles, conducted trainings, and advocated successfully under the leadership of State Representative Alice Wolf of Cambridge, Massachusetts, for a legislative budget line item offering grants to help schools become trauma-sensitive. Two schools in Cambridge and Lynn, Massachusetts, piloted various aspects of what became known as the Flexible Framework, sharing their successes and challenges with the Group. In 2004, supported by a broad constituency, the legislature made the line item into a section of the Massachusetts Education Reform Act. We are particularly pleased that one of the recipients of this new grant program, the Framingham Public Schools, is working to adapt the Framework to fit the unique needs of the many schools in its district. Framingham's experiences are deepening our understanding and furthering the Framework's continuous evolution.

Through a partnership with Harvard Law School and its Hale and Dorr Legal Services Center, the work continued to develop under the auspices of the Trauma and Learning Policy Initiative (TLPI) in 2004. Michael Gregory, an attorney and recipient of a Skadden Fellowship joined the TLPI staff and using his expertise in research, writing, and policy analysis contributed significantly to giving *Helping Traumatized Children Learn* its final form.

A strong and growing constituency is now in place to support this groundbreaking policy initiative designed to help further the goals of education reform. The release of *Helping Traumatized Children Learn* is the culmination of many years of research analysis and policy development and the start of TLPI's mobilization campaign to implement the policy agenda and spread this information to every school district in Massachusetts and beyond.

Jerry Mogul
Executive Director
Massachusetts Advocates for Children

Acknowledgements

This report would not have been possible without the generous contributions of time and financial support by so many people and organizations. We are deeply indebted to the Massachusetts Legal Assistance Corporation (MLAC), whose grants have enabled MAC and the Children's Law Support Project it leads to coordinate a Massachusetts legal agenda on behalf of children living in poverty. This interdisciplinary work led to the building of the Task Force on Children Affected by Domestic Violence and later the Trauma and Learning Policy Initiative (TLPI) from which this report has emerged. The Massachusetts Bar Foundation and the Boston Bar Foundation support MAC's intake and casework with the pro bono legal community, which is critical to identifying problems and devising new solutions for traumatized children. We are extremely grateful to the Gardiner Howland Shaw Foundation, which provided the original funding to seed TLPI and which continues as a key partner. We thank the Mellon Financial Corporation Fund, Partners HealthCare, Bank of America, trustee for Alfred E. Chase Charity Foundation, the Louis and Carolyn Sapir Family Fund, and the C.F. Adams Charitable Trust for enriching TLPI with important mental health expertise; enabling TLPI to provide outreach in domestic violence shelters; funding the research, writing, and publication of this report; and enabling us to pursue the education campaign ahead. We are grateful to the Skadden Fellowship Foundation for providing the funding for our TLPI staff attorney at the Legal Services Center.

We are most grateful to Professor Martha Minow of Harvard Law School and to Jeanne Charn, director of Harvard's legal clinic, the Hale and Dorr Legal Services Center, for creating a partnership with MAC in 2004 to launch the Trauma and Learning Policy Initiative. Their vision of teaching a new generation of law students to advocate on behalf of this most vulnerable group of children has enabled this work to flourish.

We give special thanks to our partner organizations, which have actively engaged in this work: the Governor's Commission on Sexual and

Domestic Violence, Casa Myrna Vasquez, Inc., the Child Protection Program at Children's Hospital in Boston, Children's Charter Trauma Clinic, a division of Key, Inc., the Federation for Children with Special Needs, the Framingham Public Schools, Horizons for Homeless Children, Jane Doe Inc., Lesley University's Center for Special Needs, Massachusetts Law Reform Institute, the Massachusetts Society for the Prevention of Cruelty to Children, and the Trauma Center, Justice Resource Institute.

Please see Appreciation for Contributors at the end of this report for a list of people to whom we are additionally most grateful.

Executive Summary

The goal of *Helping Traumatized Children Learn* is to ensure that children traumatized by exposure to family violence succeed in school. Research now shows that trauma can undermine children's ability to learn, form relationships, and function appropriately in the classroom. Schools, which are significant communities for children, and teachers—the primary role models in these communities—must be given the supports they need to address trauma's impact on learning. Otherwise, many children will be unable to achieve their academic potential, and the very laudable goals of education reform will not be realized. Trauma-sensitive school environments benefit all children—those whose trauma history is known, those whose trauma will never be clearly identified, and those who may be impacted by their traumatized classmates. Together, we can ensure that all children will be able to achieve at their highest levels despite whatever traumatic circumstances they may have endured.

This report proposes an educational and policy agenda that will enable schools to become supportive environments in which traumatized children can focus, behave appropriately, and learn. It translates complex research on trauma into educational terms that are useful to teachers and schools. And it provides a Flexible Framework—which can be adapted by any school—for creating a climate in which children exposed to family violence can achieve at their highest levels.[1]

This report proposes an educational and policy agenda that will enable schools to become supportive environments in which traumatized children can focus, behave appropriately, and learn.

Children's exposure to family violence is a widespread problem. A National Child Traumatic Stress Network (NCTSN) survey found that interpersonal victimization primarily in the home was the most prevalent form of trauma among children treated by Network mental health professionals.[2] Studies estimate that between 3.3 million and 10 million children in the U.S. witness violence in their own homes each year.[3] In 2003, approximately 906,000 children were found by child protective agencies to be victims of child abuse or neglect.[4] In Massachusetts, a study by the Office of the

Commissioner of Probation reported that approximately 43,000 children were named on restraining orders, which suggests that these children were affected by family violence.[5]

Even these large figures appear to represent only a fraction of the problem. The 1998 Adverse Childhood Experiences study, which sent standardized questionnaires to 13,494 adult members of a large HMO, found that 44 percent of respondents reported suffering sexual, physical, or psychological abuse as children, and 12.5 percent reported having a mother who had been treated violently.[6] In June 2005, the Massachusetts Department of Education presented information from informal surveys of 450 students who attended alternative-education programs in eleven school districts that received state-funded Alternative Education Grants (see Appendix A). The nonvalidated results of the surveys indicated that 90 percent of the students reported histories of trauma exposure, with a number of these students reporting exposure to more than one type of trauma. Of the students surveyed, 41 percent reported histories of family violence; 46 percent reported having been physically, emotionally, or sexually abused; 39 percent reported neglect; and 16 percent were living in foster care or out-of-home placements.[7]

Helping Traumatized Children Learn focuses on the educational consequences of exposure to family violence, although information in this report will be useful in addressing traumatic consequences from other sources as well. When there is family violence, home is not the safe haven it is for most children. Adults who should be relied upon for nurturance may actually be a source of terror, or they may be victims themselves and unable to provide protection.[8] When the perpetrator of violence is a caregiver—the person in whom a child has placed great trust and upon whom the child's very life depends—the betrayal a child experiences can be devastating.[9] The impact on a child's self-perception[10] and worldview[11] can get carried into the classroom, where it can interfere with the ability to process information and maintain control over

***Helping Traumatized Children Learn* focuses on the educational consequences of exposure to family violence, although information in this report will be useful in addressing traumatic consequences from other sources as well.**

behaviors and emotions. The fact that family violence is frequently kept secret from schools adds to the confusion, often making it difficult for educators to discern the reasons for a child's behavioral and learning problems.

We use the term "domestic violence" to describe violence between intimate partners. Children may have watched or overheard violence between their caregivers and may live with its consequences (e.g., maternal depression or a parent with physical injuries, such as bruises). Children may also become directly involved in a violent event by trying to stop the abuse or by calling the police.[12]

We include in the term "family violence" three forms of harm to children: witnessing domestic violence, being the direct victim of abuse, and being exposed to neglectful caretaking. Domestic violence, abuse, and neglect frequently occur together.[13] Each of these experiences can result in similar symptoms and undermine many of the same developmental foundations.[14] Analyzing them separately is enormously difficult.[15] We also recognize that familial alcoholism often occurs along with family violence and that children in homes where there is substance abuse may exhibit symptoms similar to children exposed to family violence.[16]

Traumatized children do not fit neatly into any single "box." Although many children enter school each day carrying with them the experience of exposure to violence in the home, the symptoms of their trauma can be quite varied, as the actual experiences of the following children illustrate:[17]

Tyrone

Six-year-old Tyrone was the terror of his first-grade class. He pinched, hit, and refused to obey the teacher. Frustrated with his unprovoked aggressive behavior, the school began holding suspension hearings. At home and at church, however, he was a different child, clinging to his sister and mother. He would often wake up with nightmares and a bed that was wet. Tyrone had fled with his mother, brother, and sister from a father who had abused them. To Tyrone, school felt threatening, rather than being the place of refuge he needed.

Marla

Fifteen-year-old Marla was an extremely bright student with an IQ of 139. She did not have problems with aggression. Instead, she stared out the window. She didn't do her homework. She seemed to barely be there at all. Despite her intelligence, she was failing in school because of frequent absences. Her teachers wondered how a child with so much potential could be slipping out of reach. It turned out that Marla had witnessed significant violence against her mother at home, making it impossible for her to focus in school.

Sonya

When five-year-old Sonya began kindergarten, she could not focus in the classroom and had difficulty forming relationships with adults and making friends with her peers. Complicating Sonya's situation was the fact that her leg had been broken by her father when she was less than a year old. Even though she had been too young at the time to remember the incident, the fear of that experience—the betrayal of trust—still haunted Sonya and made it difficult for her to reach out to new people. It thwarted her ability to adjust to a classroom environment and achieve in school.

There is nothing new about the presence of traumatized children in our schools. Often without realizing it, teachers have been dealing with trauma's impact for generations. What *is* new is that trauma researchers can now explain the hidden story behind many classroom difficulties plaguing our educational system. Recent psychological research has shown that childhood trauma from exposure to family violence can diminish concentration, memory, and the organizational and language abilities that children need to function well in school.[18] For some children, this can lead to inappropriate behavior[19] and learning problems in the classroom, the home, and the community.[20] For other children, the manifestations of trauma include perfectionism, depression, anxiety, and self-destructive, or even suicidal, behavior.[21] Studies show that abused children have more severe academic problems than comparison children. Specifically, they are more likely to receive special education services, have below-grade-

level achievement test scores, and have poor work habits; and they are 2.5 times more likely to fail a grade.[22]

The Adverse Childhood Experiences study found that adults exposed to adverse experiences in childhood, including those who had witnessed domestic violence or suffered abuse, were more likely to engage in risky activities such as drinking, smoking, and substance abuse.[23] In the opinion of some experts, these are behavioral "coping devices"—attempts to reduce the emotional impact of adverse experiences.[24] When teenagers engage in these risky behaviors, however, they often face disciplinary consequences at school, such as suspensions or expulsions.

Teachers can play an important role in connecting traumatized children to a safe and predictable school community and enabling them to become competent learners. To accomplish this goal, policy makers must provide schools with the tools they need to help all children learn.

Many experts, including members of the National Child Traumatic Stress Network (NCTSN), are calling for a community-wide effort to create contexts in which children traumatized by family violence can succeed.[25] NCTSN asks schools to play a key role in this effort. School is a place where it is possible for traumatized children to forge strong relationships with caring adults and learn in a supportive, predictable, and safe environment. These are factors that can help protect children from, or at least ameliorate, some of the effects of exposure to family violence.[26] In the broad-based effort this report recommends, schools will partner with parents and guardians—who may themselves be struggling with symptoms of trauma—and give teachers the support they need to teach children how to regulate or calm their emotions and behavior.

Because we know that mastering both academic and social skills are key to the healing process, the aim is to increase teaching and learning time and reduce time spent on discipline.

We are not suggesting the creation of a new category of disability that would lead to special treatment or labeling of children on the basis of trauma alone. Instead, this report provides information and an adaptable framework for addressing trauma-related challenges to children's ability to participate in the school community, whether they learn in regular or special education classrooms. Because we know that mastering both academic and social skills are key to the healing process, the aim is to increase teaching and learning time and reduce time spent on discipline. The ultimate goal is to help all traumatized students become successful members of their school communities.[27]

Educators and policy makers—with the help of mental health professionals—can put the insights of research to work by implementing relatively cost-effective strategies. These strategies will help children traumatized by exposure to family violence learn and succeed in school.

This report is divided into three chapters, as follows:

Chapter 1

The Impact of Trauma on Learning

The first step in creating trauma-sensitive schools is to help educators become aware of trauma symptoms. Chapter 1 of this report describes the trauma response and the specific ways trauma can impact learning and behavior in the classroom. Teachers can use their existing expertise more effectively when they understand that many of the academic, social, and behavioral problems of traumatized children involve such difficulties as failing to understand directions, overreacting to comments from teachers and peers, misreading context, failing to connect cause and effect, and other forms of miscommunication. This report does not suggest that teachers become therapists. However, a better understanding of the difficulties traumatized children have in modulating their emotions and behaviors should lead schools to seek out therapeutic and positive behavioral supports, rather than responding with punitive measures such as suspensions and expulsions. A better understanding of how a positive community response can actually reduce the severity of the trauma

symptoms should encourage educators to infuse trauma-sensitive approaches for students and supports for personnel throughout their schools, *because schools are the central community for most children.*

Chapter 2

The Flexible Framework: An Action Plan for Schools

The Flexible Framework has been designed to help each school community develop a plan for integrating trauma-sensitive routines and individual supports throughout the school day.[28] The Framework provides a structure that can be adapted to the unique needs of each school community, regardless of its organizational structure or educational philosophy. Each school will determine how to apply the Framework, which has six key elements:

I. Schoolwide Infrastructure and Culture;

II. Staff Training;

III. Linking with Mental Health Professionals;

IV. Academic Instruction for Traumatized Children;

V. Nonacademic Strategies; and

VI. School Policies, Procedures, and Protocols.

Rather than prescribing any one particular intervention, the Framework seeks to help schools establish environments that will enable children traumatized by exposure to family violence develop relationships with caring adults, learn to modulate their emotions and behaviors, and achieve at high educational levels. When schools have a better understanding of trauma, they can form effective linkages with mental health professionals who have an expertise in that field, make full use of available resources, and advocate for new resources and particular interventions that directly meet the needs of their students.

Chapter 3

Policy Recommendations

Schools and educators cannot do this work alone. Chapter 3 asks policy makers, legislators, and administrators to create laws and policies that support schools in addressing the trauma-related aspects of many behavioral and learning problems. Without supports within the school, teachers are almost forced to look the other way—the problems can seem so overwhelming.[29] With supports, teachers can play an important role in connecting traumatized children to a safe and predictable school community and enable them to become competent learners.[30] To accomplish this goal, policy makers must provide schools with the tools they need to help all children learn, including those who have been traumatized by exposure to family violence.

Chapter 3 sets forth the following public policy agenda:

1. The Commonwealth should provide publicly funded schools and preschools with funds necessary to develop schoolwide action plans addressing the needs of traumatized children.

2. Massachusetts stakeholders should reach consensus on the laws, policies, and funding mechanisms necessary for schools to intervene early to address the needs of traumatized students and to decrease punitive responses.

3. Teachers and administrators should learn approaches and strategies for teaching children who may be traumatized.

4. Mental health professionals and other specialists providing services in school settings should respond appropriately to trauma-related learning and behavioral problems and should provide trauma-informed consultations to educators.

5. The Department of Education should provide continuing information and support to schools.

6. Research should be funded on the extent to which learning and behavioral problems at school are related to untreated childhood trauma and on best schoolwide and individual practices for addressing the educational needs.

* * *

We are all too familiar with the extreme situation—children who try to overcome their feelings of vulnerability by inflicting violence on others.[31] When child victims become victimizers, a society that failed to help these children when they needed it most faces the consequences of shortsighted policies. We can either invest in necessary supports for educators and services for children now, or we can allow the cycle of violence and failure to continue, dealing with children later through more costly institutions, including the criminal justice system.[32]

With the help of educators, traumatized children can flourish in their school communities and master the educational tasks of childhood, despite their overwhelmingly stressful experiences. This requires school environments that support both staff and children, and that recognize and respond to the effects childhood trauma can have on children's learning and behavior.[33]

Genesis of This Report

Staff at the Massachusetts Advocates for Children (MAC), a nonprofit children's rights organization founded in 1969, regularly respond to requests from families desperately seeking help in obtaining school services to address learning problems or behaviors that have led to suspension and expulsion hearings. In 1998, MAC's attorneys realized that many of these cases involved children who had been exposed to some form of family violence, either as witnesses to domestic violence or as the direct targets of abuse. Questioning whether there were better ways to deal with the behavioral and learning problems of these children, MAC brought together groups of parents, shelter workers, court personnel, and experts in trauma psychology, neuropsychology, education, social work, and law, in an attempt to understand the causes and nature of the challenges presented by children exposed to family violence.

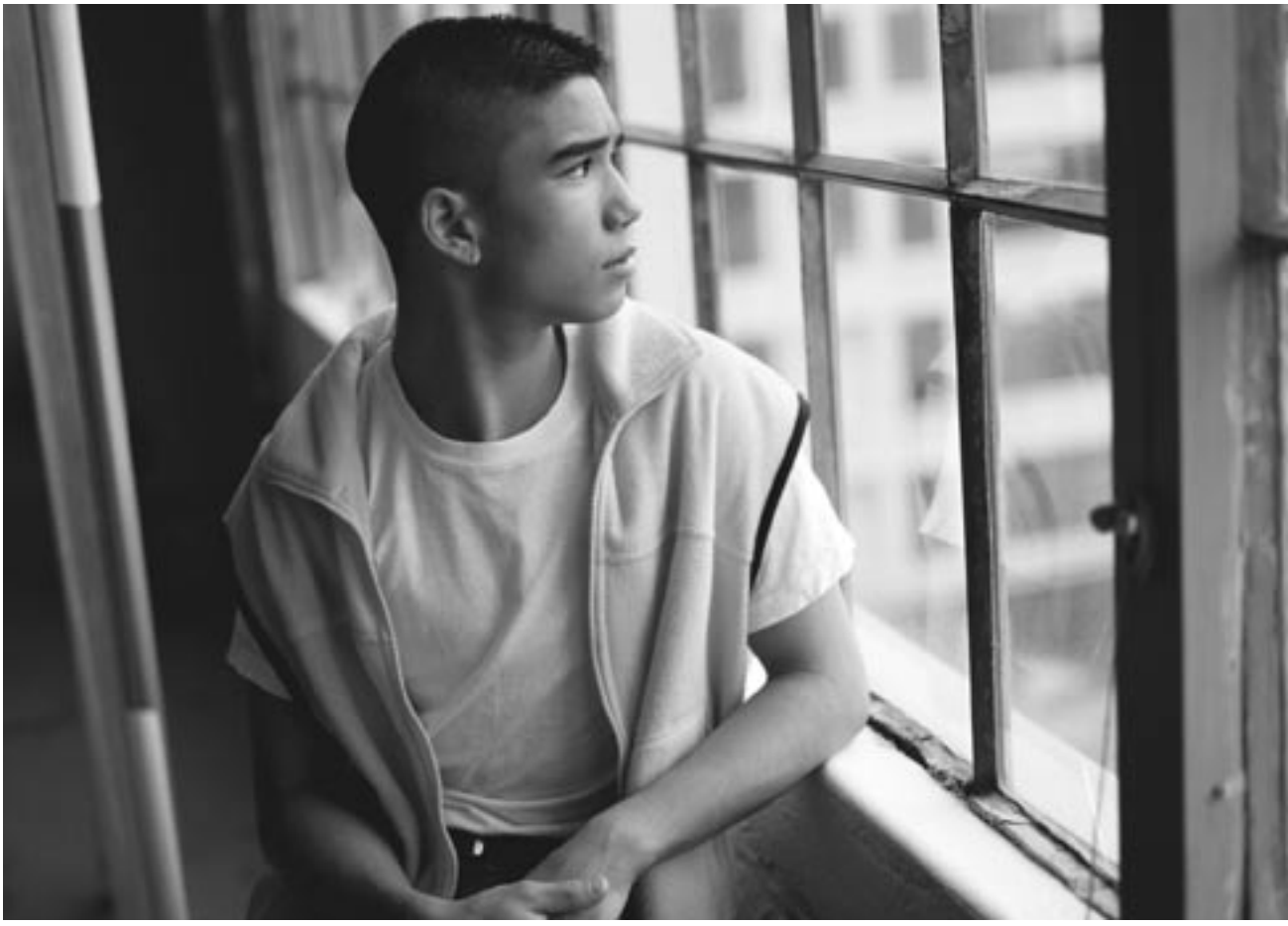
These vibrant interdisciplinary discussions, along with input from focus groups held at two Boston public schools, highlighted the many learning and behavioral difficulties that can arise when children and teenagers come to school traumatized by exposure to family violence. MAC followed up by forming the Task Force on Children Affected by Domestic Violence (the Task Force), which produced a series of working papers calling for overarching policies that schools, courts, and housing and benefits programs could implement to address the needs of these children. The working paper on schools proposed funding to help educators create trauma-sensitive classroom environments.

The Massachusetts legislature responded to the issues articulated by the Task Force. In 2000, it passed legislation establishing a grant program through the Massachusetts Department of Education called "Creating a Safe and Supportive Learning Environment: Serving Youth Traumatized by Violence." In 2004, the grant program was codified into law as "An Act for Alternative Education" (see MGL c. 69, sec. 1N, included in Appendix A). This new law, which is now part of the Massachusetts Education Reform Act, addresses the educational consequences of

trauma using a two-pronged approach: grants for alternative education programs and grants for safe and supportive school environments. In the first round of grants, six schools received pilot funding to create trauma-sensitive environments. Two of these schools used the Flexible Framework, devised by the Task Force, to increase their responsiveness to the needs of traumatized children. In the second round of grants (2004) the Framingham Public Schools adapted the framework for use across its district. This framework was refined through its use in schools, the work of the Task Force, and discussions held with many schools and community collaborators. (The Framework is set forth in chapter 2.)

In 2004, MAC expanded the work of the Task Force by joining in a partnership with the Hale and Dorr Legal Services Center of Harvard Law School to launch the Trauma and Learning Policy Initiative (TLPI). TLPI uses multiple advocacy strategies to carry out the Task Force's vision, advocating for policies, laws, and practices that can help children traumatized by family violence succeed in school. TLPI attorneys, student advocates, psychological and educational consultants, and parent specialists provide individual case advocacy; reach out to educate parents, teens, educators, and other professionals; and build coalitions that enable the voices of the most vulnerable children and their parents to be heard in the policy arena. TLPI is also convening experts to develop forthcoming guidelines for making special education evaluations and school mental health consultations trauma sensitive.

Parents, teachers in regular and special education, principals, guidance counselors, social workers, language experts, advocates for battered women and children, staff in governmental agencies, and attorneys made significant contributions to this report, as have the psychologists, neuropsychologists, and trauma experts who reviewed it for accuracy and content.



Together, we can ensure that all children will be able to achieve at their highest levels despite whatever traumatic circumstances they may have endured.

Chapter 1

The Impact of Trauma on Learning

The Trauma Response in the Classroom

Every day, children enter their classrooms bringing backpacks, pencils, paper—and their unique views of the world. Every child has his or her own expectations and insights, formed from experiences at home, in the community, and at school. When children witness violence between their adult caregivers or experience abuse or neglect, they can enter the classroom believing that the world is an unpredictable and threatening place.

A Worldview Gone Awry

Our fundamental assumptions about ourselves and about the world around us are the lens through which we view and evaluate events and relationships. They provide the conceptual framework that helps us make meaning of our experiences and enables us to function effectively.[34]

A nurturing home, in which children have stable attachments to adults and are treated with physical and emotional respect, generally instills a fundamentally affirmative self-image and view of the world as benevolent.[35] Positive expectations tend to lead to the belief that others will appreciate our strengths, that people are essentially decent, and that there is a reason to be optimistic about the future. Children with secure attachments to adults and a positive worldview usually are able to regulate their emotions and develop the solid foundation necessary for adapting well at school.[36]

Conversely, violence at home can help create negative expectations and assumptions.[37] Such children may have a diminished sense of self-worth and feel incapable of having a positive impact on the outside world.[38] Hopelessness, self-blame, and lack of control are typical of the feelings that can result from trauma; these feelings may lead to overwhelming despair and a loss of the ability to imagine the future or hope that circumstances will change. Children in this condition can be ill-prepared for the academic and social challenges of the classroom.

In Jenny Horsman's book *Too Scared To Learn,* an adult survivor of childhood sexual abuse describes how her negative worldview affected her at school:

> I remember crying in the night. I found it difficult to hear Mrs. Patterson when she spoke in the classroom. I felt as if she were speaking from beneath tumbling water, or from the end of a long tunnel. She assumed I was daydreaming. I stopped imagining that I might one day be a teacher. . . . No longer did my imagination dance me through the leaves. The sound of ringing church bells irritated me. Mostly I felt ashamed, different.[39]

Children look to their parents for stability and protection. When a parent is the source of violence, the child's sense of security and safety can be compromised or destroyed,[40] replaced instead by fear and anxiety. Lacking a sense of security, a child can have difficulty exploring the world through play, developing self-confidence, and maintaining motivation.[41] A parent's unpredictable or violent behavior can lead to difficulty forming personal attachments and may foster relationships that are based on fear and insecurity.[42]

Many children exposed to violence view the world as a threatening place, in which danger and pain are to be expected. They see the world not through rose-colored glasses, but through a lens tinted somber gray.[43] Psychiatrist and trauma expert Judith Herman explains:

> Adaptation to this climate of constant danger requires a state of constant alertness. Children in an abusive environment develop extraordinary abilities to scan for warning signs of attack. They become minutely attuned to their abusers' inner states. They learn to recognize subtle changes in facial expression, voice, and body language as signals of anger, sexual arousal, intoxication, or dissociation. This nonverbal communication becomes highly automatic and occurs for the most part outside of conscious awareness. Child victims learn to respond without being able to name or identify the danger signals that evoked their alarm.[44]

Traumatized children may anticipate that the school environment will be threatening and constantly scrutinize it for any signs of danger. Their mission is to avoid this perceived danger and pain.

Children traumatized by family violence rarely understand that they see the world in a different way than their nontraumatized peers and teachers do.[45] Traumatized children cannot simply remove their "trauma glasses" as they go between home and school, from dangerous place to safe place. They may anticipate that the school environment will be threatening and constantly scrutinize it for any signs of danger. Their mission is to avoid this perceived danger and pain.[46] Sadly, this mission often sabotages their ability to hear and understand a teacher's positive messages, to perform well academically, and to behave appropriately.

Fear as a Way of Life: The Developing Brain

The great risk for children who live in violent homes and who routinely operate in survival mode is that this way of functioning can permeate every aspect of their lives and can even take on a life of its own. According to brain researchers, when children encounter a perceived threat to their safety, their brains trigger a complex set of chemical and neurological events known as the "stress response."[47] The stress response activates a natural instinct to prepare to fight, freeze, or flee from the unsafe event. Under normal circumstances these responses to stress are constructive and help keep a child safe.

However, when a child operates in overwhelming states of stress or fear, survival responses that may be fully appropriate in danger-laden situations (e.g., shutting down, constantly surveying the room for danger, expecting to fight or run away at a moment's notice) can become a regular mode of functioning. Even when the dangers are not present, children may react to the world as if they are.[48] Unable to regulate heightened levels of arousal and emotional responses, they simply cannot turn off the survival strategies that their brains have been conditioned to employ.[49]

Neurobiologist Bruce Perry and his colleagues at the Child Trauma Academy explain that the most developed areas of a child's brain are the ones used most frequently. When children live in a persistent state of

fear, the areas of their brains controlling the fear response can become overdeveloped.[50] These parts of the brain may direct behavior even in situations in which it would be more appropriate for other parts of the brain to be in charge. It is important to note that the areas of the brain active in fearful states are different from those active in calm states, and it is predominately the areas active in calm states that are required for academic learning.[51]

Brain researchers use the term "plasticity" to explain the environment's enormous influence on the growing child's developing brain.[52] This means that children's brains are more malleable than those of adults. However, just as traumatic experiences can undermine the brain's development, good experiences can enhance it.[53] In addition, skill development is a scaffolding process, with each skill building upon the one before. Both the plasticity of brain development and the scaffolding nature of skill development are strong reasons to intervene as early as possible with supportive, ameliorative, and protective experiences. Early intervention gives a child the best chance to follow a developmental trajectory unencumbered by the effects of trauma.[54]

Trauma: Reactions to Stressful Events

Experts explain that trauma is not an event itself, but rather a response to a stressful experience in which a person's ability to cope is dramatically undermined. Lenore Terr defines childhood trauma as the impact of external forces that "[render] the young person temporarily helpless and [break] past ordinary coping and defensive operation. . . . [This includes] not only those conditions marked by intense surprise but also those marked by prolonged and sickening anticipation."[55] Similarly, Judith Herman writes that traumatic events "overwhelm the ordinary human adaptations to life. . . . They confront human beings with the extremities of helplessness and terror."[56] The range of potentially traumatic events in childhood is quite broad, including not only physical threat and harm but also emotional maltreatment, neglect, abandonment, and devastating loss.

Every traumatic experience is different, and each child's response depends on his or her coping skills and resources and on the context

and circumstances in which the stressful event occurs. Whether a child develops a trauma reaction that increases in severity, becomes chronic, and is less responsive to intervention or has a reaction that is moderate, manageable, and time limited depends on several factors. These include the nature of the experience, the characteristics of the child, and the way the family, school, and community respond (see Appendix C). For example, chronic or repetitive traumatic experiences, especially those perpetrated intentionally by a caregiver, are likely to result in a different set of symptoms than a single shocking traumatic event.[57]

The age at which a child experiences traumatic events is another factor in determining its severity.

The age at which a child experiences events resulting in trauma is another important factor in determining its severity. For example, an older child may have the verbal skills to articulate the experience and gain perspective on it more quickly than a very young child, whose lack of language development and perspective limits the extent to which the event can be understood and processed. On the other hand, an older child could be devastated by betrayal in a way that could go unnoticed by a younger child. Brain researchers also explain that growing children go through "critical periods," during which certain areas of the brain develop very rapidly and are more susceptible than usual to stressful experiences.[58]

So many factors influence individual reactions to stressful events that even children in the same family who share similar traumatic backgrounds can have different responses. One child in a family might develop an intense drive for academic achievement. Another may engage in behavior that makes concentration nearly impossible for that child and the other students in the class. A third may appear to be unaffected, yet suffer in very quiet ways.

It is critical for educators to understand that a person's social context can have a tremendous impact on the severity of the trauma symptoms. Trauma expert Mary Harvey explains that a trauma response is influenced not only by an individual's particular strengths and the nature of the event, but also by the level of support a person receives from the surrounding community.[59] When the community responds in helpful ways, there is what Harvey calls an "ecological fit" between the person and the community:

> The construct of "[ecological] fit" refers to the quality and helpfulness of the relationship existing between the individual and his or her social context. Interventions that achieve ecological fit are those that enhance the environment-person relationship—i.e., that reduce isolation, foster social competence, support positive coping, and promote belongingness in relevant social contexts.[60]

Schools are children's communities. An ecological fit for a child at school would include a welcoming environment where the staff understands trauma's impact on relationships, behavior, and learning. In this environment, schoolwide trauma-sensitive approaches would be woven throughout the school day, and individual supports, related to skill and social development, would be trauma-sensitive.

The links between exposure to family violence and children's behavior are often hidden or unclear, but a trauma-sensitive environment can provide tools for recognizing when more supports are needed. The Flexible Framework in chapter 2 sets forth a structure for establishing such a trauma-sensitive ecology or context.

So many factors influence individual reactions to trauma that even children in the same family who share similar traumatic backgrounds can have different responses.

Trauma's Impact on Academic Performance, Behavior, and Relationships

Many of the obstacles traumatized children face in the classroom result from their inability to process information, meaningfully distinguish between threatening and non-threatening situations, form trusting relationships with adults, and modulate their emotions.

For some children, the combination and extent of their reactions to trauma warrant a formal diagnosis. Post-traumatic stress disorder (PTSD) is the diagnosis given to a particular set of trauma-related symptoms. (See Appendix B for an explanation of PTSD.) As PTSD does not capture the full range of symptoms often seen in traumatized children, students can come with a range of diagnoses that may be comorbid with trauma. These include depression, attention-deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, anxiety disorder, phobic disorder, and borderline personality.[61] Because the clinical manifestations of trauma are exceedingly broad and not captured well by traditional diagnoses, Bessel van der Kolk has proposed a new diagnosis for children with histories of complex trauma called "developmental trauma disorder" that attempts to account for the emotional, behavioral, neurobiological, and developmental consequences of trauma.[62]

For many children, however, their reactions to traumatic events manifest themselves in a range of problems that do not meet the standards for a diagnosis. The children may never be identified as having trauma symptoms or may have what appear to be trauma symptoms with no indication that a traumatic event precipitated it. We caution that all children with trauma-like symptoms should not be presumed to have trauma histories. It is important to explore all possible reasons for a child's difficulty at school.

In the sections that follow, we organize the research according to the ways trauma can impact learning, behavior, and relationships at school, to broaden understanding and not to respond to a specific diagnosis. The

principles in the Framework in chapter 2 are designed to infuse trauma-sensitive supports throughout the school; their use is not contingent on whether traumatic events have been identified or a diagnosis reached.

More research is needed on the extent to which trauma plays a role in problems children experience at school, on ways to identify when these problems might be trauma related, and on strategies to address the needs specific to various forms of exposure to violence. The research to date, however, provides considerable insight into children's behavior and learning and the challenges educators face in their classrooms.

Childhood Trauma and Academic Performance

Learning to read, write, take part in a discussion, and solve mathematical problems requires attention, organization, comprehension, memory, the ability to produce work, engagement in learning, and trust.[63] Another prerequisite for achieving classroom competency is the ability to self-regulate attention, emotions, and behavior.[64]

Not surprisingly, traumatic experiences have the power to undermine the development of linguistic and communicative skills, thwart the establishment of a coherent sense of self, and compromise the ability to attend to classroom tasks and instructions, organize and remember new information, and grasp cause-and-effect relationships—all of which are necessary to process information effectively.[65] Trauma can interfere with the capacity for creative play, which is one of the ways children learn how to cope with the problems of everyday life; [66] and it can adversely affect the ability to have good peer and adult relationships.[67]

■ Language and Communication Skills

Traumatic experiences can disrupt the ability of children to learn and process verbal information and use language as a vehicle for communication. These language problems can undermine literacy skills, social-emotional development, and behavioral self-regulation.

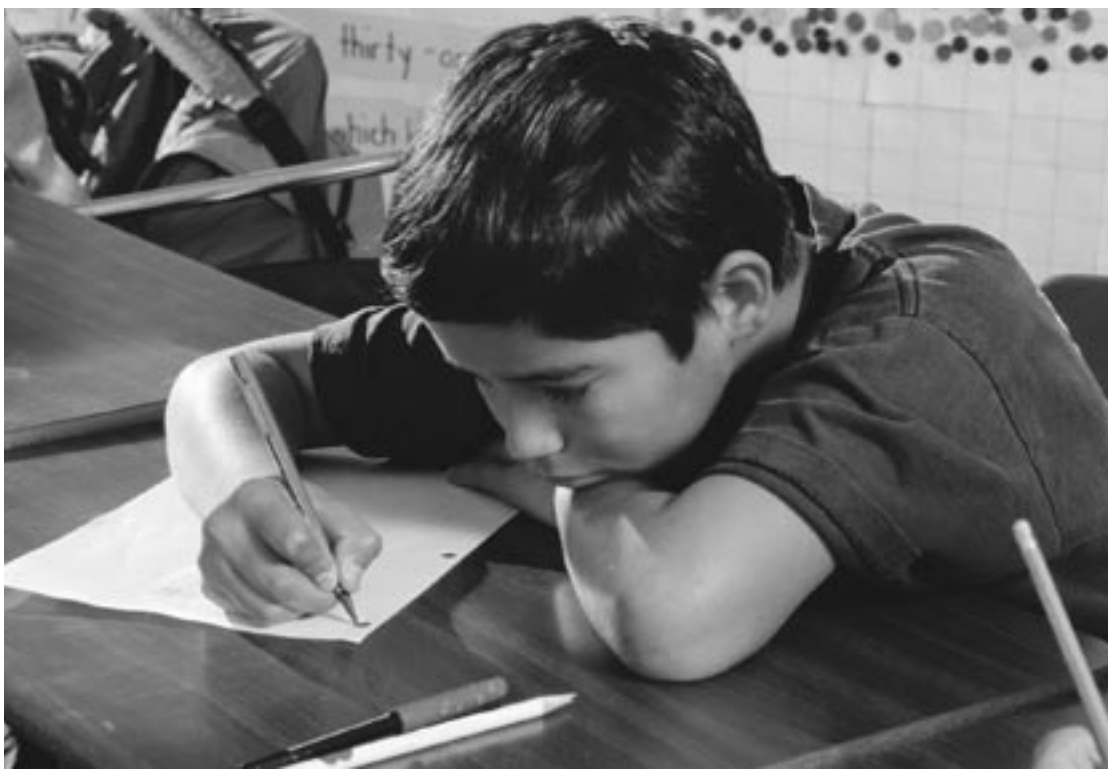
1. Learning and retrieving new verbal information

Researchers Streeck-Fischer and van der Kolk explain that traumatized children "are easily overstimulated and cannot achieve

the state of secure readiness that is necessary in order to be open to new information."[68] When traumatized children enter the classroom in a hyperaroused state, they may be unable to attend to or process academically significant information and may have great difficulty expressing themselves verbally. (See Appendix B for a discussion of hyperarousal in traumatized children.)

These findings have serious implications for the ability of traumatized children to function well within the school setting. As Perry explains, traumatized and nontraumatized children often have very different cognitive experiences in the classroom:

> The calm child may sit in the same classroom next to the child in an alarm state, both hearing the same lecture by the teacher. Even if they have identical IQs, the child that is calm can focus on the words of the teacher and, using the neocortex, engage in abstract cognition. The child in an



Trauma can disrupt the ability of children to learn and process verbal information and use language as a vehicle for communication.

> alarm state will be less efficient at processing and storing the verbal information the teacher is providing.[69]

One traumatized teenager gives a poignant description of how processing problems in the classroom affected her learning:

> I could see the math teacher's mouth moving in the classroom but couldn't hear a thing. It was as if I were in a soundless chamber. She was smiling and clearly talking, I just couldn't process a word of it. I had been an excellent math student, but the day she told me I was "spacey" and unfocused was the day I stopped connecting to math. My grades dropped and they took me out of the advanced classes.[70]

Studies are beginning to uncover neurobiological evidence that the ability to connect words to experience can be impeded by trauma. One 1996 study scanned the brains of people diagnosed with post-traumatic stress disorder. After baseline scans were taken, researchers induced fear in the subjects by reminding them of their traumatic experiences. The scans revealed that the areas of the brain involving anxiety and other intense emotions (limbic and paralimbic systems) activated when the subjects' traumatic experiences were invoked. When the limbic system activated, the area of the brain associated with language (Broca's area) became less active.[71]

It may be obvious to a child in a state of anxiety that something inside his or her head has shifted to inhibit language and thought processing. However, this shift may not be apparent to a teacher until the child is called upon to speak or demonstrate that he or she has understood and analyzed information that has been presented.

2. Social and emotional communication

Traumatized children may have a relationship to language that is different from that of their nontraumatized peers. Research suggests that communicative development is influenced by the interactive styles and social context in which early language is established.[72] This can affect mastery of basic literacy skills, the ability to use verbal skills, and how and why the child communicates. Coster and Cicchetti explain

that when a caregiver's primary interactions with a child are focused on controlling the child's behavior rather than on responding to thoughts and feelings, the child may acquire a predominantly instrumental understanding of language. For such a child, language becomes a tool that "serve[s] to get tasks accomplished," rather than a "medium for social or affective exchanges."[73]

When this pattern of using language primarily as a tool, rather than as a means to express feelings, persists throughout the preschool years, the child may have difficulty "use[ing] language to articulate needs and feelings, which has been suggested as an important step toward development of appropriate cognitive and behavioral controls."[74] According to Coster and Cicchetti, using language in a predominantly instrumental way leads to difficulty with "the ability to convey abstractions, which has been suggested as a critical transition in the acquisition of literacy skills."[75] It can also hamper "the ability to sustain coherent narrative and dialogue, which is a key competence for social exchange with both peer and adult figures."[76]

Instead of using language to build bridges with others on the basis of mutual understanding, some traumatized children use language to build walls between themselves and those they regard as potentially threatening.

Instead of using language to build bridges with others on the basis of mutual understanding, some traumatized children use language to build walls between themselves and those they regard as potentially threatening. Susan Craig explains, "Abused children use language to keep other people at a distance. Their communication style is gesture oriented and is used to define the relationship between themselves and the speaker, rather than to convey meaning."[77] She reminds us that traumatized children may have difficulty focusing on the content of language, in part because they are monitoring nonverbal messages.

3. Problem solving and analysis

Coster and Cicchetti explain that traumatized children may have had "minimal experience using verbal problem-solving methods and little exposure to adults who encourage the kind of self-reporting of ideas or feelings often expected in a classroom setting. [Children] may also have had limited experience attending to complex communications

and may have difficulty extracting key ideas embedded in more lengthy narratives."[78] This is consistent with the findings of Allen and Oliver, who found a significant correlation between child neglect and deficits in both receptive and expressive language. They hypothesize that neglected children are not adequately exposed to the types of stimulation that are critical for normative language development.[79]

Coster and Cicchetti argue that a thorough language evaluation should be part of the educational assessment of children exposed to family violence. Emphasizing that impaired language development may affect the ability to use words to problem solve, these researchers make the powerful point that the language evaluation should include not only linguistic aspects of language but also pragmatic and narrative functions.[80]

■ Organizing Narrative Material

A child's successful completion of many academic tasks depends on the ability to "bring a linear order to the chaos of daily experience."[81] Traumatic experiences can inhibit this ability to organize material sequentially, leading to difficulty reading, writing, and communicating verbally.[82]

The first step in the development of the ability to organize material sequentially is the establishment of sequential memory. In the earliest years of a child's life, memories and information are encoded episodically, as a collection of random events rather than as a coherent narrative. The transition to sequential semantic memory "is most easily made in environments marked by consistent, predictable routines and familiar, reliable caregivers."[83] Many children enduring traumatic stress are deprived of such a stable environment. Instead, they may be "raised in households in which rules and routines are subject to the whim of the parent"; for them, the move into a more sequential ordering of the world may be considerably more difficult than it is for other children.[84]

If the development of sequential memory is delayed and the ability to learn new information sequentially is impaired, traumatized children will have difficulty organizing and processing the content of academic lessons for later retrieval and application. This helps explain why traumatized children who have trouble with sequential organization

respond well to classrooms in which there are orderly transitions and clear rules and that offer them assistance with organizing their tasks.

■ Cause-and-Effect Relationships

When cognitive development occurs in an inconsistent and unpredictable environment, children may have trouble comprehending cause-and-effect relationships and recognizing their own ability to affect what happens in the world.[85] According to Craig, "Most children grasp this process during the sensorimotor period, through an active exploration of the world around them," in which they learn "they can make things happen."[86] In contrast, children living with violence may suffer from "physical restriction and unrealistic parental expectations that inhibit their exploration of the world and their emergent sense of competence."[87] When no logical cause-and-effect relationships govern their experiences at home, these children have difficulty internalizing a sense that they can influence what happens to them. Craig explains how a compromised understanding of cause-and-effect can undermine a child's motivation and behavior in the classroom:

> An extended experience of perceived low impact on the world inhibits the development of such behaviors as goal setting and delayed gratification. These skills, so important to school success, rely on a person's ability to predict and make inferences. Similarly, failure to establish an internalized locus of control can result in lack of both motivation and persistence in academic tasks, as well as a resistance to behavior-management techniques that assume an understanding of cause and effect.[88]

Children living in circumstances that do not allow them to make connections between their actions and the responses they trigger can be left wary of the future, which feels to them both unpredictable and out of their control. This may cause some children to become extremely passive.[89] A child whose inability to grasp cause-and-effect relationships is extreme may not even master the early developmental task of achieving "object constancy"—the understanding that an object or person still exists when it is hidden from sight.[90] Van der Kolk explains that failure to achieve object constancy is common among traumatized children who lack a sense of predictability in their environment.[91]

■ Taking Another's Perspective

Many traumatized children have problems with academic and social tasks that require them to take the perspective of another person. When a child learns not to express a preference before assessing the mood of the parent, he or she cannot fully develop a sense of self. In particular, this can result in an "inability to define the boundaries of the self," which can lead to difficulty making independent choices, articulating preferences, and gaining perspective.[92] In addition, if stress from family violence interferes with normal playtime and with explorative play activity, the ability to "take the role of the other or to appreciate another person's point of view may be seriously impaired."[93]

Difficulty understanding the perspective of others has serious ramifications. Deficits in this area can make it hard to solve a problem from a different point of view, infer ideas from text, participate in social conversation, and develop empathy in relationships.

■ Attentiveness to Classroom Tasks

Traumatized children can be distracted or lack focus in the classroom because anxiety and fears for their own and others' safety chronically occupy their thoughts. Streeck-Fischer and van der Kolk explain that these attentional disorders have several causes:

> [The children] do not pay attention because they are unable to distinguish between relevant and irrelevant information. They tend to misinterpret innocuous stimuli as traumatic, and if not interpreted as traumatic, they tend to ignore sensory input. Easily threatened by the unexpected, traumatised children are prone to become excessively physiologically aroused when faced with novel information.[94]

A child who is inattentive to the classroom task at hand may actually be focused on "interpreting the teacher's mood."[95] Another child might disassociate from the immediate environment and not process information presented by the teacher at all.

Children who pay attention to the wrong things and children who disassociate can find it difficult to keep up with classroom tasks. Lost and

unable to reconnect with the academic activities, their anxiety can increase, and difficulties with regulating emotion may come into play. Some of them may then engage in disruptive behavior as they try to catch up.

Many traumatized children who exhibit the symptoms of anxiety, hypervigilance to danger, and language-processing problems are diagnosed as having attention-deficit hyperactivity disorder (ADHD). Research shows that ADHD and trauma often coexist, but because both disorders have similar symptoms, trauma may be overlooked when a diagnosis of ADHD is made.[96] If a child is suffering from both ADHD and trauma, appropriate treatment can be provided that responds to both sets of problems.[97] Thus, it is important to assess whether a single diagnosis is masking the need to evaluate for trauma.

■ Regulating Emotions

According to Masten and Coatsworth, the ability to self-regulate or modulate emotions is a key predictor of academic and social success.[98]

Providing opportunities to succeed must be reinforced by a classroom environment that supports the student's success.

Shields and Cicchetti explain that deficits in the capacity to regulate emotion are a cause for serious concern because "the ability to modulate behavior, attention, and emotion underlie children's adaptive functioning in a number of key domains, including self-development, academic achievement, and interpersonal relationships."[99] Streeck-Fischer and van der Kolk emphasize that such deficits are widespread among children exposed to family violence: "Lack of capacity for emotional self-regulation so critical to school functioning is probably the most striking feature of these chronically traumatised children."[100]

Difficulty regulating emotions can lead to a host of problems in and out of school. These potential difficulties include poor impulse control, aggression against the self and/or others, trouble interpreting emotional signals, chronic uncertainty about the reliability of other people, and lack of a predictable sense of self.[101] Shields and Cicchetti suggest that hypervigilance may play a key role in undermining the development of emotional self-regulation. They postulate that, unlike the non-traumatized child, the hypervigilant child cannot shift away from distressing cues in the service of maintaining emotional regulation.[102]

Traumatized children often experience fear, anxiety, irritability, helplessness, anger, shame, depression, and guilt, but their ability to identify and express these feelings is often underdeveloped and poorly regulated. Some of these children may express emotions without restraint and seem impulsive, undercontrolled, unable to reflect, edgy, oversensitive, or aggressive. They may overreact to perceived provocation in the classroom and on the playground. Other traumatized children block out painful or uncomfortable emotions; they may appear disinterested, disconnected, or aloof. For them, the consequence of not knowing how to communicate or interpret emotions is the dampening or constricting of their feelings. Another group of traumatized children protect themselves from unmanageable stress and anxiety by dissociating—that is, by completely disconnecting emotions from the events with which they are associated.

Difficulty knowing how they feel and expressing feelings in words can put traumatized children at risk for somatic symptoms,[103] including

headaches, gastrointestinal complaints, body pains, and general malaise. Fatigue, sleeplessness, eating disorders, body-image concerns, and health problems later in life are also associated with trauma.

■ Executive Functions

The so-called "executive functions"—goal setting, anticipating consequences, and initiating and carrying out plans—are very important for achieving academic and social success and for establishing vocational goals.[104] A traumatized child can develop a bleak perspective, expectations of failure, a low sense of self-worth, and a foreshortened view of the future, all of which disrupt this ability to plan, anticipate, and hope.[105] Van der Kolk explains that because traumatized children often have distorted inner representations of the world, they have no "internal maps to guide them" and that, consequently, they "act instead of plan."[106]

This is consistent with what researchers know about the effects of trauma on the developing child's brain. The prefrontal cortex, the area of the brain primarily responsible for the development of the executive functions, has been shown to be adversely affected by trauma.[107] One study found significant deficits in executive function and abstract reasoning among maltreated children with post-traumatic stress disorder, as compared to sociodemographically matched children with no history of maltreatment.[108] In another study, boys with severe abuse histories had particular difficulty with executive-function tasks that required them to refrain from taking actions that would lead to adverse consequences.[109] Children with severe executive-function deficits may benefit from small, structured classrooms where they can be carefully taught to understand the consequences of their actions.

■ Engaging in the Curriculum

Traumatic experiences can deplete motivation and internal resources for academic engagement. Studying the effect of maltreatment on children's academic and behavioral adjustment, Shonk and Cicchetti found that academic engagement is a powerful predictor of academic success.[110] They define optimal academic engagement as "self-initiated, regulated, and persistent mastery for the sake of competence, a preference for optimally challenging tasks, and self-directed behaviors such as paying

attention and completing assignments."[111] However, as they go on to point out, because of a focus on security, "many traumatized toddlers, preschoolers, and school-age children display excessive dependency, social wariness, reduced exploration, deficits in affect regulation, and impaired autonomous mastery."[112]

Not all traumatized children suffer from the academic challenges listed above. As discussed earlier, many factors impact how severe a traumatic response will be. Overall, however, many traumatized children struggle with considerable difficulties that impede progress in school. Often, these difficulties also interfere with their ability to behave appropriately in the school setting.

Childhood Trauma and Classroom Behavior

The school setting can be a battleground in which traumatized children's assumptions of the world as a dangerous place sabotage their ability to develop constructive relationships with nurturing adults. Unfortunately, many traumatized children adopt behavioral coping mechanisms that can frustrate educators and evoke exasperated reprisals, reactions that both strengthen expectations of confrontation and danger and reinforce a negative self-image.

Traumatized children's behavior can be perplexing. Prompted by internal states not fully understood by the children themselves and unobservable by teachers, traumatized children can be ambivalent, unpredictable, and demanding.

Traumatized children's behavior can be perplexing. Prompted by internal states not fully understood by the children themselves and unobservable by teachers, traumatized children can be ambivalent, unpredictable, and demanding. But it is critical to underscore that

traumatized children's most challenging behavior often originates in immense feelings of vulnerability.

Researchers explain that when we believe an individual has complete control over his or her behavior, we are more likely to be angry when that behavior is inappropriate. But if we recognize the factors that shape a child's behavior and compromise self-control, we are more likely to attempt to ease the child's plight.[113] Because traumatized children may be used to chaotic, unpredictable caregivers, they often try hard to appear in control even though they may be feeling out of control. As a result, they are more likely to be disapproved of and condemned by busy, overburdened educators, even though they are among the students most in need of nurturance.

In his book *On Playing a Poor Hand Well,* Mark Katz describes how an adult's view of a child's problematic behavior might change if the reasons for that behavior were known:

> Not realizing that children exposed to inescapable, overwhelming stress may act out their pain, that they may misbehave, not listen to us, or seek our attention in all the wrong ways, can lead us to punish these children for their misbehavior. The behavior is so willful, so intentional. She controlled herself yesterday, she can control herself today. If we only knew what happened last night, or this morning before she got to school, we would be shielding the same child we're now reprimanding.[114]

To avoid reminders of trauma or the emotions associated with it, children may consciously or unconsciously adopt strategies such as social withdrawal, aggressiveness, or substance abuse. Aggressive or controlling behavior can be a way of coping with internal turmoil and a sense of powerlessness and vulnerability; it may also arise from hypersensitivity to danger or from identification with the aggressor at home.[115] Other traumatized children may try to cope with their fears by checking door locks, constantly expressing concerns about younger siblings, and so on. All these behaviors may be responses to feelings they cannot identify or describe.

Many of the effects of trauma on classroom behavior originate from the same problems that create academic difficulties: the inability to process social cues and to convey feelings in an appropriate manner. For this reason, traumatized children's behavior in the classroom can be highly confusing, and children suffering from the behavioral symptoms of trauma are frequently profoundly misunderstood. Whether a traumatized child externalizes (acts out) or internalizes (withdraws, is numb, frozen, or depressed), the effects of trauma can lead to strained relationships with teachers and peers.

■ Reactivity and Impulsivity

Chronic trauma can impair the development of children's ability to regulate their emotions and to control impulsive behaviors.[116] Reactions can be triggered in hypervigilant children if they feel they are being provoked or if something reminds them of the trauma. An incident or remark that might seem minor to a nontraumatized child may be perceived as threatening by a traumatized child, who then responds in a seemingly disproportionate way. It is helpful for teachers to know what triggers might cause a traumatized child to become hyperaroused or to reexperience a traumatic event in the classroom. Behaviorists may be able, through careful observation, to identify some of the child's triggers. Often, however, the help of a mental health expert is needed to be sure of what may be triggering a particular child.

■ Aggression

Hypervigilant children who are prone to reactivity and impulsiveness may become verbally and/or physically aggressive toward teachers and peers. The aggression may spring from misinterpretation of comments and actions due to the child's inability to adopt another's perspective, underdeveloped linguistic skills, and/or inexperience with verbal problem solving. Studies have shown that traumatized children often have "distorted perceptions of the intentions, feelings, and behaviors of others as well as . . . hostile/aggressive social behavior."[117] One study also found that traumatized children "were less attentive to relevant social cues, made more misattributions of others' negative or hostile intent, and were less likely to generate competent solutions to interpersonal problems."[118]

Carlson reported that in some cases this aggressive behavior occurs "in lieu of the child's expression of his [or her] trauma-related fears."[119] In this sense, aggressive behavior is less akin to the willful defiance of an obstinate student than the response of a frightened child to his or her experience of traumatic violence. Carlson also explains that "aggression towards others might occur because a person with a general expectancy of danger might take a 'strike first' position to ward off harm."[120] Shields and Cicchetti point out that "angry reactivity would be a likely response among individuals who fear victimization and exploitation. … Because maltreated children tend to perceive threat in even neutral or friendly situations, they may evidence a self-defensive reactivity that is consistent with their experiences and expectations but inappropriate to the context at hand."[121] Thus they explain that hypervigilant attention processes combine with "maladaptive social information processing to foster emotional negativity and reactivity among maltreated children; this emotion dysregulation, in turn, seems to provoke reactive aggression."[122]

Because these behaviors can be based on fear, reactivity, misinterpretation of social information, and hypervigilience, most traumatized children do best in a calm environment that accepts no bullying or teasing and in which firm limits are set on negative behavior.

■ Defiance

Children who enter the classroom in a state of low-level fear may refuse to respond to teachers either by trying to take control of their situation through actively defiant behavior or, more passively and perhaps less consciously, by "freezing." Either way, the child is not receptive or responsive to the teacher or the demands of the classroom. Children who actively try to take control may be more overt and deliberate in their unwillingness to cooperate. This can be particularly frustrating to teachers, since these children can appear to be in control of their behavior. Teachers often attempt to gain the compliance of "frozen" children via directives, but this approach tends to escalate the anxiety and solidify the inability to comply, as Perry describes:

> At this point, they tend to feel somewhat out of control and will cognitively (and often, physically) freeze. When adults around them ask them to comply with some directive, they may act as

> if they haven't heard or they "refuse." This forces the adult—a teacher, a parent, a counselor—to give the child another set of directives. Typically, these directives involve more threat. The adult will say, "If you don't do this, I will . . ." The nonverbal and verbal character of this "threat" makes the child feel more anxious, threatened, and out of control. The more anxious the child feels, the quicker the child will move from anxious to threatened, and from threatened to terrorized.[123]

■ Withdrawal

Children who withdraw in the classroom cannot participate effectively. Unsurprisingly, these children rarely attract their teachers' attention. Many demands are placed on teachers, not the least of which is managing children who disruptively act out their suffering. Richard Weissbourd, in his book *The Vulnerable Child*, describes the experience of a first-grade teacher whose classroom included several children traumatized by sexual abuse, community violence, and neglect:

> Mary Martinez is aware that many of her children are suffering from one or another of these quiet hardships, yet putting out the brushfires can take all her attention. Neglect does not get special attention from her until it becomes severe. Whereas [some children] may secure attention because they are provocative or display directly or symbolically how they have been hurt or abused, . . . the counselor at Martinez's school worries especially about neglected and abused children who, instead of acting out, come to school dead to the world, withdrawn. . . . "Withdrawn kids get zero here. You have to be extraordinarily withdrawn to be referred to me."[124]

Feelings of vulnerability may foster reluctance to engage in the classroom. As Pynoos, Steinberg, and Goenjian state, "Preschool tasks of cooperation and sharing in relationship to other children may be interfered with by withdrawal, emotional constriction, and disrupted impulse control."[125] Some traumatized children disconnect themselves from the present by dissociating, or "going away" in their minds; they

may not be aware that they have "left" the classroom and missed large amounts of information. Dissociation may be hard for a teacher to recognize unless it is extreme.

One student explains:

> I couldn't stand to be in the school. Often I felt like I couldn't breathe. I would stare out the window and let my mind go all over the place. Sometimes whole weeks would go by and I would not even be aware that time had passed. Next thing I would know I was being told I was yet again failing a course.[126]

Withdrawn behavior can be a symptom of depression, anxiety, fear of negotiating interpersonal relationships, or difficulties arising from compromised self-confidence.

■ Perfectionism

Children exposed to violence at home are often subject to the arbitrary will of caregivers who have unrealistic expectations for childhood behavior. Afraid to disappoint these caregivers and incur their explosive response, children often try, and inevitably fail, to meet these expectations. In their genuine desire for approval and success, these children may become perfectionists.[127]

Some perfectionists secretly long to excel but become easily frustrated and give up when they encounter difficulty mastering a task, often preferring to be viewed by teachers and fellow students as noncompliant rather than as unable. To the teacher, it may appear that such a child is simply refusing to try.[128]

Other perfectionists engage in an uncompromising struggle for academic success, but are never satisfied with their achievements. In an attempt to make sense of their experiences, acutely traumatized children may assume responsibility for their caregivers' crimes and deeply internalize a sense of badness. Paradoxically, this intensely negative feeling can lead to zealously perfectionist behavior that masks a grave emotional problem. According to Herman,

> In the effort to placate her abusers, the child victim often becomes a superb performer. She attempts to do whatever is required of her. She may become . . . an academic achiever, a model of social conformity. She brings to all these tasks a perfectionist zeal, driven by the desperate need to find favor in her parents' eyes.[129]

Some perfectionist children may engage in coping behaviors that cement the distance between themselves and others in order to avoid the stress resulting from their inability to perform academic and social tasks. As Craig explains, "Children may develop avoidance patterns of oppositional behavior and incomplete work as 'face-saving' techniques for getting out of play time. Though painful in themselves, these practices may seem safer to the child than the experience of failure before peers."[130]

Perfectionist children who are easily frustrated can become despondent when they encounter difficulties. Distress tends to plague even those who do succeed in achieving excellent grades and displaying exemplary conduct while in the midst of extreme adversity. These children sometimes pay a big price by living with high levels of long-term distress.[131]

Childhood Trauma and Relationships

Perhaps one of the most important roles schools can play in the lives of traumatized children is helping them to have good relationships with both peers and adults. Positive role models and ways of dealing with peers can play a major role in the healing process and lead to strong academic, social, and behavioral outcomes.

■ Relationships with School Personnel

Children's struggle with traumatic stress and their insecure relationships with adults outside of school can adversely affect their relationships with school personnel. Preoccupied with their physical and psychological safety and lacking appropriate models, traumatized children may be distrustful of adults or unsure of the security of the school setting in general. To gain a sense of control,

they may challenge school personnel, or they may overact because they misinterpret classroom encounters.[132] In either case, children may behave confrontationally, even aggressively, in their relationships with school personnel. Craig explains that "these children often vie for power with classroom teachers, since they know that they are safe only when they control the environment. They do not like surprises or spontaneous events, which are perceived as dangerous or out of their control."[133] For this reason, many traumatized children have particular difficulty with transitions during the school day.

Researchers point out that it is important for traumatized children to form meaningful relationships with caring adults. Accomplishing this goal requires a schoolwide infrastructure that allows time for positive relationships to develop between students and both academic and non-academic school personnel.

■ Relationships with Peers

Traumatized children may suffer delays in the development of age-appropriate social skills. They may not know how to initiate and cultivate healthy interpersonal relationships. Their "post-traumatic symptoms or behavior . . . may acutely disturb a developing close relationship with a best friend, create a sense of isolation from peers, or lead to social ostracism."[134] Traumatized children who are reactive, impulsive, or aggressive may mask their feelings of vulnerability with a "strike-first" posture in response to threat. Seeing through the lens of their negative worldview, they often misinterpret classroom encounters and then overreact with confrontation and aggression that frightens their peers.

Perhaps one of the most important roles schools can play in the lives of traumatized children is helping them to have good relationships with both peers and adults.

Because traumatized children are often "unable to appreciate clearly who they or others are, they have problems enlisting other people as allies on their behalf. Other people are sources of terror or pleasure, but are rarely fellow human beings with their own sets of needs and desires."[135]

Those traumatized children who are withdrawn or "spacey" alienate peers by their lack of engagement. These children may not pick up on cues to join in with others in the classroom or during breaks, and they may not know how to communicate appropriately with peers. Young children may engage in traumatic play that "may limit the flexibility of play for other developmental purposes" and which can alienate other children who do not understand and/or are "bored" by these repetitive patterns.[136]

Pynoos, Steinberg, and Goenjian explain that "re-enactment behavior, especially inappropriate sexual or aggressive behavior or aggression, may lead to a child's being labeled 'deviant' by parents, teachers, and other children."[137] Sexually abused girls, for example, may have little experience with healthy, nonsexual encounters with males. Coming to sexual knowledge prematurely, these girls may relate to boys only in sexual terms, behavior that can stigmatize and isolate them.[138] Furthermore, as students enter adolescence, "There may be an abrupt shift in [their] interpersonal attachments, including sudden dissolution or heightened attachment, increased identification with a peer group as a protective shield, and involvement in aberrant rather than mainstream relationships."[139]

A Note on Special Education

Most children experiencing trauma will not develop diagnoses or disabilities that require special education, and this report is not recommending that every student be screened for trauma. However, some percentage will require special education and studies show that abused children are more likely to be in special education, have below-grade-level achievement test scores, have poor work habits, and are 2.5 times more likely to fail a grade.[140] When evaluating a student for special education, it is important to consider the possibility that trauma may be playing a role, as it is easy to inadvertently misdiagnose some of the trauma-related symptoms.

The Trauma and Learning Policy Initiative is convening experts in trauma, neuropsychology, language, and education to develop forthcoming guidelines for making special education and non–special education evaluations, recommendations, and mental health consultations trauma-sensitive. The model will propose ways in which what is known about trauma can be incorporated into discussion about a child's cognitive profile. The hope is that these guidelines will lead to better diagnoses on school-related matters, more appropriate special education and non–special education supports and accommodations for students, and, ultimately, less-restrictive placements.

Conclusion

It is important to remember that trauma is a reaction to an external event. At school, it is not always possible or appropriate to discover whether a child's learning, relationships, and behavioral difficulties are trauma responses. However, by establishing a trauma-sensitive environment throughout the school and by being aware that exposure to violence might be at the heart of a child's learning and behavioral difficulties, school professionals can help minimize the enduring effects of trauma even among those who have not been specifically identified. In cases where trauma is known, an understanding of its effects on learning and behavior will help educators plan the most effective responses.

Chapter 2

The Flexible Framework:

Making School Environments Trauma-Sensitive

The Role of Schools in the Lives of Traumatized Children

Schools have an opportunity to ensure that family violence does not undermine children's chances for educational success. The idea that school can moderate the effects of trauma is supported by research from both developmental psychologists and trauma experts.

For example, child-development psychologists Masten and Coatsworth explored the question of why many children develop competence even under adverse conditions, such as exposure to domestic violence, abuse, homelessness, war, and community violence. They found three key factors common to all competent children, whether or not they grow up in favorable circumstances:

1. a strong parent-child relationship, or, when such a relationship is not available, a surrogate caregiving figure who serves a mentoring role;

2. good cognitive skills, which predict academic success and lead to rule-abiding behavior; and

3. the ability to self-regulate attention, emotions, and behaviors.[141]

These authors explain that "poverty, chronic stress, domestic violence, natural disasters, and other high-risk contexts for child development may have lasting effects when they damage or impair these [three] crucial adaptive systems."[142] By the same token, they point out that bolstering these three key factors can help children be successful.[143]

Similarly, a white paper published by the National Child Traumatic Stress Network (NCTSN) Complex Trauma Task Force supports these conclusions. Among this Task Force's proposals is their "ARC" model for working with traumatized children through both psychological intervention and school and community supports. The three elements of the ARC model are similar to the three factors Masten and

Coatsworth outline. The **ARC** model consists of:

1. building secure **A**ttachments between child and caregivers(s);

2. enhancing self-**R**egulatory capacities; and

3. increasing **C**ompetencies across multiple domains.[144]

Schools are uniquely positioned to help children reach their potential in each of the three areas identified by Masten and Coatsworth and the NCTSN. In particular, schools can:

- partner with families and strengthen traumatized children's relationships with adults in and out of school;
- help children to modulate and self-regulate their emotions and behaviors; and
- enable children to develop their academic potential.

Masten and Coatsworth state:

> If the goal is to change the competence of [at-risk] children, [multiple] strategies need to be considered ranging from efforts to change child capabilities (e.g., tutoring) to interventions directed at the context (e.g., parent education or school reform or opening of opportunities) to those directed at finding a better fit between a child and his or her context (e.g., changing schools).[145]

A Schoolwide Approach to Trauma-Sensitive Supports

In line with this recommendation, the Flexible Framework introduced below encourages the use of multiple strategies tailored to the needs of each school community and its individual students. Rather than advocating for one particular intervention or a one-size-fits-all approach, it offers tools for infusing trauma-sensitive perspectives and approaches throughout the school community and for ensuring that

mental health, academic and nonacademic individualized supports are sensitive to the needs of traumatized children. It is critical that these individual supports be provided within a context that recognizes the complexity of each child and of the traumatic experience.

For an example of how a successful schoolwide approach to trauma works, we can consider the case of the Ford Elementary School in Lynn, Massachusetts. The Ford School, under the direction of Dr. Claire Crane, has been widely recognized for improving dropout, suspension, and achievement rates in a high-poverty area. The school received funding in 2000 from a grant program created by the Massachusetts legislature entitled "Creating a Safe and Supportive Learning Environment: Serving Youth Traumatized by Violence." As part of the grant, the school trained its staff to respond to trauma symptoms. The story of George, a student at the Ford, demonstrates how the creation of a schoolwide trauma-sensitive context can revolutionize a traumatized child's educational experience:

Every child has an area of strength in which he or she excels, whether it is in academics, art, music, or sports. When educators can identify and focus on a child's strength, they afford the child the opportunity to experience success, with all the emotional implications of doing something well. This is an important starting point in mastering academic content and social relations, which in turn can serve as a basis for success at school.

> George had lived with domestic violence—his mother had a series of boyfriends who were often abusive—and his behavior and academic performance were on the decline. His attendance at school was erratic. By the seventh grade, he was absent so often that the principal was on the verge of filing a truancy petition with juvenile court. The staff worried that he would drop out of school by 16—or be expelled.

Fortunately, the school had set up what they called their "trauma committee" to identify children whose actions might be symptoms of trauma at home. The staff had learned the importance of identifying students' areas of strength as a strategy to reach difficult children. Staff came together for the sole purpose of identifying activities, talents, and interests of students who were not responding successfully in the classroom.

Home and school were stressful places for George, but he found solace on the baseball field. His homeroom teacher, Mr. Herman, had noticed his talent and on occasion went to the school field to watch the after-school pick-up game. He often mentioned something to George the next day about a nice catch or hit. Mr. Herman brought George's skill in, and enjoyment of, baseball to the attention of the trauma committee.

Unfortunately, George's grades had prohibited him from joining the school baseball team. Breaking with school policy, the trauma committee decided to approach George with an offer: he could join the team if he wrote a paper on why baseball was important to him. Then he would have to meet a further condition—he would have to keep his grades up if he wanted to stay on the team. George accepted, wrote a successful paper, and joined the team.

The recognition of George's abilities led to a turnaround. His grades, behavior, and self-esteem improved. He stayed on the team and met all his academic requirements. As the principal proudly stated, "We would never call the court now."

George's story illustrates how a school can use its own resources to create a trauma-sensitive approach to solving a problem. Many traumatized children will need a more intensive intervention than George did, but, in all cases, providing support early on when it can do the most good is less costly and more effective than waiting for a child to fail, drop out, or become involved in the juvenile justice system.

The Flexible Framework: An Action Plan for Schools

The Flexible Framework that is described in this chapter can be adapted to the needs of any school community, regardless of organizational structure or educational philosophy. Designed to enable a school to develop its own trauma-sensitive institutional structure, the Framework provides guidelines for establishing schoolwide practices and supports for staff and students. The Framework has six key elements, each of which is to be evaluated from a trauma-sensitive perspective:

I. Schoolwide Infrastructure and Culture;

II. Staff Training;

III. Linking with Mental Health Professionals;

IV. Academic Instruction for Traumatized Children;

V. Nonacademic Strategies; and

VI. School Policies, Procedures, and Protocols.

We hope that implementation of the schoolwide approaches that follow will in turn generate new strategies for enhancing and expanding the trauma-sensitive school environment. Although the Framework is designed for use at individual schools, the Framingham, Massachusetts, Public Schools is adapting it for use across an entire district. Using a grant from the 2004 "Act for Alternative Education Grant Programs," Framingham trained members of its guidance department, who then shared the Framework with individual principals and schools.

I. Schoolwide Infrastructure and Culture

A. Principal/Headmaster

The senior administrator's leadership role is to engage staff in the process and includes participating in strategic planning and helping staff identify ways to integrate trauma-sensitive routines into existing school operations.

B. Weaving Trauma-Sensitive Approaches into the Fabric of the School

There are several threads, or functions, involved in building a school-wide learning environment for children with trauma that benefit from the use of team or committee structures. Many of these factors will fall naturally into preexisting structures within the school community; for other tasks it may be most beneficial to create new forums. Each school will find its own method for accomplishing the following goals:

1. **Strategic planning with principals/headmasters, school administrators, and other stakeholders.** An ongoing planning/design group will decide how information on trauma should be integrated into the school community. This team should consider the following questions: How does this process fit into our school? How will we apply this information? How do we get cooperation at all levels? Whom do we involve in various aspects of planning and implementation? Which responsibilities lie with the school, and which should be handled by outside agencies?

2. **Assessment of staff training needs and desires.** This group will survey the staff to assess their needs and desires and will design and plan staff training.

3. **Confidential review and conferencing of individual cases.** This team's work will be confidential. Reviews for students who have special education or accommodations plans should take place with their teams.

4. **Review of policies with an understanding of trauma.** This group, which should include administrators, will review policies, including those on discipline, filing abuse and neglect reports, and communicating with families who may need referrals for outside help.

5. **Community-liaison team.** This group will make connections with mental health providers and Child Advocacy Centers, battered women's and homeless shelters, the Department of Transitional

Assistance (DTA), the Department of Social Services (DSS), and the police. In addition, this group will decide who will develop community-resource lists and who will be the main contact.

6. **Evaluation of the success of the program.** The jobs of this team are to decide which tools will be used to evaluate the success of the program and to carry out that evaluation. At a minimum, questionnaires assessing staff attitudes should be administered both before the program is implemented and after it has been in place for a period of time, and statistics on agreed-upon outcomes (e.g., rates of suspension, trips to the principal's office for discipline, calls to parents regarding negative behaviors, and so forth) should be gathered both before program implementation and afterward on a regular basis. Evaluation should also assess the quality of trainings and identify new barriers that may arise as the program gets underway.

C. Identifying and Addressing Barriers

Inevitably, barriers to incorporating trauma-sensitive approaches will arise within each school community. It is important to identify, acknowledge, and address these barriers from the outset by getting input from all levels of staff and stakeholders. Some examples of barriers among staff are:

- the tendency to see trauma as a home problem rather than a school problem;
- misplacing blame on students or parents (whether intentionally or inadvertently);
- the personal impact on staff of dealing with these issues, including feelings of helplessness and being overwhelmed;
- balancing individual student needs with the needs of the class as a whole; and
- lack of skills and resources for handling trauma.

The ongoing identification of barriers—through the evaluation process and by other means—will help target staff training and support to specific needs.

II. Staff Training

Bridget Rodriguez was principal of the Morse School in Cambridge, Massachusetts, when it was funded as a pilot school in the 2000 "Creating a Safe and Supportive Learning Environment" grant program. She gives an example of how education in childhood trauma changed the reactions of school staff.

> Shortly after our training, a kindergartener had an episode that we were able to recognize as a reexperiencing of a traumatic event. Something had caused her to have a traumatic flashback. Her eyes were dilated and she looked almost catatonic. Instead of intervening immediately to bring the child back into the kindergarten activities or insisting that she immediately talk about how she felt, we knew to escort her to a quiet place and help her feel safe and calm while we sought guidance from the school counselor. That was something we put to use the day after the training.

Staff training, the second of the six elements, should cover three core areas: strengthening relationships between children and adults and conveying the vital role staff play as caring adults in the lives of traumatized children and their caregivers; identifying and using outside supports; and helping traumatized children modulate their emotions and gain social and academic competence.

Because staff come to the table with differing levels of experience, each school will need to assess the level of information that is needed so that training can be targeted to staff needs. The training process can often be incorporated into existing school structures, which will minimize additional investment of resources.

The following training ideas are not a prescription, but rather a general outline of important issues to consider when creating a staff-training program. For an excellent book containing in-depth information for educators, please see Gertrude Morrow's *The Compassionate School: A Practical Guide to Educating Abused and Traumatized Children.*

A. Partnering with Parents and Other Caregivers

Parents and caregivers are fundamental to creating healthy learning environments for traumatized children. The training program should help staff understand the important role a caregiver plays in restoring a child's feeling of safety after traumatic events have occurred and identify realistic ways to integrate the parent into a child's education. Strengthening the relationship between a caregiver and school staff will help a traumatized child feel more connected to school and can greatly increase the child's chances for success. In addition, it is important for a child to know that his or her caregiver is respected and safe at school.

1. **Understanding the cycle of family violence and its effects.** An understanding of the dynamics of family violence and trauma's effects on adult and child victims can build staff's empathy for parents, who often feel marginalized or judged by others.[146] This may include understanding that a parent who lives with or is fleeing a violent partner may focus all her energy on safety, with little emotional energy for other needs, including education; that the experience of family violence can breed a feeling of unequal power and parents may be intimidated to share their own thoughts about their children; and that parents may feel guilty and thus have difficulty accepting that their children may be struggling in school. Sometimes parents withdraw because they feel unable to help their children.

2. **Understanding the legal context.** School personnel can better support parents if they are familiar with the court orders (such as restraining orders) and laws (such as the school-records access law) that protect abused parents and children. Domestic violence advocates who work in shelters or at legal services are good sources of information on legal issues.

3. **Communication strategies.** Training by clinicians can highlight strategies to help staff avoid the problems that frequently arise when communicating with adults who have been traumatized by domestic violence. Staff can learn ways to help parents feel trusting of the school; this parental trust can translate directly into trust by the student. At the start it is

important to assess the strengths a parent brings to the school (e.g., At what level can the parent read? What are the parents' work hours that might make attending meetings possible? What is the parent already doing that is helping the child succeed?). While factoring in the parent's strengths and limitations, it is important to maintain positive communications on a daily or weekly basis through written communications whether or not feedback from the parent is received. Spending time listening to parents' goals for their children and incorporating this understanding to support the child can be very empowering to parents. When holding a parent meeting it is important to be clear and structured and to provide written outlines of what is covered. Clinicians should advise staff and even role-play ways to both communicate with parents and make successful referrals to mental health professionals.

B. Supporting Staff

Training should help educators understand the significance of their role as mentors and caring adults in the lives of traumatized children and focus on the supports they need to fulfill this role.

1. **Identifying needs.** Staff should be given the opportunity to brainstorm the supports they may need to work with traumatized children in the classroom. Consultation with mental health professionals who understand the impact of trauma in the classroom can be helpful in this process.

2. **Understanding the roles of teacher and mental health professional.** Training should clarify the difference between the role of the teacher and the role of the mental health professional. The goal of training is not to turn teachers into therapists, but to enable them to create stable, supportive classrooms in which traumatized children can become full participants in the school community. Training should stress strategies for establishing stronger linkages to mental health resources and for effectively referring families to mental health professionals when necessary.

3. **Building on competencies.** The training should make clear that educators already have many of the skills needed to help traumatized children learn (for details, see section IV of the Framework, "Academic Instruction for Traumatized Children"). The focus should be on ways to build upon competencies teachers already have. For example, some teachers are particularly skilled at presenting information in a variety of ways, others are quite consistent, some are highly organized, and there are those who form positive ongoing relationships with students beyond the classroom. All these are among an array of strengths that can be reinforced and expanded with an awareness of how they can be useful in dealing with traumatized children. Teachers should also be encouraged to take advantage of resources already in place in the school. For example, a teacher might engage a physical educator or an occupational therapist to help adapt a classroom or incorporate physical activities to calm a hyperaroused child.

C. Teaching Students

Training should emphasize the important role teaching and learning can play in diminishing trauma symptoms and enabling traumatized children to reach their potential despite their difficult circumstances. It should also equip staff to understand the ways that trauma may manifest itself in the classroom. In addition to the particular teaching strategies discussed at length in section IV of this Framework, staff training should include the following:

1. **Helping children regulate emotions in order to master social and academic skills.** School provides an important opportunity to teach children how to calm their anxieties and modulate their behaviors. Traumatized children operate at a high level of arousal and fear, making it difficult for them to process information. Anything that reminds a child of the trauma (a facial expression, the color of someone's hair) can trigger behaviors that may not be appropriate in the classroom. Training can start by helping staff recognize when children might be experiencing intense emotions and then move on to a discussion of appropriate supports and responses. Physical activities such as martial arts, yoga, and theater are becoming

recognized as important activities that can help traumatized children reduce hyperarousal and can be enlisted in the classroom to help children focus and learn. Also, simple accommodations such as creating a safe space, or "peace corner," in the classroom; alerting children to any loud noises (e.g., bells, fire alarms) before they occur; and giving children goal-directed tasks that involve movement (e.g., passing out papers) can help children who are aroused regulate their emotions.[147]

2. **Maintaining high academic standards.** One of the most effective ways for children to overcome the impact of trauma is to master the academic and social goals set by the school. Upon learning that a child has been subjected to trauma, it is natural to assume that the curricula should be lightened or expectations diminished. Often adults will say, "She needs time away from academics for a while." It is understandable to want to make things easier on a stressed child, and sometimes this is appropriate. However, careful attention should be paid to the message conveyed by lowering standards. Children often interpret lowered standards as validation of a sense of themselves as worthless, a self-image created by the trauma. Ideally, it is best to let the student know that, despite the travails of his or her life, your expectation is that the student will continue to meet the high standards set for all the children, and that the school will help to make that possible.

3. **Helping children feel safe.** Many of the academic and behavioral difficulties experienced by traumatized children are consequences of the persistent state of fear in which they live. For them to be educated effectively, it is essential that they feel physically and emotionally safe at school. Training should include discussion of how the school can ensure that abusive parents do not enter the building, how to make the classroom safe from teasing and bullying, ways to help children perceive adults as safe and positive, how to reinforce predictability in the classroom, and how to help traumatized children react to the unexpected (e.g., a schedule change).

Physical activities such as martial arts, yoga, theater, and art are becoming recognized as important activities that can help traumatized children reduce hyperarousal and can be enlisted in the classroom to help children focus and learn.

4. **Managing behavior and setting limits.** Traumatized students must be held accountable for their behavior. However, a behavior-management system should be based on an understanding of why a particular child might respond inappropriately in the classroom and on the relational and academic needs of that child. (For more detail, see section VI of the Framework, "School Policies, Procedures, and Protocols.") Traumatized children may need to learn that obeying rules will make a positive difference in their lives; the experience of many children growing up in households plagued by family violence is that rules are arbitrary. It is essential to put in place a school-wide coordinated behavior-management system that emphasizes positive behavioral supports. In addition, traumatized children may benefit from social-skills groups that teach children what behaviors are socially acceptable at school, discuss ways to make friends, and help them learn to trust adults.

5. **Reducing bullying and harassment.** Traumatized students will particularly benefit from a predictable environment that is bully and harassment free. To create such an environment, schoolwide policies concerning bullying and harassment should be established and all staff and students should be trained in how to recognize and respond appropriately. The Newton, Massachusetts, Public Schools curriculum "Creating a Peaceable School: Confronting Intolerance and Bullying" emphasizes a school environment where students feel connected as a community and where older students model positive alternatives to negative peer group behavior. This curriculum also provides "opportunities for students to deal with feelings of exclusion, anger, prejudice, and disempowerment, and conversely with feelings of community, speaking one's voice and empowerment."[148]

6. **Helping children have a sense of agency.** Teachers can help traumatized children cultivate a sense that they can control their environment by creating structures within which children can make choices. Making choices strengthens one's sense of empowerment; having structured opportunities to make choices helps traumatized children overcome the chronic feeling of powerlessness that family violence induces. Learning

For traumatized children to be educated effectively, it is essential that they feel physically and emotionally safe at school.

to accept school boundaries and make appropriate choices within these boundaries can foster a much-needed sense of self-control in traumatized children who chronically seek to be in control of others.

7. **Building on strengths.** Every child has an area of strength in which he or she excels, whether it is in academics, art, music, or sports. When educators can identify and focus on a child's strength, they afford the child the opportunity to experience success, with all the emotional implications of doing something well. This is an important starting point in mastering academic content and social relations, which in turn can serve as a basis for success at school.

8. **Understanding the connection between behavior and emotion.** Traumatized children are often unable to express their experiences in ways adults can readily understand. Lacking the words to communicate their pain, they may express feelings of vulnerability by becoming aggressive or feigning disinterest in academic success because they believe they cannot succeed. Moreover, they themselves may not understand why they are upset or acting out, creating a disconnect between experience, emotion, and actions. When teachers don't understand why a child is acting out, they are likely to focus on the behavior, not on the emotion behind it. Training should help staff understand that a traumatized child's disruptive behavior often is not a matter of willful defiance, but originates in feelings of vulnerability. Once teachers grasp this critical insight, they will be able to work toward responding to what the child may be feeling, rather than solely on the problematic behavior.

9. **Avoiding Labels**. Training needs to emphasize the negative consequences of publicly labeling children "traumatized" or "abused." Labeling carries the risk of making trauma into a prominent feature of the child's identity.

III. Linking with Mental Health Professionals

Mental health professionals with expertise in trauma can offer many kinds of assistance to schools that are helping traumatized children learn. They can consult with and provide clinical supports directly to teachers, participate in consultations about individual children, do testing and evaluations, and give trainings and presentations. In all instances, it is important to clarify when confidentiality and boundaries must be maintained. For example, it may not be appropriate for a mental health professional who is providing therapy to a student and her family to lead a support group attended by that child's teachers.

When schools already have mental health professionals on staff, it is important that they be included in the training program. Schools that do not have in-house services will need to identify appropriate mental health providers who understand trauma's effects on academic and social development in school. We are not specifically advocating in-house or community-based services; instead, we recognize that schools in both situations will need some outside support from mental health professionals who have expertise in trauma and its impact on learning and behavior.

A. Clinical Supports for School Staff

A vital part of educating school staff about trauma and family violence is providing a support system that includes didactic components and clinical components. We recommend a practicum model in which staff interact with each other and with a mental health clinician who has expertise in trauma and its impact in the classroom. In these sessions, staff can review difficult cases and process their own experiences, learning from each other and from the clinician. Clinical support by trauma-knowledgeable clinicians should include:

1. **Confidential discussion.** It is essential to maintain confidentiality when identifying and developing classroom strategies to help traumatized children learn.

2. **Opportunities for staff to reflect upon how their work is affecting their own lives.** Vicarious traumatization is

a common experience among those working with trauma survivors. Teachers dealing with traumatized children may feel some of the anxiety, helplessness, and anger that the children feel and may benefit from the guidance and support of a clinician. Staff should also have opportunities to describe to colleagues and experts their successes in working with traumatized children.

3. **Opportunities to work on reacting positively to traumatized children.** Clinicians can encourage teachers to respond to a traumatized child's underlying emotions rather than solely to the child's behavior, a goal that is as important as creating a structured and predictable classroom environment. Learning to respond to a child's affect can be stressful, and teachers will benefit from the support of clinicians and fellow teachers.

4. **Teaching staff behavior-management techniques.** Clinicians and behaviorists can help teachers structure the classroom for success and for behavior management. They should make recommendations that address the needs of individual children whom the teacher has a hard time reaching.

5. **Opportunities to role-play communications with parents.** Clinicians should help educators practice communicating with parents who may themselves be traumatized and who therefore have difficulties hearing and processing what the teacher is saying.

B. Accessing Mental Health Resources for Families and Students

Teachers can play a helpful role in steering families toward appropriate mental health resources.

1. **Making referrals.** A successful referral to a mental health provider involves thought, follow-up, and giving support to the child's parent or caregiver. Simply providing a phone number for the family to call is not likely to result in a successful referral. If possible, educators or administrators should lay the groundwork for the referral by making the initial connection with the outside provider. Be sure to

communicate confidentially with the custodial parent about the need for services to avoid any additional violence within the family.

2. **Building relationships with parents/caregivers.** Ideally, after mental health services begin, the provider will give feedback to the school about the child's needs. In order for educators to gain access to information from a child's therapist, the educator is legally required to secure a parent's written permission. This will happen in the best possible way if the educator has built a positive relationship with the caregiver. A trusting relationship between the teacher and the caregiver is always in the best interest of the child, but in the case of obtaining this permission, it is also logistically necessary. If a parent is uncomfortable giving a blanket authorization for release of information from the therapist, the educator can ask for a release limited to the child's needs at school or can arrange for a three-way phone conversation, also focused on school issues. These options give the parent, who may herself be an abuse victim, more control over the sharing of sensitive information. Conversations with a child's mental health provider must remain confidential unless the parent authorizes otherwise.

3. **Building a relationship with a mental health provider.** Once a caregiver has signed a release of information, the educator should take the initiative in contacting the mental health provider. The educator should focus on obtaining information that will be useful for devising strategies helpful to that particular child, such as what self-soothing or calming techniques may be effective and what may trigger that child's anxiety (e.g., fear of separation from a parent). Periodic conferencing between a child's therapist and educator will keep both parties on the same page.

IV. Academic Instruction for Traumatized Children

Traumatized children may be difficult to identify in the classroom. Some exhibit behavioral problems, and many have learning profiles that are similar to learning-disabled students (for example, they may not be able to organize their writing or analyze narratives). Although the learning difficulties of traumatized children and learning-disabled children have different sources, similar teaching strategies are effective with both groups. Traumatized children often respond well to literacy intervention, classroom accommodations, and specialized instruction.

The following section describes overarching teaching techniques, as well as more focused language-based approaches. Please note that the key to successfully applying these well-known teaching techniques to traumatized children is keeping in mind the social and emotional barriers that these children face. The relationship between educator and student is incredibly important; for these children, this is what creates space for learning.

A. Overarching Teaching Approaches

The particular challenge when teaching traumatized students is providing an atmosphere that allows teachers to go beyond social and behavioral issues to address the student's learning needs. This teaching process consists of interrelated components:

1. **"Islands of Competence."**[149] The educator needs to discover a student's area, or island, of competence. When the student is allowed to be successful in his or her area of competence, the learning process can begin to take hold and develop. Focusing on an island of competence should not be misunderstood as "dumbing-down" an activity or lesson; rather, it is tailoring learning to a child's interests in order to achieve academic success. Not only does success bolster learning, but it is also central to developing a positive, trusting relationship with the student.

2. **Predictability.** Providing opportunities to succeed must be reinforced by a classroom environment that supports the student's success. Established routines and positive responses

are important for all children, but they are particularly helpful for traumatized children, who need a school environment that is predictable and safe, in contrast to life at home. Laura Goldman, a fifth-grade teacher at the Barbieri Elementary School in Framingham, has shared an example of how predictability can be crucial for a traumatized child: "Emma looks forward to certain activities, and can get thrown off if there are sudden changes. By posting a daily schedule on the board, she can see throughout the whole day what is coming up and what we've already done. If there is going to be a change, she has a constant reminder and nothing will be a surprise to her. I will take the initiative to tell her if there is going to be a big change, to let her know a day ahead to help her prepare for the change." Enhancing predictability in the following areas will be beneficial to traumatized children:

- **Timing of lessons and activities.** Educators enhance predictability when they clearly communicate the schedule their lessons and activities will follow. This can be accomplished by making easily readable schedule charts and by reviewing what activities will be taking place and their projected duration. Going over the schedule on a consistent basis will reinforce predictability.

- **Transitions without trauma.** Traumatized children are often particularly sensitive to transitions. To reassure them and to avoid triggering reactions, educators can preview new people and places, help children predict what will be happening next, and remind them of the uniform enforcement of rules throughout the school setting.

- **Safety.** Traumatized children benefit from classrooms that they know are physically and psychologically safe and secure. This sense of safety includes freedom from physical and verbal threats from, and assaults by, other students and protection from intrusions into classrooms by abusive parents. Traumatized children who are prone to acting out feelings of aggression should not be allowed to traumatize others or

Traumatized children benefit from classrooms that they know are physically and psychologically safe and secure.

cause harm. Supports need to be in place in every classroom to address behavior that is out of control or unsafe. (See section VI-A of the Framework, "Discipline Policies.") Children's sense of safety will be increased by incorporating functional safety skills into the regular curriculum, teaching conflict-resolution skills, and seeing teachers resolve conflict in appropriate ways.

- **Written plans.** Individualized education plans (IEPs) or accommodation plans for students with disabilities should describe in detail the accommodations, supports, services, and actions to take if a traumatic reaction is triggered. It is helpful to have a written action plan for traumatized children without disabilities, as well.

3. **Consistency with classmates.** The academic work assigned to traumatized students should be in line with the rest of the class. If there is a gap, it is best to be honest with the student about

where it is and how it can be closed. Enumerating difficulties and providing a roadmap to remediation takes the mystery out of academics and empowers the student, who now knows what needs to be done.

4. **Positive behavioral supports.** Breaking tasks into parts and providing encouragement and reinforcement throughout the day can help traumatized children feel safe. Behaviorists, who often are asked to observe a classroom to determine the antecedents of difficult behavior, may benefit greatly from working with trauma-sensitive clinicians to identify what may be triggering a traumatized child's problematic behavior. With this information, the teacher can structure the classroom day so that traumatized children receive the affirmation and support that they need.

B. Language-Based Teaching Approaches

Many traumatized children pay more attention to nonverbal signs than to words, which results in frequently missing cues or misunderstanding information. These children can easily lose track of what is happening and misinterpret instructions or expectations in the classroom. Losing track of classroom activity may trigger anxiety, which throws the student further off and makes it harder to catch up. Familiar language-based teaching strategies are effective for reducing fear and increasing the ability to take in and learn information and follow rules.

1. **Using multiple ways to present information.** Among the essential approaches for teaching traumatized children are the use of multiple modes of presenting instructions and expectations (e.g., written and auditory), having children repeat instructions, and practice and role-playing. For example, to teach a traumatized child the rules of classroom safety, it may be helpful to not only give verbal examples (no pushing in the lunch line, no pulling hair, and so forth) but also to have the child practice walking in a line and keeping his hands to himself, etc. It can be worthwhile to have the child do a homework portion in class to check if the instructions have been understood. All these techniques reduce the fear evoked

when chunks of information have been missed; a child who can move from hyperarousal into a calm state will be more available for academic and social learning.

2. **Processing specific information.** Strategies helpful for traumatized students include going over new vocabulary and concepts prior to a lesson, putting information in context, asking questions to facilitate prediction of outcomes, and emphasizing and repeating sequences of events and cause-and-effect relationships. Language therapists recommend giving examples that range from the concrete to the abstract, and they suggest using graphic organizers and physical manipulatives to help children stay on track.

3. **Identifying and processing feelings.** Trauma often impairs the ability of children to use words and pictures to identify their feelings. Children who have trouble using language to communicate emotions cannot always "formulate a flexible response" to situations and may react impulsively.[150] Learning to identify and articulate emotions will help them regulate their reactions. However, it is important to let children calm down before helping them identify their feelings. Some children have cognitive profiles that interfere with their capacity to put words to feelings; they may need specialized approaches and the help of language therapists who work closely with mental health clinicians.

C. Ensuring Appropriate Evaluation

When children receive school evaluations because they are not making progress at school, the evaluator should consider whether trauma may be playing a role. A trauma-sensitive evaluation should address the interface between trauma and the child's cognitive and learning profile.

1. **Psychological evaluations.** When a traumatized child needs a psychological evaluation—either through regular education or as part of a special education evaluation—it is helpful to make a referral to a mental health professional who has expertise in neuropsychology, childhood trauma, and trauma's impact on learning. (When it is not possible to find one mental health

professional who is knowledgeable in all three areas, a team can be set up.) Following the evaluation, the mental health professional should make specific recommendations that will help the school staff teach the child. There has been much discussion about the amount of background information the mental health professional needs to share with the school in order for the school to work effectively with a traumatized child. In general, the details of how a child became traumatized are usually far less important to a school than an understanding of what the child needs to function and be successful. This information may include traumatic triggers (e.g., the child is scared of mustaches); specific ways to help the child modulate emotions and gain a feeling of safety (e.g., places to calm down if upset); special supports, such as a language-skills group or adapted physical education; accommodations, such as sound reduction; and teaching strategies that accord with the child's cognitive profile.

2. **Speech and language evaluations.** As discussed in chapter 1, many traumatized students have trouble with receptive and expressive language, perspective taking, linguistic and narrative skills, and interpreting social context. These children can often benefit from an evaluation that covers the linguistic, pragmatic, and narrative aspects of language.

3. **Functional behavioral assessments.** A traumatized child who has difficulty regulating emotions or behaviors might benefit from a functional behavioral assessment and a behavior-intervention plan. The process consists of gathering information about the cause and purpose of the problem behavior in the classroom and then developing an effective program of intervention based on that information. Critical considerations include the child's traumatic triggers, understanding of authority, and ability to follow rules. Frequently, other clinical issues need to be factored in. In addition, there should be a careful assessment of the classroom environment.

4. **Occupational therapy evaluations.** Traumatized children can often benefit from an occupational therapy evaluation. Such an

evaluation can give the teacher and parent information about the physical activities and classroom accommodations that will help induce and maintain physiological calm in a particular child.

V. Nonacademic Strategies

When a child feels appreciated and cared for by adults at school, a sense of safety grows, and the child consequently becomes more open to learning.

A. Building Nonacademic Relationships with Children

Building a nonacademic relationship is one of the most effective ways for a teacher to help a traumatized child. When a child feels appreciated and cared for by a teacher, a sense of safety grows, and the child consequently becomes more open to learning. The mother of a child traumatized by family violence states, "When Jill was in third grade her teacher really *knew* her. That made such a difference to Jill's learning. When she left third grade she was reading at grade level." Ways to build a relationship with a student include demonstrating warmth toward the student and expressing joy in accomplishments, giving the student a special job that will increase feelings of competence, and spending an occasional lunchtime with the student. One example of a successful attempt to build such a relationship with a traumatized student comes from Barbara Neustadt, a nurse at the Barbieri Elementary School in Framingham. For this particular child, Samuel, she became a central safe figure in the school. In addition to helping Samuel learn how to gain control over his ongoing medical needs, she reinforced his competence by helping him get special jobs in the school.

B. Extracurricular Activities

As discussed above, helping a traumatized child locate areas of strength is essential for building self-esteem and confidence. For many children, the area of strength is not an academic subject but an extracurricular activity, such as theater or basketball. Researchers are beginning to investigate activities such as theater, yoga, and martial arts as important tools for helping children modulate their behaviors and emotions, thus making them more available for learning. Supporting participation in the extracurricular activities in which a child excels will help the child flourish in all aspects of the school setting.

VI. School Policies, Procedures, and Protocols

A school promulgates a culture of trauma awareness through its policies and protocols. Policies already in place need to be reconsidered from a trauma perspective, and some new policies may have to be created to make a school into a safety zone for traumatized children. We suggest that the following policies and protocols be assessed from a trauma-sensitive perspective.

A. Discipline Policies

Trauma-sensitive discipline policies can achieve the dual goals of managing problematic behavior and helping traumatized children feel respected and safe. The following principles are a starting point for planning:

1. **Balancing accountability with understanding of traumatic behavior.** An understanding of trauma-induced behavior will hopefully lead to positive and proactive behavioral approaches, emphasis on the creation of routines and rules, and therapeutic supports that are responsive to the core problem. When traumatized children engage in inappropriate behavior, it is critical to hold them accountable, but for responses to be effective, they must reflect an understanding of the origin of that behavior. Educators should keep in mind the limits of traumatized children's level of self-control, impairment in understanding rules and expectations, and frequent inability to explain why they have acted out.

2. **Teaching rules to traumatized children.** Traumatized children sometimes come from home environments in which power is exercised arbitrarily and absolutely. It is important for these children to learn to differentiate between rules and discipline methods that are abusive and those that are in their best interest. Whenever possible, school personnel should avoid battles for control, seeking instead to engage the child while reinforcing the message that school is not a violent place.

3. **Minimizing disruption of education.** The goal is to keep children in learning environments while also making school safe for all. The school must address, without exception, behavior that is disruptive to other students and to teachers. However, because it is crucial that traumatized children feel and be part of the school community, the school should address behavior before it spirals out of control by implementing positive behavioral supports and behavioral intervention plans—and more restrictive placements, though only when absolutely necessary—rather than suspension and expulsion.

4. **Creating uniform rules and consequences.** Consistency is important for all children, but it is crucial for those who have been traumatized by family violence. Expectations, rules, and consequences should be consistent from teacher to teacher and throughout all school settings. A traumatized child needs to know that the rules in the lunchroom are the same as the rules in the classroom. Consistency at school will allow a traumatized child to begin to differentiate between arbitrary rules, which they may be subject to at home, and purposeful ones. A traumatized child needs to see that rules are enforced fairly and apply to all students.

5. **Model respectful, nonviolent relationships.** When teachers resolve conflicts appropriately, they are using a powerful tool for teaching about nonviolent behavior. Their behavior serves as a model for traumatized children, who may have little or no experience with resolving difficulties respectfully.

B. Communication Procedures and Protocols

Communication among caregivers, the school, health and mental health providers, and outside agencies can be very helpful if carried out in a manner that respects the confidentiality and safety needs of the family.

1. **Confidentiality regarding students and families.** Staff need training (from school counsel, if possible) on what information they are allowed or obliged to share with, or are prohibited from disclosing to, parties such as parents who do not have custody or have a history of domestic violence, members of the school community, the local child protective service, and law enforcement and mental health professionals. Authorization from the appropriate parent or guardian is required before staff can discuss or provide school records or speak to a child's mental health provider. Staff training should especially

Consistency is important for all children, but it is crucial for those who have been traumatized by family violence. A traumatized child needs to know that the rules in the lunchroom are the same as the rules in the classroom.

emphasize the rules that apply to communicating with noncustodial parents, particularly when there is a restraining order or a history of family violence. (In Massachusetts, see MGL c. 71, sec. 37H.)

2. **Communicating with families of traumatized children.** Staff should be given training on how to talk to parents of traumatized children. The need to maintain the child's trust in the school professional should be emphasized and staff should be trained to be alert to issues involving the safety of parent and child—for example, asking the custodial parent what is the best time to call. The school needs to put into place protocols for communicating with parents when trauma is suspected and with parents who are in the midst of a violent situation. Staff must be trained in communicating with parents who are alleged perpetrators of violence.

3. **Filing an abuse and neglect report.** School personnel are mandatory reporters of child abuse and neglect, and most schools already have policies and procedures for filing an abuse and neglect report (in Massachusetts, known as a 51A). These policies protect and support both school personnel and families. The school should have in place specific procedures to follow when abuse and/or neglect is suspected and a mandated report appears to be necessary. These procedures should specify a plan for consultation among staff, the details of who, how, and when to file, and a plan for debriefing afterwards. When intervention is needed, the nonabusive parent should be informed ahead of time, if at all possible, that a report is going to be filed; this can prevent the nonabusive parent from losing trust in the school and can allow for safety planning to help stave off a potentially violent reaction to the report on the part of the abusive parent. Consideration should be given to the point prior to filing when it will be safe and appropriate to inform parents who are alleged to be perpetrators. After the report has been filed, the school should work with parents as closely as is appropriate to support their parenting skills.

C. Safety Planning

Staff should understand their role in making school a safe haven for families who are fleeing domestic violence. Family violence shelters will welcome schools' assistance in developing school safety plans.

1. **Disclosing student-record information.** Sharing student record information with perpetrators of family violence poses a danger to both adult and child victims. To ascertain if an alleged perpetrator is eligible to receive student record information, staff should seek the advice of school or town legal counsel. Massachusetts General Law, Chapter 71, Section 37H, prohibits the disclosure of student record information to parents against whom restraining orders or other domestic-violence-related court orders have been issued. *Staff should NOT release information to ineligible persons.*

2. **Transferring records safely.** Sending records from one school to another can leave a paper trail for an abusive parent to follow. For homeless families fleeing violence in Massachusetts, the Department of Education's Office of Health, Safety and Student Support Services (HSSSS) will serve upon request as a safe conduit for records going from one school to the next. Other agencies in Massachusetts, such as the Department of Social Services or the Department of Transitional Assistance, have also provided this service on an informal basis.

3. **Deleting contact information.** School personnel are required to delete the address and telephone number of the student and the custodial parent before releasing any information to a non-custodial parent with a history of family violence. Schools also are required to give parents the option of having their names and contact information withheld from school directories.

4. **Helping families select their safest school.** Children often become homeless when their families flee a violent home situation. The McKinney-Vento Homeless Assistance Act is a federal law that entitles children in homeless families (including families who are doubled up in the homes of others) to remain in the school attended before the family became homeless or

to enroll in school in the town where the family is temporarily residing. If the family moves again, the child retains the right to either stay in the school he or she has been attending or to transfer to a school in the new town. This right stays in force through the end of the school year in which the child enters permanent housing. School must provide transportation to enable students to continue in their chosen school (a McKinney Manual to help families fleeing violence published by MAC and the Task Force on Children Affected by Domestic Violence is available at www.massadvocates.org or at www.masslegalservices.org). The McKinney-Vento Act can be used to help keep children safe from batterers. McKinney-Vento requires that each school have a liaison who assists homeless families with enrollment and other decisions and helps support homeless children at school. This person should be consulted and informed about trauma issues affecting homeless children.

5. **Supporting the enforcement of court orders.** School staff should be educated about such court orders as restraining orders, custody and visitation orders, and orders that protect confidential information. This will help the school to facilitate their enforcement. Sometimes a noncustodial parent may try to convince the school to look the other way rather than comply with a restraining order. It is best to refer parents back to the court system to resolve disputes and to avoid providing advice as to whether the court order is fair, reasonable, or justified. It should also be explained to school staff that some caregivers do not seek restraining orders in order to avoid further harm to their families. Whether or not there are any court orders, schools need policies that ensure the safety of staff and of families affected by family violence.

   - **Obtaining copies of restraining orders.** School personnel should encourage parents, or the student if of sufficient age, to give copies of active abuse-prevention orders to the school.

   - **Informing relevant personnel.** Schools should keep copies of active restraining orders in accessible locations and inform all relevant school personnel of their existence.

- **Obtaining a photo.** To enable school personnel to identify an abusive person seeking to enter school premises, schools should request a photo or description of the abusive person and attach it to the copies of the restraining orders.

- **Responding to violations.** A few staff members should be trained to respond to violations of restraining orders on school grounds. Also, each school should come up with procedures to follow if an abusive noncustodial parent insists on attending school meetings or tries to communicate with a child or custodial parent through school staff. Safety should be taken into consideration when arranging transportation or school-record transfers for children fleeing an abusive parent.

- **Cooperating with law enforcement.** School policies should support and encourage staff cooperation with law enforcement and the courts, including providing testimony if requested.

- **Notifying caregiver of violations.** School staff who observe or have knowledge of a violation of a court order (e.g., a parent who is prohibited from seeing the child comes to pick the child up at school) should notify the custodial parent/caregiver or, as appropriate, the student who is protected by the order of the violation.

6. **Connecting to healthcare providers.** Schools should seek to link with a child's community-based healthcare providers when appropriate. It can be particularly important, for example, for the school nurse to be in communication with a child's pediatrician or prescribing psychiatrist. The school nurse is often the member of the school staff who is the first to see bruises or to learn of stomachaches; the nurse is also usually the person who administers medication to children during the school day. To the extent that a traumatized child has medical issues, this kind of collaboration can be crucial to his or her school success.

The academic work assigned to traumatized students should be in line with the rest of the class.

7. **Connecting families to community resources.** Schools should be aware of resources in the community, such as legal services offices and domestic violence shelters, to which they can refer families looking for help in addressing violence in their homes. However, staff should not pressure a parent or student into obtaining a restraining order, because sometimes taking this legal step can trigger additional violence.

D. Collaboration with the community

Helping children and families cope with trauma requires the intervention of more than the school system. Good working relationships with community resources are essential. The best approach is for a school to establish connections with these resources before seeking their assistance for the first time. That way, when the school needs help with a specific case, a relationship is already in place.

1. **Appoint a liaison.** In order to maximize communication and effectiveness of policies and protocols, each school should appoint a staff member to be its liaison to health and mental health providers, the department of social services, law enforcement, the court system, and other state agencies. As suggested earlier in the Framework (section 1, part B, number 5), this staff member should ideally be part of a community-liaison team.

2. **Connect with legislators, funders, and public policy makers.** Local, state, and federal legislators and policy makers have a great deal of influence in determining the resources schools have to address trauma. It is advisable to be in communication with policy makers and, if possible, to develop relationships with them. Federal grants are beginning to be available for schools to develop trauma-sensitive supports, especially when the school is part of a communitywide effort to mitigate the impact of trauma caused by family violence.

Chapter 3

Policy Recommendations

The long-term public policy goal is to ensure that children traumatized by family violence succeed in school.

Schools across Massachusetts and beyond can become environments that enable traumatized children to focus, behave appropriately, and learn. To reach this important goal, funding is required to enable each school to adopt a framework and formulate an action plan that will weave trauma-sensitive approaches across the school day and provide individual supports to teachers, parents, and students (see the Flexible Framework in chapter 2). We need to ensure that there is an adequate number of school professionals who understand the impact of family violence on children's learning and are knowledgeable about the best approaches for meeting these needs. We must also ensure that learning and behavioral problems are accurately diagnosed so that appropriate services can be provided.

We appreciate the leadership provided thus far by the Massachusetts Department of Education, and we invite the Department to continue to play a key leadership role on behalf of traumatized children. We ask for increased research on best approaches to address the school needs of these children.

We call for a major summit of key stakeholders to develop a statewide plan for intervening early to address the needs of these children and for decreasing punitive responses such as suspension, expulsion, unnecessary segregation, and referrals to the juvenile justice system.

Recommendation # 1

The Commonwealth should provide publicly funded schools and preschools with funds necessary to develop schoolwide action plans addressing the needs of traumatized children.

The grant program set forth in Massachusetts General Laws, Chapter 69, Section 1N (Chapter 194 of the Acts and Resolves of 2004; see Appendix A) should be expanded to provide funding for all public schools, including publicly funded day care and preschools, to develop and implement their own action plans. These plans should include the following:

- an administrative infrastructure responsible for weaving trauma-sensitive approaches throughout the school day;
- training, skill building, and clinical supports for staff;
- approaches for partnering with parents, who themselves may be suffering from trauma;
- teaching approaches that enable traumatized students to master academic content;
- approaches for using nonacademic activities to support traumatized children;
- individual and group supports to help children regulate their emotions and behavior;
- linkages with mental health services that are able to address the needs of traumatized students;
- review of policies and protocols (including school records laws and court orders) through a trauma-sensitive lens;
- plans to ensure that students are physically and emotionally safe at school; and
- collaborations with local agencies and community organizations, including domestic violence agencies and shelters.

Recommendation # 2

Massachusetts stakeholders should reach consensus on the laws, policies, and funding mechanisms necessary for schools to intervene early to address the needs of traumatized students and to decrease punitive responses.

Key trauma experts, leaders in education, members of the executive and legislative branches of government, and advocates should convene to develop a statewide plan to address the impact of trauma on learning and behavior and outline what schools can do to respond appropriately and effectively, without resorting to punitive responses, such as suspension, expulsion, unnecessary segregation, and referrals to the juvenile justice system.

Recommendation # 3

Teachers and administrators should learn approaches and strategies for teaching children who may be traumatized.

State certification regulations for administrators and teachers from pre-school through high school should require completion, at the pre- and post-certification levels, of course work that includes the following: identifying trauma symptoms, understanding the impact of trauma on learning, approaches to partnering with parents of traumatized children, and classroom strategies that enable traumatized children to succeed academically, behaviorally, and socially. Administrators and teachers should also be educated in how to establish effective linkages and collaborations with mental health professionals and other experts.

Recommendation # 4

Mental health professionals and other specialists providing services in school settings should respond appropriately to trauma-related learning and behavioral problems and should provide trauma-informed consultations to educators.

- Training on trauma's impact on learning, the dual roles of consultants and direct-service providers, and ways to assess the role trauma may be playing in learning and behavioral problems should be required at the pre- and post-licensing levels for mental health professionals, speech and language therapists, and other experts who provide services in schools.

- Guidelines for assessing students' trauma-related educational, language, and psychosocial needs should be developed by mental health, education, and language professionals who have expertise in childhood trauma.

- Rates of reimbursement for mental health and special education evaluations should be sufficient to ensure that the traumatic aspects of a child's needs are assessed by a qualified expert.

Recommendation # 5

The Department of Education should provide continuing information and support to schools.

The Department of Education should develop an office on trauma and schools. The duties of this office should include:

- Maintaining a section of the DOE website on best practices and curricula to address the educational, psychosocial, extracurricular, and safety needs of traumatized students .

- Providing consultation on best practices for linking families with mental health services, safety planning, partnering with parents, developing and implementing curricula, gaining access to available resources, and other topics.

- Reviewing policies, regulations, and laws and taking steps necessary to ensure that their implementation is consistent with the best psychological research on trauma. Relevant policies, regulations, and laws include, but are not limited to, those pertaining to:
    - homelessness;
    - bullying;
    - special education;
    - student support services;
    - discipline;
    - zero tolerance;
    - filing of 51As in collaboration with DSS;
    - safety planning as it relates to domestic violence and child abuse issues;

Recommendation # 6

Research should be funded on the extent to which learning and behavioral problems at school are related to untreated childhood trauma and on best schoolwide and individual practices for addressing the educational needs.

Massachusetts should fund research on information learned pursuant to its grant program "An Act for Alternative Education," codified as MGL C. 69, Sec. 1N.

Conclusion:
Removing Trauma as a Barrier to Learning

All children have a right to learning environments that will help them to calm or temper their emotions, develop positive relationships and solve conflicts peacefully, and become successful learners so that they can grow up and take their place as productive citizens. In a democratic society, no group of children should be disregarded or dismissed simply because they have faced overwhelming stress or even terror in their lives and need help reengaging the world around them.

The answer is not to thrust the problem onto the shoulders of teachers, asking them to solve bigger social problems on their own, but rather to develop a broad public policy agenda in which teachers play a key role. To ensure that children exposed to family violence and other traumatic experiences achieve at their highest potentials, we must put the research and experiences discussed in *Helping Traumatized Children Learn* to work.

Resources must be directed toward developing schoolwide and individual approaches to the problem of trauma for students in both regular and special education settings. Teachers, parents, administrators, and policy makers must put the issue of traumatized children in classrooms squarely on the table, discuss it openly, and then advocate for the resources necessary to ensure that students have the support they need to reach their highest potential.

The Trauma and Learning Policy Initiative will continue its work at the forefront of this issue:

- TLPI is currently convening top experts in trauma psychology, neuropsychology, speech and language, and education to develop guidelines for making school evaluations and consultations in regular and special education trauma-sensitive.

- TLPI will engage in an educational campaign throughout Massachusetts following the release of this report. The project will conduct presentations for parents, professionals, members of the legislature, and key stakeholders.

- TLPI will continue to work with parents and key stakeholders to refine the policy agenda presented in chapter 3.

- TLPI will work to build the broad consensus necessary to support the passage of laws, the development of policies, and the establishment of funding mechanisms necessary for schools to have the supports they need to help traumatized children learn.

Please go to the Massachusetts Advocates for Children website (www.massadvocates.org) and click on the Trauma and Learning Policy Initiative to sign up to receive updates and information on this effort.

Appendix A
Safe and Supportive Schools Legislation

In 2004, the Massachusetts Legislature passed a law designed to help schools address the needs of students traumatized by exposure to violence. Specifically, MGL c. 69, sec. 1N, created a grant program, to be administered by the state Department of Education, that addresses the educational consequences of trauma using a two-pronged approach. Subsection (a) of the law creates grants for school districts to develop innovative approaches to alternative education for older children who are at risk for truancy, failure, and dropping out of school. Subsection (b) of the law creates grants for schools to develop regular education interventions that address "the educational and psychosocial needs of children whose behavior interferes with learning, particularly those who are suffering from the traumatic effects of exposure to violence." The grants described by subsection (b) have come to be known as the "Trauma-Sensitive Schools Grants."

MGL, Chapter 69, Section 1N
Alternative Education Grant Program

Section 1N. (a) The department of education, hereinafter referred to as the department, shall establish a grant program, subject to appropriation, to be known as the alternative education grant program for the purpose of providing grants to assist school districts and Horace Mann and commonwealth charter schools with the development and establishment of alternative education programs and services to students suspended or expelled from school. The grants shall support the development of alternative education programs which would: (1) allow school districts to coordinate efforts to establish interdistrict regional alternative education collaboratives to provide educational services to suspended or expelled students; or (2) establish a district based alternative education program for those students. The grants may also be used to encourage the use of technology in alternative education programs. The grants shall also encourage voluntary expansion of existing alternative education programs

in the commonwealth, and shall be used to provide alternative education programs for students who are at risk of educational failure due to truancy, or dropping out of school. Grants may also be used to assist in developing programs that provide a range of approaches to address behavior issues, such as behavior specialists, in-school suspension rooms and crisis centers, in addition to out-of-school alternative settings.

Programs designed under the grants shall be developed at the middle and high school levels and shall afford students the opportunity to earn a high school diploma in accordance with section 1D, and to be taught to the same academic standards and curriculum frameworks established for all students in accordance with sections 1D and 1E. The programs shall make use of existing resources in school districts, educational collaboratives, community colleges, and other agencies, service providers, and organizations. Programs shall be designed as placements that, at a minimum, educate students to the same academic standards and curriculum frameworks as taught to all students, address behavioral problems, utilize small class size, address individual needs and learning styles, provide engaging instruction and a supportive environment, and, where appropriate, utilize flexible scheduling. The programs shall also provide a comprehensive array of social services to support a student's remediation of issues that cause school failure, excessive absenteeism, truancy and school dropout. Grant recipients shall develop remediation plans for students that address both academic and behavioral issues. Grants may also be made available for in-school regular education programs that include self-improvement, behavior management and life skills training to help provide students with tools to better manage their lives and attitudes, to support programs that use family-based approaches, and to assist students and teachers during the transition of students back into regular education classrooms.

A grant awarded pursuant to this subsection, shall require that recipients undertake ongoing program evaluations that document the effectiveness of the program in helping students to achieve academically to the same academic standards and curriculum frameworks required for all students, to develop self-management skills, and to reintegrate and remain in regular education classrooms. In awarding grants, priority shall be given to programs that employ interventions that have been empirically validated.

The department shall establish guidelines governing the alternative education grant program. The guidelines shall include, but not be limited to, a requirement that when a student is transferred to an alternative education program a representative of the school district shall meet with the student and the student's parents or legal guardian to develop an agreement that specifies the responsibilities of the school, the student and the student's parents or legal guardian. The agreement shall, at a minimum, include:

1. a remediation plan to address both academic and behavioral issues;

2. a plan for frequent evaluations and assessments of the student's adjustment, and academic achievement and progress;

3. a requirement that the parents or legal guardian of the student attend specified meetings or conferences with teachers, or utilize such other means of communication as determined necessary to facilitate communication, to review and assist in the student's progress;

4. a timetable for reintegrating the student into a regular education classroom;

5. the student's and the parents' or legal guardian's acknowledgement that they understand and accept the responsibilities imposed by the agreement.

(b) The department shall establish a grant program, subject to appropriation, to assist school districts with the development and establishment of in-school regular education programs and services to address within the regular education school program the educational and psycho-social needs of children whose behavior interferes with learning, particularly those who are suffering from the traumatic effects of exposure to violence. As used in this subsection, students suffering from the traumatic effects of exposure to violence shall include, but not be limited to, those exposed to abuse, family or community violence, war, homelessness or any combination thereof. The grants shall support the development of school based teams with community ties that: (1) collaborate with broadly recognized experts in the fields of trauma and family and community violence and with battered women shelters; (2) provide ongoing training

to inform and train teachers, administrators, and other school personnel to understand and identify the symptoms and trauma; and (3) evaluate school policy and existing school and community programs and services to determine whether and to what extent students identified as suffering from exposure to trauma can receive effective supports and interventions that can help them to succeed in their public school programs, and where necessary be referred quickly and confidentially to appropriate services.

Grants may also be awarded to assist school districts in developing comprehensive programs to help prevent violence in schools, from whatever causes, and to promote school safety. The programs shall be designed to meet the following objectives: creating a school environment where students feel safe and that prevents problems from starting; helping students to take the lead in keeping the school safe; ensuring that school personnel have the skills and resources to identify and intervene with at-risk students; equipping students and teachers with the skills needed to avoid conflict and violence; and helping schools and individuals to reconnect with the community and share resources.

The department shall develop guidelines governing the implementation of the grant program authorized by this subsection. A grant awarded pursuant to this subsection shall require that recipients undertake ongoing evaluations of the effectiveness of the program. In awarding grants, priority shall be given to programs that are based on empirically validated interventions.

The department of education, in consultation with the department of public health and the department of mental health, shall establish an advisory committee to assist in implementing the grant program and in assisting public schools in addressing the learning and behavior problems of students who manifest trauma-related symptoms or classroom behavior that interferes with learning. Members of the advisory committee shall include but not be limited to: 3 educators, 1 of whom shall serve as the chair, appointed by the commissioner of the department of education; 2 leaders in the field of trauma and its relationship to school learning and behavior appointed by the commissioner of the department of public health; 2 leaders in mental health with expertise in family and/or

community violence appointed by the commissioner of mental health; 1 leader in battered women's services appointed by the commissioner of public health; 1 leader in the area of homelessness and its impact on children appointed by commissioner of mental health; and 3 parents, 1 each appointed by the commissioner of education, the commissioner of public health, the commissioner of mental health. The advisory committee, at its discretion, may select additional members with relevant experience including but not limited to child advocates, medical doctors and representatives of juvenile and probate court.

(c) The commissioner shall evaluate annually the effectiveness of programs established under this section including the potential for replicating such programs throughout the commonwealth. The annual evaluation shall also examine whether students in alternative education programs funded under this section are being taught to the same academic standards required for all students, how much time students are spending in the programs, the racial profile of expelled or suspended students and the percentages of the students who are in special education or bilingual education. The commissioner shall also provide technical assistance to school districts seeking to replicate programs funded under this section, and shall provide training for teachers in the development of effective remediation plans for students in alternative education, and in the development of skills, techniques, and innovative strategies to assist the students. In evaluating programs funded under subsection (b), the commissioner shall consult with the department of public health, the department of mental health, and the advisory committee established pursuant to said subsection (b).

Appendix B
PTSD and Related Diagnoses

The broad range of traumatic symptoms displayed by children who have experienced multiple, chronic, or prolonged traumatic circumstances often reach the threshold for one or more psychiatric diagnoses. While sometimes children's behavioral, cognitive, and emotional reactions to trauma meet the threshold criteria for post-traumatic stress disorder (PTSD), there are many traumatized children who are highly symptomatic but who do not meet this threshold.[151] One possible reason for this is that the existing criteria for PTSD are not developmentally sensitive for children. To address the range of problems observed, children are instead often given a variety of comorbid diagnoses (e.g., depression, oppositional defiant disorder, attention-deficit hyperactivity disorder) that both fail to recognize trauma as an organizing framework and function "as if they occurred independently from the PTSD symptoms."[152] Some clinical researchers have called for modifications of the official diagnostic criteria for PTSD, so that symptomatic children can receive the diagnosis and become eligible for the educational and psychological services they need.[153]

In order to address concerns about the inadequacies of the PTSD diagnosis for children, van der Kolk and his colleagues at the Complex Trauma Task Force of the National Child Traumatic Stress Network have "started to conceptualize a new diagnosis, provisionally called developmental trauma disorder."[154] This proposed new diagnosis would incorporate the complex array of developmental effects of trauma in children, which the current PTSD diagnosis does not adequately capture.[155] However, until the criteria for post-traumatic stress disorder is modified or a new, more developmentally appropriate diagnosis is developed, it is important to understand the elements of PTSD.

As described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM-IV), post-traumatic stress disorder is a condition in which, following an identified traumatic event(s), a person demonstrates symptoms, lasting more than one month, of

hyperarousal, reexperiencing (i.e., involuntarily "reliving" the traumatic experience), and avoidance (i.e., avoiding traumatic reminders and/or emotions associated with the initial traumatic event).[156] Children who meet the criteria for PTSD will demonstrate symptoms within all three criteria clusters: hyperarousal, reexperiencing, and avoidance.

Hyperarousal

Hyperarousal is the first cluster of PTSD symptoms. Hyperarousal is the body's hard-wired physiological and emotional response to extreme danger, readying us for fighting, fleeing, or freezing. Under normal circumstances, this response is triggered only by threatening circumstances. A child who has PTSD, however, is chronically attuned to any sign of threat and tends to interpret objectively innocuous situations as dangerous. Because of the child's inability to evaluate effectively the level of danger, the fight-flight-freeze response is activated by any hint of danger. Chronic hyperarousal is a distressing, physically uncomfortable state and interferes with other functioning.

A hyperaroused child is constantly on edge. Such a child startles easily, is ever-vigilant, cannot relax, overreacts to minor provocations, and may not sleep well.[157] Hypervigilance diminishes the ability to appraise a situation accurately and to regulate the intensity and appropriateness of emotions. Trauma specialist Betsy McAlister Groves explains how hypervigilance "interferes with [children's] abilities to accomplish learning tasks in school":

> These children are distractible and unfocused. They do not complete assignments. They may be highly active and restless. They notice every visitor who comes into the room; they get distracted by noise or by a change in schedule. Some children describe being preoccupied with thoughts or memories of the traumatic event. One seven-year-old girl told us that whenever things were quiet in school she would remember what happened to her mother (who had been assaulted by her father). One can only imagine the ways in which this child worked to avoid quiet time in school: She was constantly disruptive and annoying to the other children.[158]

Reexperiencing

Reexperiencing, like hyperarousal, inundates a child with unbidden and unwelcome sensory experiences that can interfere with everyday functioning. A child reexperiencing the trauma is flooded with intrusive thoughts, flashbacks, or nightmares that can impair the ability to distinguish past trauma from present safety. The experience is visceral. It is as if the child is *in* the past, reliving the traumatic event. Intrusive images or memories capture not only the visual representation of the physical events but also the sensory and emotional experiences of "helplessness, terror, horror, and utter ineffectiveness."[159] Traumatic triggers, or the reminders of the trauma, are often sudden and unanticipated; the child feels unprepared and out of control, which exacerbates fears of recurrence.[160]

Avoidance

Avoidance of stimuli associated with the trauma and numbing of general responsiveness constitute the third cluster of symptoms associated with post-traumatic stress disorder. Avoidance, which can be deliberate or unconscious, is the child's attempt to protect the self from recollections of the trauma and "the disturbing re-experiencing symptoms that are triggered by such reminders."[161] Children may avoid people, places, smells, and sounds that remind them of the initial trauma. To avoid potential interactions with traumatic triggers, children may show diminished interest in activities (e.g., constricted play activities in the case of young children and, for older children, decreased involvement in academic or extracurricular activities), be socially withdrawn, or experience a sense of detachment from others. This cluster of symptoms also includes the numbing or restricting of feelings, both in variety and in intensity. In school, avoidance can manifest as inattentiveness, emotional detachment from teachers, "spaciness," or even aggressiveness (an active pushing away of traumatic reminders).

* * *

Reexperiencing and avoidance often occur almost simultaneously. A child can be engulfed and overwhelmed by viscerally experienced images of the trauma and in the blink of an eye be working actively and unconsciously to move away from anything connected to the trauma. Oscillation between the two states is prevalent in traumatized children, and it can happen rapidly, sometimes within a matter of moments.[162] Rapid oscillation gives rise to a confusing myriad of symptoms associated with both states. This is very difficult in a classroom, which by its very nature relies on predictable responses from students and teachers. However, educators can feel more in control of the classroom environment if they understand that shifting behavior is predictable for a child with PTSD.

As mentioned above, it can be difficult for children to meet the diagnostic threshold for PTSD. Furthermore, symptoms of trauma overlap with many other problems and disorders. As a result, traumatized children frequently carry diagnoses other than PTSD. When these diagnoses do not inherently recognize the child's traumatic background (e.g., conduct disorder, ADHD), they may have the unintended consequence of misdirecting intervention efforts. Sometimes these diagnoses are actually incorrect because no one has ever taken notice of the trauma history. Sometimes they are accurate but do not capture the full nature and complexity of the child's problems.

Appendix C
Factors Influencing the Trauma Response[163]

Characteristics of the Individual	Characteristics of the Environment	Characteristics of the Traumatic Event(s)
■ Child's age and stage of development	■ Immediate reactions of caregivers or those close to child	■ Frequency, severity, and duration of the event(s)
■ Prior history of trauma	■ Type of, quality of, and access to constructive supports	■ Degree of physical violence and bodily violation
■ Intelligence	■ Attitudes and behaviors of first responders and caregivers	■ Level of terror and humiliation involved
■ Strengths and vulnerabilities of personality style; coping and resiliency skills	■ Degree of safety afforded the victim in the aftermath	■ Persistence of the threat
■ Individual's culturally based understanding of the trauma	■ Prevailing community attitudes and values	■ Physical and psychological proximity to the event (i.e., when the individual him/herself is not the victim)
	■ Cultural and political constructions of gender, race, and sexual orientation	

Notes

Executive Summary

[1] The special challenges of dealing with childhood trauma necessitates the creation of climates or contexts that are supportive both for traumatized children and for the educators who teach them. For this particular insight about the importance of community and context we owe much gratitude to Judith Herman. In her groundbreaking book, *Trauma and Recovery*, she emphasized the importance of a supportive community for adults who are in a helping role with trauma victims and the need for a larger social context that "affirms and protects the victim and joins victim and [helper] in a common alliance." Herman, J. (1997). *Trauma and Recovery*. New York: Basic Books, p. 9.

[2] Spinazzola, J., Ford, J.D., Zucker, M., van der Kolk, B.A., Silva, S., Smith, S.F., and Blaustein, M. (2005). "Survey Evaluates Complex Trauma Exposure, Outcome, and Intervention Among Children and Adolescents." *Psychiatric Annals*, 35(5): 433–439. In a survey of 1,699 children served in 25 mental health treatment sites, the following types of trauma exposure were reported for approximately one in two children: psychological maltreatment, traumatic loss, dependence on an impaired caregiver (mental illness or substance abuse) and domestic violence. One in three children were victims of sexual maltreatment and neglect. Fewer than one in 10 children had trauma exposure not involving interpersonal victimization (accidents, medical illness, disaster). See also Harris, W.W., Putnam, F.W., and Fairbank, J.A. (In press). "Mobilizing trauma resources for children." In A.F. Lieberman and R. DeMartino (Eds.), *Interventions for Children Exposed to Violence*. New Brunswick, NJ: Johnson & Johnson Pediatric Institute LLC; and van der Kolk, B.A. (2005). "Childhood Trauma: Our largest preventable public health issue." Presentation at *Closing the Achievement Gap: Removing Trauma as a Barrier to Learning*, a briefing to the Massachusetts Legislature. March 22, 2005. (Dr. van der Kolk's slide presentation is on file with the authors.) The authors of both presentations discuss the fact that consequences of childhood trauma, in general, constitute a major public health concern; both also point out that family violence is one particular—and very significant—source of this childhood trauma.

[3] Carlson, B.E. (1984). "Children's observations of interparental violence." In Roberts, A.R. (Ed.), *Battered Women and Their Families* (pp. 147–167; 160). New York: Springer Publishing; estimating that at least 3.3 million children are exposed to violence in their homes each year. Straus, M.A. (1992). "Children as Witness to Marital Violence: A risk factor for lifelong problems among a nationally representative sample of American men and women." *Report of the 23rd Ross Roundtable*. Columbus, OH: Ross Laboratories. Fantuzzo and Mohr analyze these often-cited studies and find them both methodologically flawed. They conclude, however, that "[a]lthough no databases provide reliable prevalence estimates, research findings to date underscore that domestic violence occurs in large numbers of households with children." Fantuzzo, J.W., and Mohr, W.K. (1999). "Prevalence and Effects of Child Exposure to Domestic Violence." *The Future of Children*, 9(3): 21–32; 23.

[4] U.S. Department of Health and Human Services. (2003). "Child Maltreatment 2003." Available online at http://www.acf.hhs.gov/programs/cb/publications/cm03/chapterthree.htm. Last accessed on May 31, 2005.

[5] Adams, A., and Powell, A. (1995). "The Tragedies of Domestic Violence: A qualitative analysis of civil restraining orders in Massachusetts." Boston, MA: Office of the Commissioner of Probation.

[6] Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., and Marks, J.S. (1998). "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults." *American Journal of Preventive Medicine*, 14(4): 245–257; 248d. Other reported measures of household dysfunction were substance abuse (25.6%), mental illness (18.8%), and criminal behavior (3.4%).

[7] Burns, J. (2005). "Preliminary Report—Grant 790: Alternative Education Program." Malden, MA: Mass. Department of Education, pp. 4–5. Grant 790 is one of two programs funded pursuant to MGL c. 69, sec. 1N. Subsection A of the law provides for alternative education for children who have been suspended or expelled or

who are at risk for such actions; Subsection B provides funding for schools to create learning environments that are safe and supportive for traumatized children. (See Appendix A of this document for the text of the law.) The report concludes, "Students at-risk, exposed to trauma, appear across the continuum in our education system. This continuum extends from pre-kindergarten to post secondary age students. This data is compelling in support of continued and expanded educational services for student [*sic*] exposed to trauma" (p. 5). The report also listed students' response rates for other forms of trauma: 37.5% had a caregiver with a substance-abuse problem; 31% reported histories of bullying or harassment; 19% reported having a caregiver with a mental illness; 11.5% reported a history of sexual assault; and 6% reported histories of homelessness.

[8] See Groves, B.M. (2002). *Children Who See Too Much: Lessons from the Child Witness to Violence Project.* Boston, MA: Beacon Press. For a discussion of the particular effects that family violence (as opposed to other forms of violence) has on children, see Chapter 3, "When Home Isn't Safe." Groves states, "Domestic violence, violence that occurs between adult caregivers in the home, seems to be the most toxic form of exposure to violence for children" (p. 50). She continues, "Perhaps the greatest distinguishing feature of domestic violence for young children is that it psychologically robs them of both parents. One parent is the terrifying aggressor; the other parent is the terrified victim. For young children, who depend exclusively on their parents to protect them, there is no refuge. These situations are different from those of families who face community violence. In most of those cases, parents are not fearful for their own lives and can be both heroic and resourceful in their efforts to protect their children" (p. 59).

[9] Ibid., pp. 58–59. Domestic violence and/or abuse by a caretaker introduces chaotic unpredictability and danger into a place that should be a haven where children may retreat. It also inhibits a parent's ability to facilitate children's coping and continued development. As a result, the need for social support systems increases.

[10] Briere, J.N. (1992). *Child Abuse Trauma: Theory and Treatment of the Lasting Effects.* Newbury Park, NJ: SAGE Publications. Briere highlights the effect that family violence can have on a child's self-perception. He describes the attempts children make to resolve what he terms "the abuse dichotomy" that occurs when they are abused by a trusted caregiver. Abused children often reach the self-perpetuating conclusion that "I was (and continue to be) hurt because of my badness, and evidence of my badness is that I have been (and continue to be) hurt" (pp. 27–28).

[11] Terr, L.C. (1991). "Childhood Traumas: An Outline and Overview." *American Journal of Psychiatry*, 148(1): 10–20. According to Terr, there are four major characteristics of childhood trauma that have the ability to last long into adulthood. One of these is what she calls "changed attitudes about people, life, and the future." She gives examples of ideas like "You can't trust the police" or "You can't count on anything or anyone to protect you" as ways that trauma can alter a child's worldview (p. 14).

[12] Fantuzzo, J.W., and Mohr, W.K. (1999), p. 22.

[13] Edleson, J.L. (1999). "The Overlap Between Child Maltreatment and Woman Battering." *Violence Against Women*, 5(2): 134–154; 136. Edleson reviews studies on the overlap between domestic violence and child maltreatment and finds that, in families where one form of violence occurs, the other will also occur 30% to 60% of the time.

[14] Kilpatrick and Williams, for example, conducted a study of children who had witnessed domestic violence and found great similarity in trauma outcomes between these children and children who had been sexually or physically abused. Kilpatrick, K.L., and Williams, L.M. (1997). "Post-Traumatic Stress Disorder in Child Witnesses to Domestic Violence." *American Journal of Orthopsychiatry,* 67(4): 639–644.

[15] In his work on child neglect, for example, De Bellis points out that "psychobiological research . . . is inherently difficult because neglected children may suffer from different subtypes of neglect and adversities other than neglect, which may also compromise neuropsychological and psychosocial outcomes." De Bellis, M.D. (2005). "The Psychobiology of Neglect." *Child Maltreatment*, 10(2): 150–172; 150.

[16] Ritter, J., Stewart, M., Bernet, C., and Coe, M. (2002). "Effects of Childhood Exposure to Familial Alcoholism

and Family Violence on Adolescent Substance Use, Conduct Problems, and Self-Esteem." *Journal of Traumatic Stress*, 15(2): 113–122.

[17] The names of all children in this report have been changed to protect their anonymity.

[18] See, for example, Streeck-Fischer, A., and van der Kolk, B.A. (2000). "Down Will Come Baby, Cradle and All: Diagnostic and therapeutic implications of chronic trauma on child development." *Australian and New Zealand Journal of Psychiatry*, 34: 903–918. Streeck-Fischer and van der Kolk review the literature on the impact of chronic trauma on child development and discuss the learning difficulties that many traumatized children encounter. See also Beers, S.R., and De Bellis, M.D. (2002). "Neuropsychological Function in Children with Maltreatment-Related Posttraumatic Stress Disorder." *American Journal of Psychiatry,* 159(3): 483–486 (finding that children with maltreatment-related PTSD performed more poorly than others on measures of attention and executive function); and Nelson, C.A., and Carver, L.J. (1998). "The Effects of Stress and Trauma on Brain and Memory: A view from developmental cognitive neuroscience." *Development and Psychopathology* 10: 793–809 (concluding that the developing brain is particularly vulnerable to the effects of stress and trauma, which have the potential to impair a child's memory).

[19] McFarlane et al., for example, found higher rates of internalizing, externalizing, and total behavior problems among children of abused mothers, ages 6–18, than among children of the same age and sex of nonabused mothers. These authors endorse the recommendation of the American Academy of Pediatrics Committee on Child Abuse and Neglect that all women receive a routine screening for abuse at the time of the well-child visit. McFarlane, J.M., Groff, J.Y., O'Brien, J.A., and Watson, K. (2003). "Behaviors of Children Who Are Exposed and Not Exposed to Intimate Partner Violence: An Analysis of 330 Black, White, and Hispanic Children." *Pediatrics*, 112(3): e202–e207. Shields and Cicchetti also found that maltreated children were more likely than nonmaltreated children to engage in aggressive behaviors and to experience attention deficits and emotional dysregulation. Their data suggest that physically abused children are at particular risk for reactive aggression. Shields, A., and Cicchetti, D. (1998). "Reactive Aggression Among Maltreated Children: The Contributions of Attention and Emotion Dysregulation." *Journal of Clinical Child Psychology*, 27(4): 381–395.

[20] See, for example, Shonk, S.M., and Cicchetti, D. (2001). "Maltreatment, Competency Deficits, and Risk for Academic and Behavioral Maladjustment." *Developmental Psychology*, 37(1): 3–17.

[21] See, for example, Carlson, E.B., Furby, L., Armstrong, J., and Shales, J. (1997). "A Conceptual Framework for the Long-Term Psychological Effects of Traumatic Childhood Abuse." *Child Maltreatment*, 2(3): 272–295. See also Lansford, J.E., Dodge, K.A., Pettit, G.S., Bates, J.E., Crozier, J., and Kaplow, J. (2002). "A 12-Year Prospective Study of the Long-term Effects of Early Child Physical Maltreatment on Psychological, Behavioral, and Academic Problems in Adolescence." *Archives of Pediatric and Adolescent Medicine*, 156: 824–830. This study found that physical maltreatment in the first five years of life predicts the development of psychological and behavioral problems during adolescence. Specifically, the researchers found increased levels of anxiety and depression among maltreated children.

[22] Shonk, S.M., and Cicchetti, D. (2001), p. 5. The authors review several studies on the academic consequences of childhood maltreatment.

[23] Felitti, V.J., et al. (1998). In addition to alcohol and substance abuse, the list of health risk factors among adults exposed to abuse as children included severe obesity, physical inactivity, promiscuity, and suicide attempts—all behaviors that can contribute to disease and/or early death.

[24] Ibid. The authors postulate that victims of abuse may engage in increased levels of smoking, substance abuse, overeating, and promiscuity because these behaviors "may have immediate pharmacological or psychological benefit as *coping devices* in the face of the stress of abuse, domestic violence, or other forms of family and household dysfunction" (p. 253; emphasis added).

[25] Cook, A., Blaustein, M., Spinazzola, J., and van der Kolk, B. (Eds.). (2003). "Complex Trauma in Children and Adolescents: White Paper from the National Child Traumatic Stress Network Complex Trauma Task Force." Los

Angeles: National Child Traumatic Stress Network (available online at http://www.nctsn.org). On community-wide responses to complex trauma, see pp. 25–27. See also, Baker, L.L., Jaffe, P.G., Ashbourne, L., and Carter, J. (2002). "Children Exposed to Domestic Violence: A Teacher's Handbook to Increase Understanding and Improve Community Responses." London, Ontario: Centre for Children & Families in the Justice System (available online at http://www.lfcc.on.ca/teacher-us.PDF); and Carter, L.S., Weithorn, L.A., and Behrman, R.E. (1999). "Domestic Violence and Children: Analysis and Recommendations." *The Future of Children*, 9(3): 1–20; and Harris, W.W., et al. (2004); calling for major collaborations and a mobilization of resources directed to "finding, treating, and helping traumatized children and their families" (p. 36).

[26] Masten, A.S., and Coatsworth, J.D. (1998). "The Development of Competence in Favorable and Unfavorable Environments." *American Psychologist*, 53(2): 205–220. In reviewing the literature on favorable outcomes for children at risk, the authors recognize three key factors in the lives of children who manage to develop well even under adverse conditions, such as domestic violence, maltreatment, homelessness, and war: 1) strong parent-child relationships or, when this is not available, a relationship with a surrogate caregiving figure in a mentoring role; 2) strong cognitive skills, which predict academic success and lead to rule-abiding behavior; and 3) the ability to self-regulate attention, emotions, and behavior. They point to attending effective schools as a key characteristic of resilient children and adolescents. Cook et al., endorse a treatment model for children with complex trauma histories that echoes the three key factors outlined by Masten and Coatsworth. The model they discuss (called ARC) emphasizes three key areas: "1) building secure "a"ttachments between child and caregiver(s); 2) enhancing self-"r"egulatory capacities; and 3) increasing "c"ompetencies across multiple domains." Cook, A., et al. (Eds.). (2003), p. 26.

[27] Herman states that recovery from trauma "follows a common pathway. The fundamental stages of recovery are establishing safety, reconstructing the trauma story, and *restoring the connection between survivors and their community*." Herman, J. (1997), p. 3; emphasis added. Perhaps the most important community for children is their school. Schools can help children who have been traumatized feel safe—both physically and psychologically—and enable them to become successful members of their community. Our goal is for schools to become contexts in which traumatized children can thrive.

[28] There is support for this dual type of approach in the literature. Masten and Coatsworth argue, for example, that "[i]f the goal is to change the competence of children, multiple directed strategies need to be considered ranging from efforts to change child capabilities (e.g., tutoring) to interventions directed at the context (e.g., parent education or school reform or opening of opportunities) . . . . " Masten, A.S., and Coatsworth, J.D. (1998), p. 206.

[29] For this particular insight, we owe much gratitude to Judith Herman. In her groundbreaking book, *Trauma and Recovery*, she emphasizes the importance of a supportive community for adults who are in a helping role with trauma victims and the need for a larger social context that "affirms and protects the victim and joins victim and [helper] in a common alliance." Herman, J. (1997), p. 9.

[30] Macy speaks to the important role teachers can play in helping traumatized children succeed. He says that "local teachers . . . must be empowered at their neighborhood level to respond to and guide threatened youth, and fiscal and administrative support for these local responses must be sustained over time." Macy, R.D. (2003). "Community-based Trauma Response for Youth." *New Directions for Youth Development*, 98: 29–34; 31.

[31] Lewis, D.O., Mallouh, C., and Webb, V. (1989). "Child Abuse, Juvenile Delinquency, and Violent Criminality." In D. Cicchetti and V. Carlson (Eds.), *Child Maltreatment* (pp. 707–721). Cambridge: Cambridge University Press. These authors explain that, while there is clearly an association between childhood abuse and subsequent aggressive acts, "most abused children do not become violent delinquents" (p. 707). Several studies do indicate, however, that while the number of abused children who become violent is relatively small, the number of violent delinquents who were abused or neglected or both has been found to be very high—as high as 80% in one study. The authors report that severe physical abuse is most likely to be associated with violent delinquency and criminality when one or more of the following additional factors is present: "the child suffers from some sort of central nervous system dysfunction that impairs his ability to modulate his emotions and control his responses;

the child suffers from some form of psychiatric disturbance that impairs his reality testing at times so that he misperceives his environment and feels needlessly and excessively threatened; *the child is exposed to extraordinary household violence between parents or caretakers*" (p. 717; emphasis added).

[32] Streeck-Fischer and van der Kolk describe the social costs of failing to address the needs of traumatized children early: "If not prevented or treated early, these children are likely to grow up to lead traumatised and traumatising lives. Their problems with affect modulation are likely to lead to impulsive behaviour, drug abuse and interpersonal violence. Their learning problems interfere with their becoming productive members of society. Early intervention is of critical importance, because, once they drop out beyond ordinary social safety nets, they make their presence known as individuals who pay a very high price for their (mis)behaviour. Providing these maltreated children with care, sustenance and specialised therapeutic interventions has been shown to considerably lessen the long-term risk they pose to themselves and to society at large." Streeck-Fischer, A., and van der Kolk, B.A. (2000), pp. 915–916.

[33] Herman explains quite eloquently the societal urge we often feel to remain in denial about traumatic experiences and the corresponding need for environments that support those who work with trauma victims. She writes, "Without a supportive social environment, the bystander usually succumbs to the temptation to look the other way. This is true even when the victim is an idealized and valued member of society. Soldiers in every war, even those who have been regarded as heroes, complain bitterly that no one wants to know the real truth about war. When the victim is already devalued (a woman, a child), she may find that the most traumatic events of her life take place outside the realm of socially validated reality. Her experience becomes unspeakable." She further explains that "[t]o hold traumatic reality in consciousness requires a social context that affirms and protects the victim and that joins victim and witness in a common alliance." Herman, J. (1997), pp. 8, 9.

Chapter One

[34] Janoff-Bulman, R. (1992). *Shattered Assumptions: Towards a New Psychology of Trauma.* New York: Free Press, p. 5.

[35] Ibid., p. 6.

[36] Cicchetti, D., Toth, S.L., and Hennessy, K. (1989). "Research on the Consequences of Child Maltreatment and Its Application to Educational Settings." *Topics in Early Childhood Special Education*, 9(2): 33–55. Cicchetti et al., explain the relevance of attachment theory to children's readiness for school: "children with sensitive caregivers come to view themselves as acceptable and worthy of care, whereas children with insensitive and/or unresponsive caregivers learn to see themselves as unacceptable and unlovable. Thus, it is argued that these internalized working models of the self and attachment figures, resulting from the infant's early experiences of care, profoundly influence both the acquisition and integration of later developmental competencies, such as the formation of positive peer relationships, adaptation to the classroom, and the motivational orientation to achieve" (p. 38).

[37] Several authors have described the devastating impact traumatic experiences can have on children's expectations of the world. Pynoos et al., for example, propose that "the critical link between traumatic stress and personality is the formation of trauma-related expectations as these are expressed in the thoughts, emotions, behaviors, and biology of the developing child. By their very nature and degree of personal impact, traumatic experiences can skew expectations about the world, the safety and security of interpersonal life, and the child's sense of personal integrity." The authors describe how traumatic experiences "contribute to a schematization of the world, especially of security, safety, risk, injury, loss, protection, and intervention." Pynoos, R.S., Steinberg, A.M., and Goenjian, A. (1996). "Traumatic Stress in Childhood and Adolescence: Recent developments and current controversies." In B.A. van der Kolk, A. McFarlane and L. Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* (pp. 331–358). New York: Guilford Press; pp. 332, 349–350. Herman also discusses the impact of trauma on one's worldview. She writes, "Traumatic events destroy the victim's fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation." Herman, J. (1997), p. 51.

[38] As Katz explains, "[Exposure to violence] can alter how we see the world, how we see others, and how we perceive

our own worth. The effects may be especially severe in children because children lack perspective. They have nothing to compare their circumstances to. It can appear as though there really is no alternative; this is how it's going to be. The child tries over and over again to alter the painful and frustrating circumstances he finds himself in, but to no avail. It's beyond his ability to control. His job now is to try and adapt as best he can." Katz, M. (1997). *On Playing a Poor Hand Well: Insights from the Lives of Those Who Have Overcome Childhood Risks and Adversities*. New York: W.W. Norton & Co., p. 5, citing Terr, L. (1990), *Too Scared to Cry*. New York: Basic.

[39] Horsman, J. (2000). *Too Scared To Learn: Women, Violence and Education.* Mahwah, NJ: Lawrence Erlbaum Associates, Inc., p. 86, quoting Brooks, A.-L. (1992). *Feminist Pedagogy: An Autobiographical Approach*. Halifax: Fernwood (pp. 21–22).

[40] See Janoff-Bulman, R. (1992), p. 79.

[41] See Cicchetti, D., et al. (1989), particularly pp. 40–44.

[42] Caregiving relationships in infancy and early childhood establish models upon which children approach their environment as they grow and develop. Sroufe explains: "In the secure attachment case … the child develops generally positive and trusting attitudes toward others. Along with this, the child takes forward a sense of his or her own effectance and personal worth. Being able to effectively elicit responsiveness and care from the parent, they expect to master challenges and to have power in the world. They believe in themselves. Likewise, they value relating and have an internalized template for empathy and reciprocity in relationships." They develop a sense of curiosity, a skill in exploration, and they learn to express and modulate emotion. Anxious attachment patterns, on the other hand, undermine the development of these capacities in children. Sroufe, A. (1997). "Psychopathology as an Outcome of Development." *Development and Psychopathology*. 9: 251–268; 262.

[43] All individuals have worldviews and as such see the world through a set of "glasses." The traumatized child's gaze in the world brings all encounters into marked relief according to his or her expectations of danger. As Carlson et al. note, "Even after children have escaped from abusive environments, they may continue to interpret ambiguous and neutral cues as threatening and, therefore, respond with fear and avoidance." Carlson, E.B., et al, (1997), pp. 276–277.

[44] Herman, J. (1997), p. 99.

[45] Van der Kolk suggests that these children may sense that their perceptions are not entirely accurate, but not know why and to what degree. This perception can increase a child's anxiety, compounding his or her learning problems. Van der Kolk, B.A. Remarks at "Helping Traumatized Children Learn," a conference co-sponsored by Lesley University, Massachusetts Advocates for Children (MAC), and the Task Force on Children Affected by Domestic Violence. Cambridge, MA. January 16, 2001. (Transcripts of the conference are on file with the authors.)

[46] Van der Kolk explains, "Many problems of traumatized children can be understood as efforts to minimize objective threat and to regulate their emotional distress. Unless caregivers understand the nature of such re-enactments, they are likely to label the child as 'oppositional,' 'rebellious,' 'unmotivated,' or 'anti-social.'" Van der Kolk, B.A. (2005), "Developmental Trauma Disorder." *Psychiatric Annals*, 35(5): 401–408, p. 403, citing Pynoos, R.S., Frederick, C.J., Nader, K., et al. (1987). "Life Threat and Posttraumatic Stress in School-age Children." *Archives of General Psychiatry*, 44(12): 1057–1063.

[47] For a general discussion of the stress response in traumatized children and a review of recent studies on this topic, please see Bevans, K., Cerbone, A.B., and Overstreet, S. (2005). "Advances and Future Directions in the Study of Children's Neurobiological Responses to Trauma and Violence Exposure." *Journal of Interpersonal Violence*, 20(4): 418–425.

[48] As Bremner and Narayan point out, this appears to be a paradox: the stress response, designed to be a survival tool, can actually be detrimental to the organism in certain contexts. Since maladaptive responses may linger even after the organism has achieved safety, they argue from an evolutionary perspective that "long-term function is sacrificed for the sake of short-term survival." Bremner, J.D., and Narayan, M. (1998). "The Effects of Stress on Memory and the Hippocampus throughout the Life Cycle: Implications for childhood development and aging."

Development and Psychopathology, 10: 871–885; 875.

[49] For a discussion of the loss of self-regulation in traumatized children, see van der Kolk, B.A. (1998). "The Psychology and Psychobiology of Developmental Trauma." In A. Stoudemire (Ed.), *Human Behavior: An Introduction for Medical Students* (pp. 383–399; 389). Philadelphia: Lippincott-Raven.

[50] Perry et al. explain how experiencing constant fear can affect the development of children's brains: "The more frequently a certain pattern of neural activation occurs, the more indelible the internal representation. Experience thus creates a processing template through which all new input is filtered. The more a neural network is activated, the more there will be use-dependent internalization of new information needed to promote survival." Perry, B.D., Pollard, R.A., Blakely, T.L., Baker, W.L., and Vigilante, D. (1995). "Childhood Trauma, the Neurobiology of Adaptation, and 'Use-dependent' Development of the Brain: How 'States' Become 'Traits.'" *Infant Mental Health Journal*, 16(4): 271–291; 275.

[51] See Perry, B.D. (2002), at note 69, infra.

[52] See, for example, Glaser, D. (2000). "Child Abuse and Neglect and the Brain—A Review." *Journal of Child Psychology and Psychiatry*, 41(1): 97–116; 101.

[53] Fisher et al. documented improved behavioral adjustment among children in an early-intervention foster care program. They also documented reductions in these children's salivary cortisol levels, suggesting that early environmental interventions may indeed have the potential to impact the neurobiological system positively. Fisher, P.A., Gunnar, M.R., Chamberlain, P., and Reid, J.B. (2000). "Preventive Intervention for Maltreated Preschool Children: Impact on children's behavior, neuroendocrine activity, and foster parent functioning." *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(11): 1356–1364.

[54] Manly et al. explain this scaffolding process in children's mastery of developmental tasks: "From infancy through childhood, children are faced with tasks that are central to each developmental period, and the quality of the resolution of these tasks primes the way that subsequent developmental issues are confronted. … Early competent resolution of stage-salient developmental tasks facilitates successful negotiation of successive developmental tasks, whereas difficulty mastering earlier developmental challenges may potentiate later maladaptive outcomes." Manly, J.T., Kim, J.E., Rogosch, F.A., and Cicchetti, D. (2001). "Dimensions of Child Maltreatment and Children's Adjustment: Contributions of developmental timing and subtype." *Development and Psychopathology*, 13: 759–782; 760.

[55] Terr, L.C. (1991), p.11.

[56] Herman, J. (1997), p. 33.

[57] Terr, L.C. (1991), p. 14. Terr distinguishes between Type I traumas that involve "single shocking intense terrors" and Type II traumas that involve more complicated events, such as ongoing and chronic abuse. She says that the former is marked by "1) full, detailed, etched-in memories, 2) 'omens' (…cognitive reappraisals…), and 3) misperceptions and mistimings." While a single event can have long-lasting symptoms, she states that Type I traumas are less likely to "breed the massive denials, psychic numbings, self-anesthesias, or personality problems that characterize type II disorders." For another discussion of the difference between prolonged or chronic trauma and a single terrible event, see chapters 4 and 5 in Herman, J. (1997). See also Carlson, E.B., et al. (1997), p. 139. The authors explain that physical or sexual abuse can have a harsher impact—resulting from feelings of betrayal—when it is perpetrated by a "caretaker with whom the child had a previous healthy attachment."

[58] See Nelson, C.A. and Bloom, F.E. (1997). "Child Development and Neuroscience." *Child Development*, 68(5): 970–987: 980, citing Bornstein, M.H. (1989). "Sensitive Periods in Development: Structural characteristics and causal interpretations." *Psychological Bulletin*, 105: 179–197.

[59] According to Harvey, much of the literature on trauma focuses on the psychological characteristics of individuals and neglects the importance of environmental contributions to the response and recovery trajectory. She proposes an "ecological" model to explain individual trauma responses in the context of human community. Harvey, M.R.

(1996). "An Ecological View of Psychological Trauma and Trauma Recovery." *Journal of Traumatic Stress*, (9)1: 3–23. See also Carlson, E.B., et al. (1997), p 287. The authors state "the availability of social support is expected to act as a mitigating factor in the response to traumatic abuse. This is anticipated because those who do not have support are expected to feel less hopeful of achieving control over the aversive experiences." They further explain, "The first type of social support would be provided by individuals such as a relative or teacher. The second might be provided by community or societal institutions." Groves also argues for a contextual approach to the issue of violence and children. See Groves, B.M. (2002), particularly chapters 4, 5, and 6.

[60] Harvey, M.R. (1996), p. 7.

[61] Terr, L.C. (1991), p. 10. Terr explains that these are technically correct diagnoses depending on how the symptoms might manifest on a particular day. However, she raises serious concerns about this array of diagnoses, stating, "We must organize our thinking about childhood trauma, however, or we run the risk of never seeing the condition at all. Like the young photographer in Cortazar's short story and Antonioni's film, 'Blow Up,' we may enlarge the diagnostic fine points of trauma to such prominence that we altogether lose the central point—that external forces created the internal changes in the first place. We must not let ourselves forget childhood trauma just because the problem is so vast." See also Famularo, R., Fenton, T., Kinscherff, R., and Augustyn, M. (1996). "Psychiatric Comorbidity in Childhood Post Traumatic Stress Disorder." *Child Abuse & Neglect*, 20(10): 953–956. These researchers demonstrated that PTSD was comorbid with ADHD, other anxiety disorders, brief psychotic disorder, suicidal ideation, and a trend toward mood disorders.

[62] Van der Kolk, B.A. (2005).

[63] Greenwald O'Brien, J.P. (2000). "Impacts of Violence in the School Environment: Links between trauma and delinquency." *New England Law Review*, 34: 593–599; 597.

[64] Masten, A.S., and Coatsworth, J.D. (1998), p. 210.

[65] As Greenwald O'Brien explains, family violence "make[s] it difficult to attend, focus, or concentrate. Information is processed carelessly, or inaccurately, stored incorrectly, poorly remembered, or unable to be retrieved. When violence compromises family functioning, there may be no one at home to facilitate an education orientation, or motivate children to value learning or to excel in school. A teenager's emotional energy is occupied with safety concerns which erode the needed momentum for school. The very nature of violence can imperil a child's ability to trust teachers and other school professionals." Greenwald O'Brien, J.P. (2000), p. 597. See also Craig, S. (1992), p. 67.

[66] Streeck-Fischer, A., and van der Kolk, B.A. (2000), p. 912.

[67] De Bellis explains that the superior temporal gyrus, the area of the brain thought to be primarily responsible for the development of social intelligence, can be significantly impacted by chronic maltreatment. This may be an explanation for why individuals with a history of maltreatment often have difficulty with social relationships. De Bellis, M.D. (2005), p. 161.

[68] Streeck-Fischer, A., and van der Kolk, B.A. (2000), p. 912.

[69] Perry, B.D. (2002). "Neurodevelopmental Impact of Violence in Childhood." In D.H. Schetky and E.P. Benedek (Eds.), *Principles and Practice of Child and Adolescent Forensic Psychiatry* (pp. 191–203; 200). Washington, DC: American Psychiatric Publishing, Inc.

[70] This story comes from an anonymous member of the Task Force on Children Affected by Domestic Violence.

[71] Rauch, S.L, van der Kolk, B.A., Fisler, R.E., Alpert, N.M., Orr, S.P., Savage, C.R., Fischman, A.J., Jenike, M.A., and Pitman, R.K. (1996). "A Symptom Provocation Study of Posttraumatic Stress Disorder Using Positron Emission Tomography and Script-Driven Imagery." *Archives of General Psychiatry*, 53(5): 380–387. More specifically, this study monitored the regional cerebral blood flow (rCBF) of PTSD patients who listened to both traumatic and neutral scripts. When the patients listened to the traumatic scripts, the researchers noted increased rCBF in right-sided limbic and paralimbic structures and in the right secondary visual cortex. They noted decreased rCBF in the

left inferior frontal cortex (Broca's area) and the left middle temporal cortex. See also Ford J, (2005). "Treatment Implications of Altered Affect Regulations and Information Processing Following Child Maltreatment." *Psychiatric Annals* 35 (5) 412–419. This article, published too close to HTCL press deadlines for analyzing in detail here, summarizes studies on the brain that explain why some women with abuse-related PTSD have impairments in information processing, including the ability to categorize information and access verbal information.

[72] Coster, W. and Cicchetti, D. (1993). "Research on the Communicative Development of Maltreated Children: Clinical implications." *Topics in Language Disorders*, 13(4): 25–38; 31.

[73] Ibid.

[74] Ibid., citing Santostefano, S. (1978). *A Biodevelopmental Approach to Clinical Child Psychology*. New York: John Wiley.

[75] Ibid., citing Donaldson, M. (1978). *Children's Minds*. New York: Norton.

[76] Ibid., citing Hemphill, L., et al. (1991). "Narrative as an Index of Communicative Competence in Mildly Mentally Retarded Children." *Applied Psycholinguistics*, 12: 263–279; and McCabe, A. and Peterson, C. (Eds.) (1991). *Developing Narrative Structure*. Hillsdale, NJ: Erlbaum.

[77] Craig, S. (1992). "The Educational Needs of Children Living with Violence." *Phi Delta Kappan*. 74: 67–71; 68, citing Helfer, R.E., and Kempe, C.H. (1980). "Developmental Deficits Which Limit Interpersonal Skills." In idem (Eds.) *The Battered Child*, 3rd Ed. (pp. 36–48). Chicago: University of Chicago Press. See also Coster, W., and Cicchetti, D. (1993), pp. 34–35.

[78] Coster, W., and Cicchetti, D. (1993), pp. 34–35.

[79] Allen, R.E., and Oliver, J.M. (1982). "The Effects of Child Maltreatment on Language Development." *Child Abuse and Neglect*, 6: 299–305.

[80] Coster, W., and Cicchetti, D. (1993), pp. 34.

[81] Craig, S. (1992), p 67.

[82] Pynoos et al. explain: "Advances in child developmental psychology are providing more refined tools to evaluate the impact of traumatic stress on developmental competencies. For example, in recent years, research has elucidated the normal developmental achievement of narrative coherence (i.e., children's ability to organize narrative material into a beginning, middle, and end). Current research among preschool children exposed to both intrafamilial and community violence has indicated interference with this task, resulting in more chaotic narrative construction. Achievement of this developmental task is essential to subsequent competencies in reading, writing, and communication skills." Pynoos, R.S., Steinberg, A.M., and Goenjian, A. (1996), p. 342, citing Osofsky, J.D. (1993). "Applied Psychoanalysis: How research with infants and adolescents at high psychological risk informs psychoanalysis." *Journal of the American Psychoanalytic Association*, 41: 193–207.

[83] Craig, S. (1992), p. 67.

[84] Ibid.

[85] Van der Kolk, B.A. (2005), p. 403.

[86] Craig, S. (1992), p. 68.

[87] Ibid.

[88] Craig, S. (1992), p. 68. Perry elaborates further on the connection between cause-and-effect and the behavior of traumatized children; he explains: "the sense of time is altered in alarm states. In [traumatized] children, the sense of the future is foreshortened, and the critical time period for the individual shrinks. The threatened child is not thinking (nor should she think) about months from now. This has profound implications for understanding the cognition of the traumatized child. Immediate reward is most reinforcing. Delayed gratification is impossible.

Consequences of behavior become almost inconceivable to the threatened child." Perry, B.D. (2002), p. 200.

[89] Coster, W., and Cicchetti, D. (1993), p. 30.

[90] Craig, S. Remarks at "Helping Traumatized Children Learn," a conference co-sponsored by Lesley University, Massachusetts Advocates for Children (MAC), and the Task Force on Children Affected by Domestic Violence. Cambridge, MA. January 16, 2001. (Transcripts of the conference are on file with the authors.)

[91] Van der Kolk, B.A. (2005), p. 403.

[92] Craig, S. (1992), p. 68.

[93] Ibid.

[94] Streeck-Fischer, A., and van der Kolk, B.A. (2000), p. 912, citing van der Kolk, B.A., and Ducey, C.P. (1989). "The Psychological Processing of Traumatic Experience: Rorschach patterns in PTSD." *Journal of Traumatic Stress*, 2: 259–265; and McFarlane, A.C., Weber, D.L., and Clark, C.R. (1993). "Abnormal Stimulus Processing in Posttraumatic Stress Disorder." *Biological Psychiatry*, 34: 311–320.

[95] Craig, S. (1992), p. 68.

[96] See Famularo, R., et al. (1996); and Thomas, J.M. (1995). "Traumatic Stress Disorder Presents as Hyperactivity and Disruptive Behavior: Case presentation, diagnoses, and treatment." *Infant Mental Health Journal*, 16(4): 306–316.

[97] Perry's study of the neurodevelopmental effects of childhood trauma reports that the ADHD diagnosis of traumatized children can be misleading. "It is not," he explains, "that [traumatized children] have a core abnormality of their capacity to attend to a given task, it is that they are hypervigilant. These children have behavioral impulsivity and cognitive distortions that result from a use-dependent organization of the brain. During development, these children spent so much time in a low-level state of fear . . . that they were focusing consistently on non-verbal cues." Perry, B.D. (1997). "Incubated in Terror: Neurodevelopmental factors in the 'cycle of violence.'" In J.D. Osofsky (Ed.), *Children in a Violent Society* (pp. 124–149; 136). New York: Guilford Press citing Pynoos, R.S., and Eth, S. (1985). "Developmental Perspectives on Psychic Trauma in Childhood." In C.R. Figley (Ed.), *Trauma and Its Wake* (pp. 36–52). New York: Brunner/Mazel; Pynoos, R.S. (1990). "Post-traumatic Stress Disorder in Children and Adolescents." In B. Garfinkel, G. Carlson, and E. Weller (Eds.), *Psychiatric Disorders in Children and Adolescents* (pp. 48–63). Philadelphia: W.B. Saunders; and Perry, B.D., et al. (1995). The relationship between ADHD and trauma is complicated and, as yet, not fully understood. Several studies have reported striking levels of ADHD in traumatized samples, while others have reported similar levels of concurrent ADHD and PTSD, and still others have reported the independent comorbidity of ADHD and PTSD with a number of additional and common childhood disorders such as oppositional defiant disorder, conduct disorder, anxiety disorder, and depression. As a result, the level of symptom overlap contributing to the confusion of ADHD and the symptoms of trauma, particularly as manifest in the child's classroom behavior, is complicated by the interrelationship between and concurrence of ADHD and trauma with a variety of behavioral and social problems prominent in several childhood disorders. Insofar as the relationship is not fully understood, it is important that the traumatic history of a child displaying ADHD symptoms in the classroom be considered and, when necessary, it is important that both be treated accordingly. In light of recent studies that indicate that children exposed to violence may develop a series of behavioral, social, and emotional problems, the traumatic history of a child being assessed for ADHD based on disruptive behavior in the classroom is of considerable significance. See Pelcovitz, D., et al. (1994). "Post-Traumatic Stress Disorder in Physically Abused Adolescents." *Journal of the American Academy of Child and Adolescent Psychiatry*. 33: 305–312. Simply put, the effects of trauma as they appear in the classroom can be deceptive, and school personnel need to be aware of the possibility that traumatic exposure to domestic violence may be the origin of behavioral problems, even though they need not necessarily assume at the outset that such problems are the result of traumatic exposure.

[98] Masten, A.S., and Coatsworth, J.D. (1998), p. 208.

[99] Shields, A., and Cicchetti, D. (1998), p. 391, citing Cicchetti, D. "How Research on Child Maltreatment Has

Informed the Study of Child Development: Perspectives from developmental psychopathology." In D. Cicchetti and V. Carlson (Eds.), *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect*. (pp. 377–431). New York: Cambridge University Press.

[100] Streeck-Fischer, A., and van der Kolk, B.A. (2001), p. 905, citing Toth, S.C., and Cicchetti, D. (1998). "Remembering, Forgetting, and the Effects of Trauma on Memory: A developmental psychopathologic perspective." *Developmental Psychopathology*, 10: 580–605.

[101] Ibid.

[102] Shields, A., and Cicchetti, D. (1998), p. 391.

[103] Van der Kolk, B.A. (1998), p. 391.

[104] Mezzacappa, E., Kindlon, D., and Earls, F. (2001). "Child Abuse and Performance Task Assessments of Executive Functions in Boys." *Journal of Child Psychology and Psychiatry*, 42(8): pp. 1041–1048; 1042.

[105] Lubit, R., Rovine, D., Defrancisci, L., and Eth, S. (2003). "Impact of Trauma on Children." *Journal of Psychiatric Practice*, 9(2): 128–138; 133.

[106] Van der Kolk, B.A. (2005), p. 403.

[107] De Bellis, M.D. (2005). "The Psychobiology of Neglect." *Child Maltreatment*, 10(2): 150–172, 160. De Bellis explains that chronic stress and its resulting increased activation of catecholamines can "turn off" the prefrontal cortex's inhibition of the limbic system; this can cause children to lose the ability to focus and attend in school.

[108] Beers, S.R., and De Bellis, M.D. (2002): pp. 483–486.

[109] Mezzacappa, E., et al. (2001).

[110] Shonk, S., and Cicchetti, D. (2001).

[111] Ibid, p. 4.

[112] Ibid.

[113] Katz, M. (1997), p. 7, citing Weiner, B. (1993). "On Sin Versus Sickness: A theory of perceived responsibility and social motivation." *American Psychologist*, 48(9): 957–965.

[114] Ibid.

[115] Lubit, R., et al. (2003), p. 133.

[116] De Bellis, M.D. (2005), p. 161. De Bellis explains that repeated maltreatment can result in the chronic activation of the amygdala, which inhibits the development of the prefrontal cortex, the part of the brain primarily responsible for emotional and behavioral regulation.

[117] Shonk, S.M., and Cicchetti, D. (2001), p. 4, citing Dodge, K.A., Bates, J.E., and Pettit, G.S. (1990). "Mechanisms in the Cycle of Violence." *Science*, 250: 1678–1683; and Rogosch, F.A., and Cicchetti, D. (1994). "Illustrating the Interface of Family and Peer Relations through the Study of Child Maltreatment." *Social Development*, 3: 291–308.

[118] Ibid., citing Dodge, K.A., et al. (1990).

[119] Carlson, E.B., et al. (1997), p. 279.

[120] Ibid., p. 277, citing Herrenkohl, R.C. and Herrenkohl, E.C. (1981). "Some Antecedents and Developmental Consequences of Child Maltreatment." In R. Rizely and D. Cicchetti (Eds.), *New Directions for Child Development: Developmental Perspectives on Child Maltreatment*. (pp. 31–56). San Francisco: Jossey-Bass.

[121] Shields, A., and Cicchetti, D. (1998), p. 391, citing Dodge, K.A, Pettit, G.S., Bates, J.E., and Valente, E. (1995). "Social Information-Processing Patterns Partially Mediate the Effect of Early Physical Abuse on Later Conduct

Problems." *Journal of Abnormal Psychology*, 104: 632–643; and Rogosch, F.A., Cicchetti, D., and Aber, J.L. (1995). "The Role of Child Maltreatment in Early Deviations in Cognitive and Affective Processing Abilities and Later Peer Relationship Problems." *Development and Psychopathology*, 7: 591–609.

[122] Ibid.

[123] Perry, B.D., et al. (1995), p. 280.

[124] Weissbourd, R. (1996). *The Vulnerable Child: What Really Hurts America's Children and What We Can Do About It*. Reading, MA: Addison-Wesley; p. 15.

[125] Pynoos, R.S., et al. (1996), p. 344.

[126] This story comes from an anonymous client of the Trauma and Learning Policy Initiative.

[127] Morrow, G. (1987). *The Compassionate School: A Practical Guide to Educating Abused and Traumatized Children*. Englewood Cliffs, NJ: Prentice-Hall; p. 36.

[128] Ibid.

[129] Herman, J. (1997), p. 105.

[130] Craig, S. (1992), pp. 68–69.

[131] Masten, A.S., and Coatsworth, J.D. (1998), p. 213.

[132] As Perry explains, traumatized children often "over-read (misinterpret) nonverbal cues (e.g., eye contact means threat, a friendly touch is interpreted as an antecedent to seduction and rape); interpretations that are accurate in the world they came from but now, hopefully, out of context. During development, these children spent so much time in a low-level state of fear . . . that they were focusing consistently on nonverbal cues." Perry, B.D. (2002), p. 200.

[133] Craig, S. (1992), p. 68.

[134] Pynoos, R.S., et al. (1996), p. 344.

[135] Van der Kolk, B.A. (2005), p. 403.

[136] Pynoos, R.S., et al. (1996), p. 344.

[137] Ibid.

[138] Ibid. See also van der Kolk, B.A. Remarks at "Helping Traumatized Children Learn." January 16, 2001.

[139] Pynoos, R.S., et al. (1996), p. 344, citing Pynoos, R.S., and Nader, K. (1993). "Issues in the Treatment of Post-Traumatic Stress in Children and Adolescents." In J.P. Wilson and B. Raphael (Eds.), *International Handbook of Traumatic Stress Syndromes* (pp. 535–549). New York: Plenum Press.

[140] See Shonk, S.M., and Cicchetti, D. (2001), at note 21, supra.

Chapter 2

[141] Masten, A.S., and Coatsworth, J.D. (1998), p. 215.

[142] Ibid.

[143] Ibid.

[144] Cook, A., et al. (Eds.). (2003), p. 26. Kinniburgh, K.J., Blaustein, M., and Spinazzola, J. (2005). "Attachment, Self-Regulation, and Competency: A comprehensive intervention framework for children with complex trauma." *Psychiatric Annals*, 35(5): 424–430. These authors developed ARC as a framework that can be applied across settings to address the needs of children with complex trauma. The white paper relied upon an earlier precursor to this article.

[145] Masten, A.S., and Coatsworth, J.D. (1998), p. 206.

[146] Boykin-McCarthy, J. (1999). "Emancipatory Learning: A study of teachers' perspective shifts regarding children of battered women." *Dissertation Abstracts International*, 60(09), 3325A (UMI No. 9945913). Boykin-McCarthy's findings indicate that when teachers understand better the personal and societal complexities of battering and recent trauma research explaining how some student behaviors are not resolved by traditional classroom management techniques, they can increase their comfort level, classroom skills, and sense of competence in working with students who are children of battered women.

[147] For teaching us about these and other accommodations that help children regulate their emotions, we owe much thanks to Jane Koomar, Ph.D., ORT/L of Occupational Therapy Associates in Watertown, MA.

[148] Beardall, N. (2004). "Creating a Peaceable School: Confronting Intolerance and Bullying." Newton, MA: Office of Curriculum and Instruction, Newton Public Schools, p. 2.

[149] Brooks, R. (1991). *The Self-Esteem Teacher.* Loveland, OH: Treehaus Communications, Inc. Brooks contends that "every person in this world possesses at least one small 'island of competence,' one area that is or has the potential to be a source of pride and achievement. This metaphor is not intended to be merely a fanciful image, but rather a symbol of respect and hope, a reminder that all children and adolescents have areas of strength. Those who are teaching and raising children have the responsibility to find and build upon these islands of competence so that they will soon become more prominent than the ocean of self-doubt" (p. 31).

[150] Van der Kolk, B.A. (1998), p. 391.

Appendix B

[151] Van der Kolk, B.A. (2005), p. 404; citing Kiser, L.J., Heston, J., Millsap, P.A., and Pruitt, D.C. (1991). "Physical and Sexual Abuse in Childhood: Relationship with post-traumatic stress disorder." *Journal of the American Academy of Child and Adolescent Psychiatry*, 30(5): 776-783. Van der Kolk notes elsewhere that the consequences of childhood trauma "go well beyond the core definition of PTSD: how to trust people after you know how much they can hurt you, how to calm yourself down when you are upset, how to pay attention while faced with emotionally arousing situations, how to deal with bodily responses to upsetting events, and how to think positively about oneself when faced with adversity." Van der Kolk, B.A. (1998), p. 384. See also Streeck-Fischer, A., and van der Kolk, B.A. (2000).

[152] Van der Kolk, B.A. (2005), p. 5.

[153] See, for example, Scheeringa, M.S., Peebles, C.D., Cook, C.A., and Zeanah, C.H. (2001). "Toward Establishing Procedural, Criterion, and Discriminant Validity for PTSD in Early Childhood." *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(1): 52–60; and Scheeringa, M.S., Zeanah, C.H., Myers, L., and Putnam, F.W. (2003). "New Findings on Alternative Criteria for PTSD in Preschool Children." *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(5): 561–570.

[154] Van der Kolk, B.A. (2005), p. 405.

[155] Ibid. According to van der Kolk, the developmental effects of trauma include: complex disruptions of affect regulation; disturbed attachment patterns; rapid behavioral regressions and shifts in emotional states; loss of autonomous strivings; aggressive behavior against self and others; failure to achieve developmental competencies; loss of bodily regulation in the areas of sleep, food, and self-care; altered schemas of the world; anticipatory behavior and traumatic expectations; multiple somatic problems, from gastrointestinal distress to headaches; apparent lack of awareness of danger and resulting self-endangering behaviors; self-hatred and self-blame; and chronic feelings of ineffectiveness.

[156] The official criteria a person must meet in order to qualify for a diagnosis of PTSD are as follows:

a. The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

b. The traumatic event is persistently reexperienced.

c. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma).

d. Persistent symptoms of increased arousal (not present before the trauma).

e. Duration of the disturbance is more than one month.

f. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th Ed.* (DSM-IV). Washington, DC: American Psychiatric Association, pp. 427–429.

[157] Herman, J. (1997). See, in particular, Herman's discussion of "Attacks on the Body," pp. 108–110.

[158] Groves, B.M. (2002), p. 47.

[159] Pynoos, R.S., et al. (1996), p. 345. The authors caution that "we tend to speak of intrusive images as if they are merely reproductions of original photographic negatives of a gruesome scene. In doing so, we risk missing the experiential and clinical significance of these 'pictures in the child's mind.'" (p. 345).

[160] Ibid., pp. 341–342.

[161] Carlson, B.E., et al. (1997), p. 277.

[162] Ibid., p. 278.

Appendix C

[163] The entries in this table are credited to Harvey, M. (1996), pp. 7–8.

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