

Understanding Childhood Trauma: Ten Reminders for Preventing Retraumatization

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Abstract

Traumatic events can leave a staggering impact on a child's development. School counselors are in the primary position to assist children with traumatic symptoms, however, counselors often work alongside educators, administrators, and school personnel alike. Consequently, it is necessary that *all* adults develop an understanding of traumatic reactions and the steps to provide stability and comfort. This article integrates trauma research to provide a compilation of reminders that adults can implement to prevent unnecessary retraumatization.

As children spend a significant portion of their weekdays in the school environment, mental health professionals working in schools and professional school counselors could be arguably the adults held most accountable to manage traumatic responses in children (Powers, Ressler, & Bradley, 2008). Currently, it is estimated that one in four children will experience a traumatic event during their childhood or adolescent years (Duke, Pettingell, McMorris, & Borowsky, 2010). With school shootings and other acts of violence, student and teacher deaths, natural disasters, and other world events affecting the American student's psychological well-being, it is important, now more than ever, that school counselors be equipped with adequate skills to intervene when traumatic reactions occur for children (Allen, Burt, Bryan, Carter, Orsi & Durken, 2002).

Trauma can be defined as an emotional reaction to a recognizable stressor that will be qualitatively different for different people (Rowling, 2008; Weathers & Keane, 2007). Traumatic events can also be regarded as "incidents that are perceived as terrifying, shocking, sudden, or that potentially pose a threat to one's life, safety, or personal integrity" (Black, Woodworth, Tremblay, & Carpenter, 2012, p. 192). For elementary school-aged children, trauma reactions can include worrying, anxiety, somatic complaints, behavioral and academic changes, disruptions to sleeping and eating, and hypersensitivity to sound, smells, and other senses (Gurwitch, Silovsky, Schultz, Kees, & Burlingame, 2001). With middle school-aged children, each of these emotional and behavioral reactions may be present, as well as preoccupation with thinking about and discussion of the trauma-causing event. Trauma reactions for high school-aged children can present similarly to the reactions of younger youth (i.e. worry, anxiety, excessive thinking about the event, somatic complaints), although it can also present similarly to adult reactions including higher risk of antisocial, delinquent, or risk-taking behavior (Duke et al., 2010; Gurwitch et al., 2001; Mueser, Rosenberg & Rosenberg, 2009). As traumatic psychological effects can have short and long-term impact (Carr, 2004; Powers et al., 2008), school counselors and other personnel must have the skills necessary to detect symptomatology, halt the impact of suffering, and prevent retraumatization over time.

This paper seeks to offer simple reminders that school personnel and helping professionals in school settings can utilize to promote restabilization or to prevent retraumatization to children experiencing traumatic reactions to a crisis incident. While this piece is written largely to provide members of a school community with resources to appropriately work with traumatized students, the concepts are applicable to helping professionals in a variety of disciplines (i.e. nursing, rehabilitation, education, etc.). The hope is that by reminding ourselves of basic principles that communicate support to children, the direct services we offer will become more beneficial and far-reaching, thus positively affecting the lives of greater numbers of children.

Recognize that events do not have to be extreme to be traumatic

Traumatic events can come in many shapes and sizes. Single traumatic events, also known as acute trauma or Type I events (Bath, 2008), are “short-term, unexpected, single incidents, and quick recovery is more likely from this type of trauma exposure” (Kruczek & Salsman, 2006, p. 461). Complex traumatic events, also known as Type II events (Bath, 2008) or polytraumatization (Gustafsson, Nilsson, & Svedin, 2009), are more “prolonged, chronic, or repetitive experiences” and are more likely to involve “severe stress reactions and difficulty with adjustment” (Kruczek & Salsman, 2006, p. 461).

Possibly one of the greatest disservices school leaders and adult figures alike can do is to assume that trauma must be extreme, complex, or repetitive to be worthy of mental health services or appropriate attention. What deems significant in one child’s life may not be an issue for another child or even to adults. For example, imagine that a child was in a car accident during the weekend and now fears riding in the car on his way to school. By definition, this event would qualify as a Type I or single traumatic event, therefore suggesting a quicker recovery of symptoms than from a complex trauma. Meiser-Stedman, Smith, Glucksman, Yule, and Dalgleish (2007) studied the impact of single-event traumas by interviewing 90 child-parent groups to see the degree of agreement in parent-reported and child-reported symptoms when assessing for Acute Stress Disorder (ASD) or Posttraumatic Stress Disorder (PTSD). Results from the study indicated low parent-child agreement for ASD and fair parent-child agreement on PTSD symptoms, with the child-report being more likely to meet the criteria for ASD and PTSD symptom clusters. Findings from this study support that a child’s perceived traumatization may differ from how others witness or experience it, particularly with single-event traumatic incidents. Children, in fact, may perceive the event to be more detrimental than adults perceive it to be, whether the trauma-causing event is big or small.

It is important that helping professionals and school personnel alike understand that trauma reactions vary between children, even if the incident seems minor, acute, or short-lived. School leaders need to be prepared to witness a spectrum of traumatic responses given the variety of trauma-causing situations that children may experience during their school-aged years. Recognizing that even seemingly small issues can provoke a traumatic response in children may help school leaders better detect *when* and *what* situations trigger retraumatization in the school setting.

Understand that crises often co-occur

School personnel must be mindful that often times, one traumatic event is accompanied by another, which over time, may lead to more complex levels of traumatization (Bath, 2008; Gustafsson et al., 2009; Powers et al., 2008). To more fully understand this concept, let us revisit the scenario of the child in the car accident mentioned in the previous section. Imagine that this child has experienced a divorce within his family and is now being transitioned into a new school community. This child may experience low levels of traumatization due to the adjustment, loss of friends, new family dynamics, and transition to a new environment. Now, with the addition of the car accident on the way to school, the child may be experiencing added fear, anxiety, and worry about coming to school and leaving his primary support system. The co-occurring traumas can lead to several issues within the school settings, such as difficulty making or engaging friendships, distractibility or disorganization in the classroom, or withdrawal from potential support systems.

Each trauma independently could have created difficulty for this child; collectively, the compounded traumas can lead to deeper, more complex symptomatology (Gustafsson et al., 2009). Furthermore, experiencing a traumatic event in the presence of an additional potentially traumatic vulnerability factor (Costello, Erkanli, Fairbank, & Angold, 2002) such as poverty, family relationship issues, or family psychopathology, begins to elucidate just how easily the co-occurrence of trauma-causing situations can emerge.

Each of the beginning two reminders (i.e. “Recognize that events do not have to be extreme to be traumatic” and “Understand that crises often co-occur”) can help school personnel understand the impact of trauma in a child’s life. The following six reminders serve as a guide for “ways of being” that can positively affect the child-adult relationship in the aftermath of a trauma-causing event.

Provide safety

Bath (2008) asserted that safety, connection, and emotional regulation are the three pillars for helping children heal following a trauma-causing event. “The first imperative...is creating a safe space for them” (p. 19), thus indicating the role that a secure system, and the people within the system, play in facilitating the restorative process for children (Sandoval, Scott, & Padilla, 2009). Safety can be promoted in the school by reestablishing a routine for children, including consistent rules and expectations, reliability and predictability in engagement by others, and availability of adult support (Bath, 2008). Safety can also be encouraged by offering information to children with honest communication using age-appropriate language. Perry (2009) noted that such dialogue could help alleviate anxiety or worry about the incident, leading children to trust the communicating adult and feel safe in his or her presence. Each of these considerations is not only important, but also necessary, for school leaders to show concern for safety and continued stabilization following trauma-causing incidents.

Provide supportive relationships

For many children, trauma can feel like an isolating experience. Whether the trauma stems from physical, emotional, or sexual abuse, loss, or a variety of other causes, supportive relationships can serve as a vehicle for healing. “Positive relationships are necessary for healthy human development, but trauma undermines these life-giving connections” (Bath, 2008, p. 19). As children are surrounded by peer groups and school leaders, it would be reasonable to suggest

that positive relationships be promoted and fostered within the school setting (Ko et al., 2008). Rowling (2008) asserted that school support and relational connectedness can contribute to overall well-being in children who experience loss. Furthermore, a child's subjective belief about the availability of emotional support can influence the way in which he or she reacts to situations (Powers et al., 2008).

"Teachers, school psychologists, counselors, and school social workers typically receive little formal training or continuing education about the impact of trauma on students and ways they can help traumatized students achieve better educational outcomes" (Ko et al., 2008, p. 298). One way to provide a supportive relationship is to offer a child undivided attention. For example, attending to someone involves communicating nonverbally that the other person has your full and present attention. "It means using your body, your face, your eyes...to say 'Nothing exists right now for me except you. Every ounce of my energy and being is focused on you'" (Kottler & Kottler, 2007, p. 51). Following trauma-causing events, children may lack trust with adults (Bath, 2008), therefore offering your full and present attention can be the gateway for promoting a supportive relationship.

Furthermore, children can be sensitive to nonverbal cues, such as tone of voice, volume, posturing, and facial expressions (Perry, 2009). Sandoval et al. (2009) recommended affect stability and modeling calmness and composure, in order for children to help themselves stay affectively regulated. Having an awareness of the way in which information is delivered can be helpful in establishing a calm, communicative relationship. Simple reminders about relationship skills can sometimes mean the difference between helping a child experience restabilization and continuing to inadvertently retraumatize the child.

Beyond the school scene, school counselors and personnel alike can help students foster supportive relationships with their parents, guardians, or other influential adults (Sandoval et al., 2009). When a continuity of care and learning is promoted from school to home, the skills children are learning in one domain may positively influence their development in another area (Ellis, Nixon, & Williamson, 2009; Kruzczek & Salsman, 2006). Simply put, if school counselors and personnel can (a) work on the frontline to provide supportive relationships with children and (b) then teach parents, guardians, or other adults about the skills necessary to foster such relationships at home, then (c) students can begin to feel safe and supported in both major areas of their life. One important caution to note, however, is that if the child's primary source of traumatization stems from the home environment (such as in cases of abuse), it is imperative that school leaders consider the ramifications of helping the child establish relationships with the offender. Often times, such relationships can lead to retraumatization, as the child feels unsafe and unsupported.

Promote self-regulation

Beyond safety and support by the school system and personnel within it, promoting a child's emotional regulation is the next most important step following traumatization (Bath, 2008). Trauma symptoms can persist in affective, behavioral, cognitive, and physical ways (Little, Akin-Little, & Gutierrez, 2009). Within the school setting, outward traumatic symptoms may resemble impulsive behaviors, excessive talking, withdrawal, inattention, or even destruction. As each of these aforementioned trauma symptoms breeds its own set of challenges,

and as children are expected to abide by rules that govern the school system, it is important that school counselors and personnel teach children about self-regulation (Sandoval et al., 2009; Weber, 2009).

Self-regulation can be taught to students through a variety of means. Kruczek and Salsman (2006) offered a discussion about debriefing techniques in which children are encouraged to name feeling words associated with traumatic events. As children begin to understand the types of feelings associated with trauma, they may then be better able to understand the symptoms and presentation of those feelings. When the feeling occurs at school, children can then be taught to calm themselves down through deep breathing or muscle relaxation (Little et al., 2009). As children experiencing trauma may not have adult figures in their home life who have taught them how to regulate feelings and emotions, sometimes having a school figure “co-regulate” feelings can deem helpful (Bath, 2008, p. 20). To start, a child can be encouraged to use a “code word” to let the school personnel know when he or she is experiencing overwhelming feelings, which may distract his or her learning. A teacher or counselor can then sit with the child for a few minutes during the unregulated state, assist him or her in a self-calming exercise, use active listening and help the child understand the nature of the problem, label the feeling, and develop a coping strategy for future occurrences. For older children, the teacher or counselor can even log the event in a small notebook and let the child “sign-off” on the experience. Doing so helps the student track the pattern of the incident and claim ownership in the steps taken to correct the issue.

Little et al. (2009) also discussed cognitive techniques to help children emotionally regulate in-the-moment feelings, such as by thought-stopping techniques, positive imagery, positive self-talk, and through psychoeducational social skills training. Psychoeducational small group counseling can be equally effective in helping children build the skills to affectively and behaviorally recalibrate (Kruczek & Salsman, 2006). All of these interventions can be brief in nature and monitored and implemented by children directly, thus impacting their ability to reregulate and remain in the classroom setting.

Each of these relational moments can teach the child about self-regulation and communicate care and concern on behalf of the school leader. It is important to note that if a solid, supportive, healthy relationship between the child and school leader has not first been established, then any attempt to help the child self-regulate may be ineffective. As stated in the reminder entitled “Provide supportive relationships”, opportunities for healthy relationships with peers and adult figures is key to children feeling understood in their traumatic response and preventing retraumatization in the classroom (Bath, 2008; Ko et al., 2008; Perry, 2009). By offering these teachable self-regulation moments with the child as often as needed, children may begin to learn that they can control previously unmanageable feelings, thoughts, and behaviors.

Encourage autonomy

School counselors and other personnel can also avoid retraumatization by empowering the child through encouraging autonomy (Weber, 2009). Following a traumatic incident, children may show regressive behaviors, including clinging and dependence on adult figures (Gurwitsch et al., 2001). Providing basic opportunities for autonomy can communicate a belief that the child is a resilient being who is capable of healing.

Autonomy can be encouraged in fundamental ways and facilitate lasting impacts. At a basic level, school personnel can invite the child to make age-appropriate choices and decisions (Perry, 2009). Doing so can instill the belief that the child is able, a message which can help promote more autonomy by the child. Sandoval et al. (2009) suggested the strategy of “one-downsmanship” (p. 248) in which the adult acknowledges the child’s contribution to problem solving and task completion while minimizing the adult’s contribution. This strategy can be one way to promote a sense of ability and accomplishment within the child. Other opportunities to facilitate independence, autonomy, and ability in the school setting could be achieved by asking children to complete small tasks such as collecting papers, running small errands around the school, picking up the teacher’s mail, collaborating in decision-making, or distributing papers to peers. While these tasks may seem small in nature, each example provides an opportunity for the child to accomplish a responsibility and for autonomy to be further reinforced.

Emphasize the positive

It is clear to see from the aforementioned reminders that trauma-causing incidents can have significant impacts on children. As children’s day-to-day functioning in school can be impacted due to the traumatic symptoms and responses (Kruczek & Salsman, 2006; Olesen, Macdonald, Raphael, & Butterworth, 2010), it is vital that school leaders offer minimal encouragers and positive reinforcement to emphasize the positive. Sandoval et al (2009) suggested that helping professionals “can emphasize what positive there is in a situation, even if it seems relatively minor” (p.248). The authors further recommend congratulating survivorship and affirming self-worth as two simple ways to reframe the client’s situation from the lens of their character or personal strength.

Children may have difficulty identifying growth, positive change, or healthy choices following trauma-causing incidents (Sandoval et al., 2009). Particularly if the trauma is due to a relational issue in the child’s family of origin, he or she may be accustomed to the *absence* of praise or encouragement. Arguably worse, the child also may not have a stable adult figure who can help dispute negative appraisals about the trauma-causing incident or offer collaborative solutions to coping and problem solving. Ellis et al. (2009) studied this phenomenon by assessing the impact of parental negative appraisals of traumatic events on acute stress and depressive symptoms in 97 children (aged 7-17 years old). Results indicated that negative appraisal by parents was highly correlated with both increased acute stress and depressed symptoms ($r = .69$ and $.61$, respectively). Findings from this study highlight the impact of adult negative evaluation of the event on child stress and/or depressive symptoms. As such, it becomes vital that parents and school personnel alike emphasize the positive when possible, especially for those children who may have negatively affected senses-of-self following a trauma-causing event.

Appreciate the human capacity for resilience

Whether the trauma-causing event is categorized as Level I or Level II, some degree of traumatization is expected. However, what is often overlooked is the reservoir of strength and resilience that a child may access within him or herself to make meaning of the incident and move forward through the trauma (Sandoval et al., 2009). It is important to note that some characteristics exist that impact a child’s ability to cope, such as age, developmental level, gender, race, social support, positive self-esteem, history of adaptive coping, problem solving

skills, and cognitive appraisal of the situation. Regardless of these characteristics, school leaders can “enhance motivation for growth and future success by helping the child believe in his or her own skills and potential” (Weber, 2009, p. 3). Ultimately, a child’s ability to believe in potential and choose to be forward moving after a trauma-causing event reflects a child’s inner capacity for resilience.

When school leaders expect that a child of a trauma-causing event will be defeated, they, in turn, may inadvertently treat a child as if he or she is not able. However, if school leaders believe in the human capacity for resilience, then he or she may actively choose to treat a child as if he or she has the potential to move through suffering toward a more balanced state of being. “Traumatic experiences can...serve as a vehicle for growth” (Tarakeshwar, Hansen, Kochman, Fox, Sikkema, 2006, p. 450). While the journey toward growth may be tumultuous and uncomfortable, fundamentally children *are* able to demonstrate resilience in both small changes and significant strides (Little et al., 2009). As stated in the section entitled “Emphasize the positive,” school personnel can acknowledge steps taken toward growth and positive change and validate the child’s worth in spite of the trauma-causing event. As such, the school leader is conveying his or her belief that children can still succeed—that children are resilient—even in the face of or aftermath of trauma-causing events.

The previous six reminders have identified the “ways of being” that school personnel and helping professionals alike can consider in order to work effectively with children who have experienced trauma. The final two reminders will explore the impact of time and resources on the adult-child helping relationship following trauma-causing events.

Offer support through time

While skills and techniques can be learned to facilitate a helping relationship, central to this concept is that a school leader or adult figure is merely spending time with a child. Through time, a positive relationship can be nurtured. Sometimes simply sharing space with a child, with nothing more than undirected play, a child can feel understood in his or her experience (Landreth, 2002). Support through time can also be evidenced in school leaders allowing a child to step away from his or her lesson to self-regulate or express his or her feelings in art or writing (Rowling, 2008; Sandoval et al., 2009). Fundamentally, school personnel can offer seconds, minutes, hours, or more to a child to convey an attitude of caring or concern. By stopping a child in the hallway who appears to be distressed, by taking a few extra minutes to explain a concept in a calm and understanding voice, or by inviting the child to participate in a group counseling experience, the school leader can help the child feel further understood and connected to another.

School personnel can also offer support to children experiencing trauma by committing time to receiving educational training or in-service learning opportunities on childhood trauma and related topics (Ko et al., 2008; Kruczek & Salsman, 2006). While this support may appear to be secondary, the skills, techniques, and general understanding that school personnel can gain from such educational experiences will directly benefit the lives of students.

House helpful resources on site

As the school setting encourages a collaborative relationship between school personnel, parents/guardians, and community resources, it is important that appropriate materials regarding

child traumatization are available for all to reference (National Child Traumatic Stress Network [NCTSN], 2004). One such resource may be an assessment tool for understanding the nature of trauma, such as the Adverse Childhood Experiences assessment (ACE; Felitti et al., 1998). The ACE assessment has shown that individuals with greater exposure to adverse childhood experiences, such as abuse, neglect, or trauma in the household, have also shown a higher chance of persistent emotional and behavior difficulties, adult disease and disability, or other serious social problems. While the ACE does not directly predict long-term effects due to childhood traumatization, it can serve as a tool to assess the *risk* based on the number of trauma-causing events experienced. Assessing risk is an important step to providing trauma services to children (Kruczek & Salsman, 2006), and as such, ACE or other trauma assessments can serve as a valuable way to gather information about the severity of traumatization and the need for subsequent referral.

When considering resources to house on-site, equally important to *assessing risk* is *providing referrals* for students needing specialized counseling services more long term (Sandoval et al., 2009). Hamlet and Redekop (2010) emphasized the value in school-community collaboration for providing appropriate counseling referrals. The authors recommend for school counselors to research local outpatient agencies and clinicians, invite community agencies to a meet-and-greet- and roundtable discussion to learn about specialties provided, organize a comprehensive spreadsheet with specific contact information for the clinicians and agencies, and disseminate this information to helping professionals and personnel within the school or local school district. “Treatment of children exposed to complex trauma will itself be complex and long-lasting” (Bath, 2008, p. 20). It is from this understanding that referral information is necessary and easily accessible—stored on site—for school counselors and personnel to utilize when needed.

Conclusion

The reminders in this article serve as an overview of skills that we, as helping professionals, may all have been taught, but due to high case loads and institutional demands, may overlook on a day-to-day basis. Children who have experienced trauma are constantly reminded of the trauma-causing event due to sounds, sights, smells, memories, or other reminders of the event. While school leaders cannot protect children from these penetrating influences, we can work to protect children from further retraumatization by offering safe, supportive relationships (Bath, 2008), providing resources to students and parents/guardians (Hamlet & Redekop, 2010), and striving to trust the resiliency and positive changes available (Sandoval et al., 2009; Weber, 2009) within children following trauma-causing events. “Much of the healing from trauma can take place in non-clinical settings” (Bath, 2008, p. 17). As such, school counselors, educators, personnel, and administrators are in the unique position to promote stabilization and prevent retraumatization to children experiencing trauma-causing events.

While these basic tenets may help serve many children in the school setting, it is important to note the limitations to these suggestions. For some children, primary intervention through psychoeducational techniques or debriefing of the trauma-causing event may not affect change in symptom presentation (Kruczek & Salsman, 2006). For such children, screening, specific intervention strategies, and/or referral to an outside agency may be needed. Furthermore,

some of these suggestions may be met with resistance by children, particularly by children who are unable or unwilling to acknowledge the nature and/or impact of the trauma-causing event in their life. Because trauma is uniquely experienced by individuals (Weathers & Keene, 2007), so may be the treatment needed to promote healing. Helping professionals may be well served to understand that general reminders can be helpful, but a “one-size fits all” approach to providing counseling to children of trauma will likely limit their scope of impact.

Another limitation to these reminders is that each reminder addresses the counseling professional or school personnel’s direct work with or for children. One area minimally addressed in the section entitled “Provide supportive relationships” is the impact of working with the parents or guardians of these children. Ellis et al. (2009) discussed the impact of negative parental appraisal of the traumatic event on the child’s presentation of acute stress and depressive symptomatology. Furthermore, Meiser-Stedman et al., (2007) noted the misperception by parents concerning the severity of child symptomatology following a single-event traumatic incident. Because of the parent or guardian role in the detection of symptoms and the recovery of traumatization following a trauma-causing event, it is critically important for helping professionals to consider their work directly with parents to prevent retraumatization. Further discussion and research into specific skills needed to work with the caregivers of these children can be warranted in future research.

Trauma-causing events can affect children differently and present in a variety of different ways. For children in the school setting, receiving services at school from the professional school counselor or school-based counselor is most appropriate if academic and personal/social adjustment is being maintained (Kruczek & Salsman, 2006). For these children, counseling professionals and school personnel alike can promote healing through simple steps of understanding trauma, demonstrating helpful ways of being, and showing commitment through time and resources. For other children with more complex traumatization, referral may be necessary. In either case, the helping professional and school personnel are charged with the tasks of preparedness and appropriate response to serve these children. Because school counselors work within an interdisciplinary team of educators, administrators, school personnel, and other mental health professionals, it is necessary that *all* adults, not just school counselors, develop an awareness of traumatic reactions and symptoms by children and the steps needed to provide stability and comfort.

References

- Allen, M., Burt, K., Bryan, E., Carter, D., Orsi, R., & Durkan, L. (2002). School counselors’ preparation for and participation in crisis intervention. *Professional School Counseling, 6*(2), 96-102.
- Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth, 17*(3), 17-21.
- Black, P. J., Woodworth, M., Tremblay, M., & Carpenter, T. (2012). A review of trauma-informed treatment for adolescents. *Canadian Psychology, 53*(3), 192-203. doi: 10.1037/a0028441

- Carr, A. (2004). Interventions for post-traumatic stress disorder in children and adolescents. *Pediatric Rehabilitation*, 7(4), 231-244. doi: 10.1080/13638490410001727464
- Costello, E. J., Erkanli, A., Fairbank, J. A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress*, 15, 99–112. doi:10.1023/A:1014851823163
- Duke, N. N., Pettingell, S. L., McMorris, B. J., & Borowsky, I. W. (2010). Adolescent violence perpetration: Associations with multiple types of adverse childhood experiences. *Pediatrics*, 125, 778–786.
- Ellis, A. A., Nixon, R. D., & Williamson, P. (2009). The effects of social support and negative appraisals on acute stress symptoms and depression in children and adolescents. *British Journal of Clinical Psychology*, 48, 347-361. doi: 10.1348/014466508x401894
- Felitti, V. J., Anda, R. F., Nordenberg, E., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14, 245-258. doi: 10.1016/S0749-3797(98)00017-8
- Gurwitch, R. H., Silovsky, J. F., Schultz, S., Kees, M., & Burlingame, S. (2001). Reactions and guidelines for children following a trauma/disaster. Retrieved from http://www.co.kern.ca.us/kcmh/disaster/Reactions_Guidelines.pdf
- Gustaffson, P. E., Nilsson, D., & Svedin, C. G. (2009). Polytraumatization and psychological symptoms in children and adolescents. *European Child & Adolescent Psychiatry*, 18, 274-283. doi. 10.1007/s00787-008-0728-2
- Hamlet, H., & Redekop, F. (2010). Connecting schools with community mental health resources. Retrieved from <http://ct.counseling.org/2010/03/connecting-schools-with-community-mental-health-resources/>
- Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., Brymer, M. J., & Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology*, 39(4), 396-404. doi: 10.1037/0735-7028.39.4.396
- Kottler, J. A., & Kottler, E. (2007). *Helping skills for teachers (2nd ed.)*. Thousand Oaks, CA: Sage Publications.
- Kruczek, T., & Salsman, J. (2006). Prevention and treatment of Posttraumatic Stress Disorder in the school setting. *Psychology in the Schools*, 43(4), 461-470. doi: 10.1002/pits.21060
- Landreth, G. L. (2002). *Play therapy: The art of the relationship (2nd ed.)*. New York, NY: Brunner-Routledge
- Little, S. G., Akin-Little, A., & Gutierrez, G. (2009). Children and traumatic events: Therapeutic techniques for psychologists working in the schools. *Psychology in the Schools*, 46(3), 199-205. doi: 10.1002/pits.20364
- Meiser-Stedman, R., Smith, P., Glucksman, E., Yule, W., & Dalgleish, T. (2007). Parent and child agreement for Acute Stress Disorder, Post-Traumatic Stress Disorder, and other

- psychopathology in a prospective study of children and adolescents exposed to a single-event trauma. *Journal of Abnormal Child Psychology*, 35, 191-201. doi: 10.1007/s10802-006-9068-1
- Mueser, K. T., Rosenberg, S. D., & Rosenberg, H. J. (2009). Trauma and posttraumatic stress disorder in vulnerable populations. In H. J. Rosenberg (Ed.), *Treatment of posttraumatic stress disorder in special populations: A cognitive restructuring program* (pp. 9–35). Washington, DC: American Psychological Association. doi:10.1037/11889-001
- National Child Traumatic Stress Network. (2004). *Childhood traumatic grief educational materials*. Retrieved from http://www.nctsn.org/nctsn_assets/pdfs/reports/childhood_traumatic_grief.pdf
- Olesen, S. C., Macdonald, E., Raphael, B. & Butterworth, P. (2010). Children's exposure to parental and familial adversities: Findings from a population survey of Australians. *Family Matters*, 84, 43-52.
- Perry, B. (2009). Principles of working with traumatized children. Retrieved from Scholastic.com
- Powers, A., Ressler, K. J., & Bradley, R. G. (2008). The protective role of friendship on the effects of childhood abuse and depression. *Depression and Anxiety*, 26, 46-53.
- Rowling, L. (2008). Linking spirituality, school communities, grief and well-being. *International Journal of Children's Spirituality*, 13(3), 241-251.
- Sandoval, J., Scott, A. N., & Padilla, I. (2009). Crisis counseling: An overview. *Psychology in the Schools*, 46(3), 246-256. doi: 10.1002/pits.20370
- Tarakeshwar, N., Hansen, N. B., Kochman, A., Fox, A., & Sikkema, K. J. (2006). Resiliency among individuals with childhood sexual abuse and HIV: Perspectives on addressing sexual trauma. *Journal of Traumatic Stress*, 19(4), 449-460.
- Weathers, F. W., & Keane, T. M. (2007). The criterion A revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of Traumatic Stress*, 20(2), 107-121.
- Weber, S. (2009). Treatment of trauma- and abuse-related dissociative symptom disorders in children and adolescents. *Journal of Child and Adolescent Psychiatric Nursing*, 22(1), 2-6.