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Developing a Common Language in Connecticut: A Dictionary of Terms Related to Trauma-Informed Schools

Trauma-Informed School Mental Health Task Force

Contents

Overview

Thank you for your interest in our dictionary of trauma-related terms. Our Trauma-Informed School Mental Health Task Force was developed in 2017 in response to the growing need for integrated trauma supports in the state of Connecticut across school-based practitioners, community-based providers, and state government stakeholders. The committee members quickly realized that they utilized the different terms to describe trauma based on their different backgrounds, training experiences, and treatment settings. As a result, a recommendation was made to build common language, including to develop a dictionary of common terms related to trauma and trauma-responsive practices

This document was created with input from multiple stakeholders with expertise in behavioral health from across the state of Connecticut—including leadership from the Connecticut Department of Children and Families (DCF), the State Department of Education (SDE), the Collaboratory on School and Child Health (CSCH) at the University of Connecticut, the Child and Health Development Institute of Connecticut (CHDI), Clifford Beers Clinic, Capitol Region Education Council (CREC), and others listed below.

The structure of this document is adapted from the National Child Traumatic Stress Network (NCTSN)'s *Glossary of Terms Related to Trauma-Informed, Integrated Healthcare*, which groups terms by theme such as "terms to describe the event" and "terms to describe reaction/response." We chose to use this structure as an organizational foundation, and expanded the alphabetized dictionary to include other terms used in Connecticut that are relevant to school-based trauma-informed service delivery. As the landscape of trauma-informed schools and terminology is rapidly developing and expanding, this document is intended to be the first version of a living document. As such, it is expected that this reference will be periodically updated as terminology and available interventions, assessment tools, and other trauma-informed approaches are developed and updated.

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Terms to describe the event

These terms are used to describe exposure to an event that may or may not be interpreted or experienced by the individual as traumatic.

Trauma/trauma event: exposure to a situation that may be physically or psychologically harmful; experience or exposure to a traumatic event does not necessarily indicate that the student will experience negative outcomes. May also be referred to as trauma exposure, trauma experience, or a potentially traumatic event (PTE) (Chafouleas et al., 2018; SAMHSA, 2014)

Traumatic response: the way in which an individual experiences an event, series of events, or set of circumstances as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning (Chafouleas et al., 2018, SAMHSA, 2014); as stated above, exposure to a trauma or trauma event does not necessarily mean that a child will develop a traumatic response—more information about factors that influence the likelihood of developing a traumatic response can be found here

Terms to describe traumatic experiences

Trauma or traumatic events can take many different forms; the terms below describe different kinds of trauma that may be experienced during childhood.

Acute trauma: single traumatic event that is limited in time and scope, such as an auto accident, a shooting, witnessing a violence episode, or experiencing a natural disaster (SAMHSA, 2014b)

Adverse Childhood Experiences (ACEs): situations or experiences occurring during childhood (that may or may not lead to a trauma response) but are frequently associated with negative long-term outcomes across the lifespan (Felitti et al., 1998)

Adverse Childhood Experiences Study (ACE Study): a decade long scientific study linking negative childhood events with serious and life altering social, emotional, physical and behavioral difficulties; these studies found that number of ACEs is associated with higher risk of poor long-term outcomes (CDC; 2010; Felitti et al., 1998)

Attachment trauma: adverse interpersonal experiences, occurring in early childhood (ages birth to 6), which are repetitive, chronic and between child and caregiver or in a care-giving relationship. Generally, abuse and neglect (sexual, physical, emotional, psychological) (Attachment & Trauma Network, n.d.)

Chronic trauma: repeated exposure to negative experiences or events, such as repeated sexual or physical abuse or exposure to ongoing domestic violence (SAMHSA, 2014b)

Complex trauma: exposure to multiple different kind of traumatic events over an extended period of time that often have long-term impacts on development across domains (Cook et al, 2005; Gaurino & Chagnon, 2018; NCTSN Integrated Care Collaborative Group, 2018)

Toxic stress: negative events that are often perceived as unexpected, uncontrollable, and chronic that result in overuse of the body's stress response system (National Scientific Council on the Developing Child. (2005/2014).

Terms to describe maladaptive responses to trauma

Traumatic experiences can take many different forms; the terms below describe different kinds of trauma that may be experienced during childhood.

Avoidance: when an individual avoids people, places, or other reminders of a traumatic event in an effort to avoid emotions, thoughts, or feelings associated with the trauma (APA, 2013)

Flight, fight or freeze response: physical manifestation of an individual's biological stress response system made up of different, interacting systems that work together to direct the body's attention toward protecting the individual against environmental life threats; these responses are often affected by trauma exposure (Gaurino & Chagnon, 2018)

Hypervigilance: changes in arousal and reactivity that may make an individual more alert of their environmental surroundings even in situations when such high reactivity is not necessary (APA, 2013, p. 272)

Intrusive symptoms: distressing thoughts or dreams that are "recurrent, involuntary, and intrusive" (APA, 2013, p. 271)

Posttraumatic Stress Disorder (PTSD): a serious mental condition, lasting at least a month in duration that some people develop after a traumatic event; those with PTSD may experience avoidance, hypervigilance, intrusive thoughts, and re-experiencing (defined below) (American Psychiatric Association, 2013)

Re-experiencing: distressing flashbacks or memories of an event during which the individual feels that are again in the moment of the traumatic experience (APA, 2013)

Secondary traumatic stress: the emotional duress that results when an individual works with clients or students who have described traumatic experience; may also be called compassion fatigue or vicarious trauma (Baird & Kracen, 2006)

Trauma bond: when individuals who have experienced trauma form emotional and psychological relationships with their abusers/aggressors (Hom & Woods, 2013; Pilgrim, 2012)

Terms to describe factors affecting response to adverse experiences

While some individuals experiencing a traumatic event will not experience negative outcomes, many children will. The terms below describe factors that affect the likelihood that a child may have a maladaptive response to exposure to a traumatic event.

Protective factors: conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that aid an individual in coping more effectively with stressful events and mitigate or eliminate risk in families and communities; these may interrupt the trajectory from risk to pathology (Gaurino & Chagnon, 2018)

Psychological safety: an individual's trust in that the world is generally a safe place free from harm (Chadwick Trauma-Informed Systems Project, 2013)

Regulation: ability to identify, evaluate, and modify the experience and expression of affect or emotion; this ability may be negatively impacted as a result of exposure to trauma (Gaurino & Chagnon, 2018)

Resilience: an individual's ability to overcome adversity and continue his or her normal development. In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-

being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways (Panter-Brick, 2015; Rutter, 1993)

Risk factors: characteristics, variables or hazards that, if present, make it more likely that the individual is vulnerable to develop a disorder or a traumatic response to an adverse experience (Gaurino & Chagnon, 2018)

Terms to describe approaches to responding to trauma

This section includes terms that describe overarching approaches to preventing and responding to child traumatic stress.

Trauma aware: the first step to building trauma-informed systems; components of being trauma aware include understanding the widespread prevalence of traumatic event exposure, the potential impact of trauma, recognizing the signs and symptoms of trauma in clients, families, staff, and others (Cook, McCoy, Wisconsin Department of Public Instruction, 2018)

Trauma-informed: systems-level approach to trauma that incorporates both trauma-sensitive practices and trauma-specific interventions (see definitions below); trauma-informed systems understand the widespread impact of trauma and respond by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. Key components of the Substance Abuse and Mental Health Services Administration's (SAMHSA) definition of trauma-informed approach include realizing the prevalence of trauma, recognizing the signs of traumatic response, responding to individuals who need support, and resisting re-traumatization (also known as the four R's) (Chafouleas et al., 2016; SAMHSA, 2014). More information about systems-level approaches to trauma response can be found here.

Trauma-responsive: strategies applied at the individual, group, and systems levels to prevent and/or reduce the potential for re-traumatiziation (Cook, McCoy, Wisconsin Department of Public Instruction, 2018); may also be called trauma sensitive practices (Cole, Eisener, Gregory, & Ristuccia, 2013)

Trauma specific interventions: treatment or intervention delivered to small groups or individual students or clients to address negative reactions to traumatic events (Chafouleas et al., 2016); examples of trauma-specific interventions can be found here.

Terms to describe trauma screening assessments

These terms describe assessment tools that can be used to identify children who may have been exposed to or who are having a maladaptive response to a traumatic event. These tools may be useful for determining students who may benefit from a trauma-specific intervention. For a full review of trauma screening measures for children see Eklund et al., 2018.

Exposure: screening tools that assess exposure to different traumatic events such as abuse, neglect, parental separation or divorce, accidents or injury, parental substance abuse (Eklund et al., 2018)

Symptomatology: screening measures that evaluate PTSD symptomatology such as re-experiencing, hyperviligance, and/or avoidance (Eklund et al., 2018)

Trauma screening: tools that are used to identify students who may be in need of intervention as a result of experiencing a traumatic event; screening tools may evaluate exposure to trauamatic events, symptomatology related to exposure to a traumatic event, or both (defined below; Eklund et al., 2018)

Example of screening tools that are commonly used in Connecticut*:

Acute Stress Checklist in Children: 29 item self-report rating scale evaluating both trauma exposure and response for ages 8 – 17; also available in short version (Kassam-Adam & Marsac, 2016)

Child PTSD Syptom Scale (CPSS): 24 item self-report measure evaluting trauma symptomatoogy for children and adolescents ages 8-18 (Foa et al., 2001)

Child Trauma Screen (CTS): 10 item measure evaluating trauma symptomatology for ages 7-16; both parent- and self-report forms available (Lang & Connell, 2017)

Child Trauma Screening Questionnaire: 10 item screener evaluate trauma symptomatology for children ages 7-16 (Kenardy et al., 2006)

School Health Assessment and Performance (SHAPE) System: a free, web-based platform designed for school and district mental health teams that allows you to document, track and analyze your school-based mental health goals as well as assess trauma responsiveness (Center for School Mental Health, 2015)

Structured Trauma-Related Expriences and Symptoms Screener (STRESS): a 46 item self-report measure avaluating with trauma exposure and response in children ages 7-18 (Grosso et al., 2015)

Trauma Responsive Schools Implementation Assessment (TRS-IA): a component of the SHAPE system that assessed how well schools are implementing trauma-informed practices and supports (Center for School Mental Health, 2015)

Trauma Symptom Checklist for Children (TSCC): 54 item screening measure that evaluates PTSD symptomatology in children ages 8-15; also available in a 29 item short form and in a young children version for ages 3-12 (Briere, 1996; 1999)

***Please note that the Trauma-Informed School Mental Health Task Force does not endorse any particular assessment or screening tool included in this document.**

Terms to describe trauma-specific interventions or treatment

These terms describe treatments delivered to small groups or individuals with a maladaptive response to a traumatic experience. This is not meant to be an exhaustive list of all trauma-specific interventions but rather an overview of some of the most common treatments. For a more comprehensive review of interventions please visit CHDI's review of trauma-informed initiatives and NCTSN's website for more detailed information about interventions.

Cognitive-Behavioral Therapies: interventions that focus on the interactions between thoughts, feelings, and behaviors and changing maladaptive thoughts that influence behavior (Cobb et al., 2011)

Psychoeducation: a component of many trauma-focused CBT interventions; involves teaching students, teachers, and/or parents about trauma including different types of trauma and common responses to exposure to traumatic experiences (Jaycox et al., 2012)

Example of interventions commonly used in Connecticut*:

Attachment, Regulation and Competency Training (ARC): a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress targeted on attachment, regulation, and competency (Blaustein & Kinniburgh, 2018)

Bounce Back Program: a school-based group intervention for elementary students (ages 5-11 or grades 1-5)

exposed to stressful and/or traumatic events (Langley et al., 2015)

Child and Family Traumatic Stress Intervention (CFTSI): an intervention is designed for use in the days and weeks following a traumatic event or disclosure of a past traumatic event for children ages 7-18 (Berkowitz et al., 2010)

Cognitive Behavioral Intervention for Trauma in Schools (CBITS): a school-based trauma-specific intervention for upper elementary, middle, and high school students (ages 10-16 or grades 5-12) exposed to stressful and/or traumatic events (Jaycox et al., 2010; Kataoka et al., 2003; Stein et al., 2003)

Dialectical Behavior Therapy (DBT): a cognitive-behavioral treatment approach, for the treatment of trauma, with two key components: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on processes (Dimeff & Koerner, 2007)

Eye Movement Desensitization and Reprocessing (EMDR): form of psychotherapy that uses a structured eight-phase approach to address the past, present, and future aspects of a traumatic or distressing memory (Dowd & McGuire, 2011; Rodenburg et al., 2009)

Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC): a intervention delivered to individual students that providers can address multiple comorbidities associated with exposure to a traumatic event (Chorpita et al., 2013; Weisz et al., 2012)

Support for Students Exposed to Trauma (SSET): this intervention is an adaptation of CBITS and is designed to be implemented by school staff without clinical training such as school counselors and teachers (Jaycox et al., 2009)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): manualized intervention that helps children develop and enhance their ability to cope with and regulate their responses to troubling memories, sensations and experiences for children ages 3-18 (Cohen et al., 2006)

Trauma-Focused Coping in Schools (TFC)/Multimodality Trauma Treatment (MMTT): a school-based group intervention for elementary, middle, and high school students (grades 4-12) exposed to stressful and/or traumatic events (Amaya-Jackson et al., 2003; March et al., 1998)

***Please note that the Trauma-Informed School Mental Health Task Force does not endorse any particular intervention or treatment included in this document.**

Terms to describe systems-level approaches to preventing and responding to trauma

Unlike trauma-specific interventions which target individual or small groups, these trauma-sensitive practices are intended to address trauma at the systems level.

Multi-tiered systems of support (MTSS): a framework that is commonly used in schools to provide a continuum of academic and behavioral supports from prevention to intervention; typically supports are divided into three tiers—with Tier 1 serving all students, Tier 2 dedicated to targeted interventions for students, and Tier 3 providing individualized, intensive supports to students with the highest need—with movement through tiers guided by data-based decision making (Fuchs & Fuchs, 2006; Center on Response to Intervention, 2009); tiered supports may also be referred to as response to intervention (RtI) or scientific research based interventions (SRBI) in Connecticut; trauma-informed supports can also be delivered through an MTSS framework (Reinbergs & Fefer, 2018)

School climate: the psychosocial aspects of school experiences such as feeling connected to other students and adults in the school building; school climate initiatives seek to prevent violence and promote safety and a welcoming environment for all students, staff, and families (National Center on School Climate, n.d.)

Schoolwide positive behavioral interventions and supports (SWPBS): school-wide practices that focus on

reinforcing appropriate behavior and modeling, teaching, and reinforcing behavioral expectations throughout the school (Horner & Sugai, 2015); these behavioral approaches combat traumatic experiences by promoting transparency, predictability, safety, empowerment, and choice (RESC, 2018; Wisconsin Department of Public Instruction, 2011, Wolpow, Johnson, Hertel, & Kincaid, 2016)

Social and emotional learning (SEL): coordinated strategies across classrooms, schools, homes, and communities that focus on developing social and emotional competency in children in five domains: self-management, self-awareness, social awareness, relationship skills and responsible decision making (CASEL, 2017); examples of SEL curriculums and interventions include RULER (Brackett, Rivers, Reyes, & Salovey, 2010) and Second Step (Frey, Hirchstein, & Guzzo, 2000)

Terms to describe behavioral approaches to trauma

Children who have experienced trauma may develop behavior difficulties; these terms are used to describe behavior and behavioral intervention strategies that can be used in a trauma-informed approach.

Consequence: immediate response that occurs after a behavior and may be positive (e.g., praise, positive acknowledgment) or negative (e.g., punishment, removal of privileges) (Bamabara & Kern, 2005); an important component of trauma-informed approaches is developing consequences to behavior that avoid re-traumatization (Chafouleas et al., 2018)

Cycle of escalation: the pattern of problem behavior that becomes more intense and potentially unsafe over time; although the specific behaviors exhibited in each stage may vary from student to student, the stages of the cycle and pattern of escalation are generally predictable across students. Exposure to trauma may alter a student's stress response cycle and make them more likely to demonstrate escalated behavior. This may also be called the acting out cycle or stress response cycle. (Colvin & Scott, 2014)

Function: refers to factors that maintain problem behavior or cause unwanted behavior to continue to occur (Bambara & Kern, 2005); function of behavior is to escape/avoid or get/obtain something; a student's trauma history may impact the function of their behavior, but trauma history itself is not a function of behavior

Setting event: circumstances that do not directly cause problem behavior but make the occurrence of problem behavior more likely; examples of setting events include alterations in sleep, medication effects, and appetite (Bamabara & Kern, 2005); these are also conceptualized as "slow triggers" (see below)

Stress response: evolutionary response to danger in the environment; when working properly, it helps individuals stay focused and alert; when children are exposed to trauma they may experience an abnormal stress-response reaction (Guarino & Chagnon, 2018)

Trigger: an event in the environment that immediately precedes a behavior and may act as an antecedent to post-traumatic stress symptoms or problem behavior; this may be something in the environment that is a reminder of a traumatic experience (Gaurino & Chagnon, 2018)

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