

RESEARCH-BASED PRACTICE

Trauma-Informed Care in Schools: A Social Justice Imperative

BY TAMIQUE J. RIDGARD, SETH D. LARACY, GEORGE J. DUPAUL, EDWARD S. SHAPIRO, & THOMAS J. POWER

The mental health field has long recognized the negative consequences associated with a range of traumatic events, including physical assault, sexual assault, natural or man-made disasters, accidents, and medical incidents (American Psychiatric Association [APA], 2013). The shockingly high prevalence of exposure to violence among America's children and adolescents highlights the importance to school psychologists of understanding the effects of violence and effective intervention strategies.

THE PREVALENCE OF TRAUMA AMONG YOUTH

The National Survey of Children's Exposure to Violence conducted in 2011 indicated that 41.2% of children had been victims of physical assault within the last year, with 10.1% of these incidents causing physical injury and 6.2% of the incidents including the use of a weapon (Finkelhor, Turner, Shattuck, & Hamby, 2013). During the same time period, 5.6% of children and adolescents were victimized sexually, with rates reaching as high as 22.8% among adolescent females. In addition to threats in the community, 13.8% were subjected to neglect or physical, sexual, or emotional abuse by a caregiver. Furthermore, 22.4% of youth witnessed violence at home, at school, or in the community. Taking into account 50 different [CONTINUED ON PAGE 12]



DAVID HERBICK

GENDER AND SCHOOL PSYCHOLOGY

Keeping Up With Transgender Youth

BY ELIZA A. DRAGOWSKI & JAMES J. PHILLIPS

On January 20, 2015, President Obama became the first United States president to use the word transgender as he called for respect and protections for societally marginalized people during the State of the Union address (The White House, Office of the Press Secretary, 2015). This historic call was the start of the groundbreaking year for transgender rights, recognition, and visibility; a year in which transgender-related news is generated so frequently that we have rewritten significant portions of this work more than once, in order to include all the current important scientific, social, and popular cultural events surrounding the issue. Today, transgender-identified people are running for political offices (e.g., Kristin Beck), transgender actors and characters are featured on popular and critically acclaimed shows (e.g., *Orange Is the New Black*, *Transparent*), transgender athletes are openly participating in sports (e.g., Fallon Fox, mixed martial arts fighter; Schuyler Bialar, NCAA Division I swimming), and the Pentagon has been reported to be moving toward allowing transgender people to serve in the military (Rosenberg, 2015).

Overall, people whose gender identity and/or expression do not correspond to traditional norms are increasingly sharing their life experiences publicly. These narratives are offered by adults (e.g., Janet Mock, Laverne Cox, Caitlyn Jenner), as well as children and their families. Within the last year, almost every major television network and news [CONTINUED ON PAGE 16]

RESEARCH-BASED PRACTICE

Are Minority Students Under- or Overrepresented in Special Education?

BY DANIEL R. COHEN, MATTHEW K. BURNS, CHRISTOPHER RILEY-TILLMAN, & JOHN L. HOSP

Recently, in a *New York Times* op-ed entitled "Is Special Education Racist?" Morgan and Farkas (2015) confront conventional wisdom that there are too many minority students in special education, stating "The real problem is that Black children are underrepresented in special-education classes when com-

pared with White children with similar levels of academic achievement, behavior, and family economic resources" (p. 1). They made this bold statement because on the same day, they published an article in the journal *Educational Researcher* (Morgan et al., 2015) with data that they interpreted to indicate that there are not enough mi-

nority students in special education. In translating their findings to policy recommendations, they note that:

For policymakers, our results suggest that current federal educational legislation and policymaking designed to minimize overidentification of minorities in special education may be misdirected (Government Accountability Office, 2013; U.S. Department of Education, 2014), including the reallocation of Part B funding to early intervening services designed to reduce minority overrepresentation in special education. (p. 288)

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Trauma-Informed Care

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victimization categories, 57.7% of youth had some exposure to violence, 15.1% had been exposed to six or more categories, and 4.9% had been exposed to 10 or more categories.

Rates of exposure to community violence are especially high among children living in urban, low-income, predominantly racial/ethnic minority communities. For example, adolescents from families with incomes of less than \$20,000 are more likely than those from families with incomes greater than \$50,000 to have witnessed violence (49.8% vs. 34.8%) or been the victim of physical assault (24.2% vs. 15.0%; Crouch, Hanson, Saunders, Kilpatrick, & Resnick, 2000). Rates of exposure to violence are also higher among adolescents from racial and ethnic minority backgrounds. Lifetime prevalence of having witnessed violence is higher among African American (57.2%) and Hispanic (50.0%) youth than Caucasian (34.3%) youth. Similarly, having been the victim of physical assault is higher among African American (24.2%) and Hispanic (20.7%) youth when compared to Caucasian (15.5%) youth (Crouch et al., 2000). Critically, the protective influence of higher income on exposure to violence was only found among Caucasian adolescents; children from high-income African American and Hispanic households were exposed to more violence than teenagers from low-income Caucasian households (Crouch et al., 2000). In addition to higher rates of exposure to traumatic violence, African American, Hispanic, and Native American individuals demonstrate higher rates of posttraumatic stress disorder (PTSD) even after controlling for levels of traumatic exposure and other demographic variables (APA, 2013). Additionally, children who are recent immigrants are at especially high risk for a history of victimization or exposure to violence, with up to 32% reporting symptoms of PTSD and 16% reporting clinically significant symptoms of depression (Jaycox et al., 2002).

THE IMPACT OF TRAUMA ON SCHOOL FUNCTIONING

Exposure to trauma or chronic stress has a negative impact on several domains of functioning related to school performance. Traumatic experiences and exposure to community violence can contribute to dysregulation of the hypothalamic-pituitary-adrenal axis, which in turn can manifest as either hypoarousal or hyperarousal in response to different routine or distressing stimuli (Lynch, 2003). Traumatic exposure at home, school, or in the community has been associated not only with PTSD, but also higher rates of separation anxiety, social anxiety, depression, suicidal ideation, and oppositional and aggressive behavior (Overstreet & Mathews, 2011; Ruchkin, Henrich, Jones, Vermeiren, & Schwab-Stone, 2007). Trauma also has a negative impact on academic functioning with higher symptoms of traumatic stress predicting poorer reading, math, and science achievement scores among elementary students (Goodman, Miller, & West-Olatunji, 2012). Additionally, traumatic symptoms are associated with a three-fold increase in odds of having an Individualized Education Program for learning or behavior problems (Goodman et al., 2012).

THE ROLE OF SCHOOLS

Despite the serious consequences of trauma and other mental health concerns, the majority of youth with mental health concerns lacks access to treatment, and those that receive treatment often receive ineffective care (Weist & Evans, 2005). Schools may represent an ideal setting for expanding mental health treatment to youth in need. Schools are already the most common location for youth to receive mental health services (Farmer, Burns, Phillips, Angold, & Costello, 2003), and the ability of educational systems to identify and intervene with children and adolescents in a natural setting offers an opportunity to reach high-risk populations. School-based mental health intervention may also reduce racial and ethnic disparities in access to mental health services (Kataoka, Stein, Nadeem, & Wong, 2007). The importance of school mental health services has led to calls for expansion of services that rely on partnerships between schools, families, and community agencies to provide evidence-based and data-driven prevention and intervention programs in schools (Weist & Evans, 2005).

Major traumatic events, such as Hurricane Katrina and the events of September 11, 2001, have demonstrated that well-prepared schools with comprehensive mental health programs and training in crisis and trauma response are better equipped to deal with community-wide trauma than those without such programs (Jaycox, Stein, Amaya-Jackson, & Morse, 2007). These events and a growing awareness of the effects of trauma on youth have led many schools to do an admirable job of training and preparing for crisis response (Brock & Cowan, 2004). Less is known, however, about the preparedness of schools to deal with the effects of ongoing community violence. Providing effective interventions for students exposed to violence may help to reduce longstanding concerns with disproportionality of discipline, given that exposure to violence increases the odds of truancy and suspension from school (Ramirez et al., 2012). Helping students cope with the potentially traumatic effects of community violence promotes school engagement and success; treating behavior that may be related to trauma as a disciplinary concern, rather than a mental health concern, is neither effective nor socially just.

Schools may address the negative academic, behavioral, and psychological impact

of trauma on their students by adopting a trauma-informed approach. The trauma-informed approach is not an intervention; rather, it is a way of providing services to children and families that facilitates the improved functioning of those negatively affected by trauma (Keesler, 2014; SAMSHA, 2014). Because students from racial/ethnic minority and low socioeconomic backgrounds may disproportionately experience some potentially traumatic events, provision of trauma-informed care in schools may minimize disparities in academic, behavioral, and psychosocial outcomes related to the experience of trauma. When framed this way, the use of a trauma-informed approach becomes more than an issue of mental health service delivery; it becomes an issue of social justice.

TRAUMA-INFORMED SERVICE DELIVERY

Defining trauma-informed care. The Substance Abuse and Mental Health Service Administration (SAMHSA, 2014) identifies four aspects of a trauma-informed approach to service delivery. The first is to “*realize* the widespread impact of trauma and understand potential paths for healing” (SAMSHA, 2014, p. 1); the second is to “*recognize* the signs and symptoms of trauma in staff, clients, and others involved with the system” (SAMSHA, 2014, p. 1); the third is to “*respond* by fully integrating knowledge about trauma into policies, procedures, practices, and settings” (SAMSHA, 2014, p. 1); and the fourth is to “*actively resist re-traumatization*” (SAMSHA, 2014, p. 1). Any organization or system that serves victims of trauma, including schools, can incorporate a trauma-informed approach into their practice.

Implementing trauma-informed care. A trauma-informed approach can be incorporated in schools through the use of a multitier service delivery system for students exposed to trauma (Keesler, 2014; Walkley & Cox, 2013). Systemic changes to school policies, practices, and procedures can be thought of as the universal, or Tier 1, level of service delivery. For a school to adopt a trauma-informed approach, changes need to be made to the culture, policies, and procedures that govern the school community (Keesler, 2014; Walkley & Cox, 2013). Schools can make these necessary changes to establish a universal tier of service delivery by integrating the four aspects of trauma-informed care (i.e., realize, recognize, respond, and resisting retraumatization) into school practice.

The first two aspects of the trauma-informed approach, realizing the widespread impact of trauma and recognizing the signs and symptoms of trauma, can be achieved through additional staff training and universal screening for symptoms of trauma (Ko et al., 2008; Walkley & Cox, 2013). Staff training may improve school personnel’s knowledge of the pervasive impact of trauma and their ability to respond appropriately to the academic and behavioral manifestations of trauma symptoms. Research related to implementing trauma-informed care in other child-serving professions (e.g., child welfare) suggests that staff training can increase knowledge about trauma-informed care, improve attitudes toward the use of trauma-informed care, and increase use of trauma-informed practices (Brown, Baker, & Wilcox, 2012; Conners-Burrow et al., 2013). In addition, universal screening is an important component of a Tier 1 level of service delivery. Schools implementing a trauma-informed approach should conduct screenings to identify students who have experienced a potentially traumatic event, exhibit symptoms associated with trauma, and are not responding to universal strategies to address the negative impact of trauma (Conradi & Wilson, 2010; Walkley & Cox, 2013).

To incorporate the third aspect of the trauma-informed approach (i.e., responding by integrating knowledge about trauma into practice) into a universal level of service delivery, school policies and procedures could be adjusted to include the six principles of a trauma-informed approach: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues (SAMSHA, 2014). These principles are closely aligned with best practices in the school setting, so modifications can easily be made to existing policies and procedures to align school practices with a trauma-informed approach. For example, in a trauma-informed approach, trustworthiness and transparency are defined by open and honest communication, consistent and reliable interactions, and clear expectations (Keesler, 2014). Schools often have clear expectations for student behavior that are posted throughout the school building; to become more trauma-informed, schools could also develop clear expectations for staff behavior and post those expectations in the school building alongside student expectations (Walkley & Cox, 2013).

The final aspect of a trauma-informed approach, preventing retraumatization, may be achieved through modifications to discipline practices. Many schools use school-wide positive behavior support to manage students’ behavior, which is consistent with the “compassionate and effective” discipline practices that are recommended for a trauma-informed approach (Walkley & Cox, 2013, p. 125). Harsh, negative discipline practices, such as restraint, have the potential to retraumatize children (Keesler, 2014). Schools integrating a trauma-informed approach in a multitiered system of service delivery should alter discipline practices for all students by decreasing the use of punitive strategies, such as suspension and expulsion, as the main methods of discipline and increasing the use of positive strategies, such as positive behavior supports and restorative practices (e.g., practices that allow students to be accountable for their actions and address the harm that their actions may have caused; Walkley & Cox, 2013).

USING A TRAUMA-INFORMED APPROACH AS A SCHOOL PSYCHOLOGIST

In addition to advocating for universal policies and procedures for schools to become more trauma-informed, school psychologists can make adjustments to their practice

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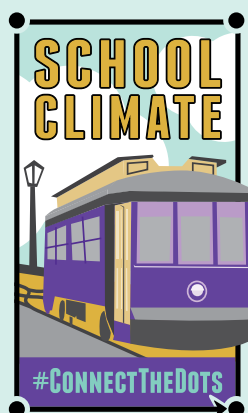
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when working with individual students at Tier 2 and Tier 3 levels of service delivery. A trauma-informed approach can be incorporated within the context of a multitiered model of service delivery by making modifications to the core domains of school psychology practice, including assessment, consultation, and intervention.

Assessment. School psychologists can consider trauma when conducting psychoeducational evaluations with students. As part of a comprehensive assessment, school psychologists can gather information about past trauma history. When obtaining information about developmental and medical history, school psychologists should pay attention to relatively recent data as well as children's early childhood experiences. Children experience rapid brain development in early childhood, and therefore are particularly vulnerable to the negative impact of trauma on the brain during this period (Walkley & Cox, 2013). In addition, school psychologists can incorporate the principles of the trauma-informed model into their assessments. In the medical field, physicians typically assess the ABCs (i.e., airway, breathing, and circulation). In a trauma-informed model of healthcare, the assessment of the ABCs can be followed by an evaluation of the DEFs (i.e., distress, emotional support, and family; Marsac, 2015). In school psychology we assess our own ABCs (i.e., antecedents, behavior, consequences); incorporating the DEFs is a highly useful complement to our assessment practices. Assessing distress refers to gathering information about the child's fears and worries related to the assessment process and the child's experience of grief and loss (Marsac, 2015). The child's fears and worries should be addressed by giving the child control during the assessment process; the child should understand assessment procedures and have the ability to provide input (e.g., choosing which assessment measure to complete first, as appropriate; Marsac, 2015). In addition, it is important to assess the child's understanding of the process, clarify misconceptions, and give the child reassurance (e.g., they are not in trouble; Marsac, 2015). The second part of assessing distress is considering the child's experiences of grief and loss and how that trauma may be impacting their academic, behavioral, psychosocial functioning (Marsac, 2015).

Consultation. Assessing the second two parts of the DEFs can be conducted in the context of engaging in consultation with parents. Partnership with parents and families is an essential component of providing trauma-informed care (Conradi & Wilson, 2010). The E in the DEFs represents emotional support. Assessing emotional support for a child involves understanding what supports the child needs to cope and barriers to accessing these supports. Assessing emotional support involves consulting with families to understand successful coping strategies used at home, ensuring that parents understand the reasons for assessment and possible methods of intervention, asking parents to contribute to the evaluation, and encouraging parents to use successful coping strategies used at school, at home (Marsac, 2015). The last part of evaluating the DEFs, assessing family, involves examining family resources and stressors (Marsac, 2015). This fits well in a consultation model for school psychologists. When school psychologists gather information about family resources and stressors, they can encourage parents and siblings to access additional resources needed, such as outside mental health care, which may lead to a more stable and supportive environment overall for the student. In addition to engaging in consultation with parents, school psychologists can initiate consultation with other professionals (e.g., primary care providers or social workers) who are coordinating care for the student to ensure effective and comprehensive services (Conradi & Wilson, 2010).

Intervention. School psychologists can also contribute to the delivery of evidence-based, trauma-focused interventions in schools (Conradi & Wilson, 2010). Manualized intervention packages, such as Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox et al., 2007) can be implemented with groups of students at Tier 2. Students who do not respond to Tier 2 group interventions can participate in Tier 3, individualized interventions packages adapted to their needs. These interventions should target the negative consequences of trauma that are directly related to learning and academic success, including "decreased cognitive capacity, poor memory and concentration, language delays, and the inability to create and sustain positive relationships" (Brunzell, Waters, & Stokes, 2015, p. 4). As school psychologists, we are familiar with implementing interventions that target many of these areas. Additional intervention strategies that would be helpful for school psychologists to incorporate into their practice include a focus on promoting self-regulation and secure attachment (Brunzell et al., 2015).

When developing interventions related to self-regulation, school psychologists should consider students' physical and emotional self-regulation (Brunzell et al., 2015). Self-regulation strategies could include rhythmic, patterned activities, such as songs with movement or exercise, that give students an opportunity to continually practice physical self-regulation skills (Brunzell et al., 2015). To practice emotional regulation, students may benefit from the opportunity to practice identifying their feelings, linking their feelings to their experiences, and learning strategies to calm themselves down (Brunzell et al., 2015). These emotional regulation strategies are often taught in cognitive-behavioral therapy intervention programs.

Some students may have experienced traumatic or highly stressful events in the absence of the consistent, nurturing presence of a supportive person, which may result in a failure to seek help or a tendency to respond to stress in maladaptive ways (e.g., aggression, withdrawal, or bullying; Brunzell et al., 2015). Trauma-informed interventions can help students build positive, trusting relationships with adults and peers in the school, which may increase students' feelings of safety and belonging (Brunzell et

al., 2015). In order to build positive relationships, school staff need to be empathetic, warm, and make students feel respected and valued. It is recommended that staff interact with students in this way at all times, regardless of the student's behavior or response (Brunzell et al., 2015). In all interventions, a strengths-based approach is recommended; school psychologists can focus their efforts on building students' competencies and skills to promote improvement in academic, psychosocial, and behavioral functioning (Brunzell et al., 2015; Conradi & Wilson, 2010).

TRAUMA-INFORMED CARE AND RACIAL/ETHNIC DISPARITIES

Given racial/ethnic and socioeconomic disparities in the experience of trauma and chronic stress, use of a trauma-informed care approach may reduce disparities in the emotional and health outcomes of these students, which may then positively impact students' academic and behavioral functioning. Failure to detect and address the trauma experienced by students exposed to violence may perpetuate disparities in educational and health outcomes (Brunzell et al., 2015; Walkley & Cox, 2013). Using a trauma-informed approach in schools virtually ensures that the negative impact of trauma is recognized and that the needs of students who have experienced trauma are addressed. Some schools are beginning to incorporate a trauma-informed approach and are seeing the benefits. For example, during the 2010 to 2011 school year, Lincoln High School in Walla Walla, Washington adopted a trauma-informed approach to discipline. The school saw a significant reduction in suspensions (85%), expulsions (40%), and written referrals (50%; Walkley & Cox, 2013). Schools that would like to integrate a trauma-informed approach into their practice may consider using a multitiered system of service delivery in which they make adjustments to school policies and procedures at Tier 1, provide group interventions and consultation at Tier 2, and develop individualized interventions to address the effects of trauma at Tier 3. As advocates for social justice, school psychologists are charged with the task of providing appropriate supports to meet the needs of all students; providing trauma-informed care may be a necessary part of meeting the needs of many students from racial/ethnic minority and low socioeconomic backgrounds. ■

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Brock, S. E., & Cowan, K. (2004). Coping after a crisis. *Principal Leadership*, 4(5), 9-13. Retrieved from <http://www.nasponline.org/resources/principals/PTSD%20NASSP%20January%2004.pdf>
- Brown, S. M., Baker, C. N., & Wilcox, P. (2012). Risking Connection trauma training: A pathway toward trauma-informed care in child congregate care settings. *Psychological Trauma: Theory, Research, Practice and Policy*, 4, 507-515.
- Brunzell, T., Waters, L., & Stokes, H. (2015). Teaching with strengths in trauma-affected students: A new approach to healing and growth in the classroom. *American Journal of Orthopsychiatry*, 85, 3-9.
- Connors-Burrow, N., Kramer, T. L., Sigel, B. A., Helpenstall, K., Sievers, C., & McKelvey, L. (2013). Trauma-informed care training in a child welfare system: Moving it to the front line. *Children and Youth Services Review*, 35, 1830-1835.
- Conradi, L., & Wilson, C. (2010). Managing traumatized children: A trauma systems perspective. *Current Opinion in Pediatrics*, 22, 621-625.
- Crouch, J. L., Hanson, R. F., Saunders, B. E., Kilpatrick, D. G., & Resnick, H. S. (2000). Income, race/ethnicity, and exposure to violence in youth: Results from the national survey of adolescents. *Journal of Community Psychology*, 28, 625-641.
- Farmer, E. M., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services*, 54, 60-66.
- Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2013). Violence, crime, and abuse exposure in a national sample of children and youth: An update. *JAMA Pediatrics*, 167, 614-621.
- Goodman, R. D., Miller, M. D., & West-Olatunji, C. A. (2012). Traumatic stress, socioeconomic status, and academic achievement among primary school students. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4, 252-259.
- Jaycox, L. H., Stein, B. D., Amaya-Jackson, L. M., & Morse, L. K. (2007). School-based interventions for child traumatic stress (pp. 16-19). In S. W. Evans, M. Weist, & Z. Serpell (Eds.), *Advances in school-based mental health interventions* (Vol. 2). Kingston, NJ: Civic Research Institute.
- Jaycox, L. H., Stein, B. D., Kataoka, S. H., Wong, M., Fink, A., Escudero, P., & Zaragoza, C. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41, 1104-1110.
- Kataoka, S. H., Stein, B. D., Nadeem, E., & Wong, M. (2007). Who gets care? Mental health services use following a school-based suicide prevention program. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 1341-1348.
- Keesler, J. M. (2014). A call for the integration of trauma-informed care among intellectual and developmental disability organizations. *Journal of Policy and Practice in Intellectual Disabilities*, 11, 34-42.
- Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., ... Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, 39, 396-404.
- Lynch, M. (2003). Consequences of children's exposure to community violence. *Clinical Child and Family Psychology Review*, 6, 265-274.
- Marsac, M. L. (2015, June). *Posttraumatic stress & pediatric injury: promoting full physical & emotional recovery*. Keynote address presented at the Annual Michigan Pediatric Trauma Conference, Ann Arbor, MI. Retrieved from http://mitrauma.org/wp-content/uploads/2015/06/2015-Marsac_MI-Trauma-Conference.pdf
- Overstreet, S., & Mathews, T. (2011). Challenges associated with exposure to chronic trauma: Using a public health framework to foster resilient outcomes among youth. *Psychology in the Schools*, 48, 738-754.
- Ramirez, M., Wu, Y., Kataoka, S., Wong, M., Yang, J., Peek-Asa, C., & Stein, B. (2012). Youth violence across multiple dimensions: A study of violence, absenteeism, and suspensions among middle school children. *Journal of Pediatrics*, 161, 542-546.
- Ruchkin, V., Henrich, C. C., Jones, S. M., Vermeiren, R., & Schwab-Stone, M. (2007). Violence exposure and psychopathology in urban youth: The mediating role of posttraumatic stress. *Journal of Abnormal Child Psychology*, 35, 578-593.
- Substance Abuse and Mental Health Service Administration. (2014, May 20). *Trauma-informed approach and trauma-specific interventions*. Retrieved from <http://www.samhsa.gov/nctic/trauma-interventions>
- Walkley, M., & Cox, T. L. (2013). Building trauma-informed schools and communities. *Children and Schools*, 35, 123-126.
- Weist, M. D., & Evans, S. W. (2005). Expanded school mental health: Challenges and opportunities in an emerging field. *Journal of Youth and Adolescence*, 34, 3-6.

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