



UNDERSTANDING TRAUMA AND TRAUMATIC STRESS

Guide & Resource

July 2020



TABLE OF CONTENTS

Objectives and Key Concepts	3	What is Racial Trauma?	9
What is Trauma?	3	What is Traumatic Grief?	10
What is the Prevalence of Trauma and Adverse Childhood Experiences among Youth in our Schools?	5	What is Traumatic Stress?	10
What about Kentucky?	5	Additional Resources	11
What are Adverse Childhood Experiences?	6	References	12
What is Complex Trauma?	8		

KENTUCKY DEPARTMENT OF EDUCATION



Vision

Ensure each and every student is empowered and equipped to pursue a successful future.

Mission

To partner with districts, schools, families, students, business and industry, and communities to provide leadership and support to ensure success for each and every student.

About

The Kentucky Department of Education is a service agency of the Commonwealth of Kentucky, and part of the Education and Workforce Development Cabinet. The department provides resources and guidance to Kentucky's public schools and districts as they implement the state's P-12 education requirements. The department also serves as the state liaison for federal education requirements and funding opportunities.

OBJECTIVE AND KEY CONCEPTS

Objective: Understand what trauma is and how it impacts students.

KEY CONCEPTS

1. Trauma is uniquely experienced by each individual and impact varies across many areas of functioning.
2. Educators must use a “trauma lens”: What happened to this student?
3. Trauma-informed strategies in school are important to mitigate the negative effects of trauma.
4. Trauma-informed responses should be universally provided to ensure all students may benefit; schools often do not know who among their students may have experienced trauma.

WHAT IS TRAUMA?

Trauma, trauma-informed care, and trauma-informed practices are terms and concepts that have become ubiquitous across child-serving systems, most recently extending to include education. It is imperative to have a shared understanding of what constitutes trauma and how it relates to students, staff and school communities. The term “trauma” contains several concepts: an event, an experience and the effects of the experience. The Substance Abuse and Mental Health Services Administration (SAMHSA) summarizes and defines trauma as consisting of “Three E’s”:

Individual trauma results from an **event**, series of events or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual’s functioning and mental, physical, social, emotional or spiritual well-being.

A traumatic **event** may occur once or repeatedly, and include many types of incidents, individual or collective, such as:

- Child maltreatment (physical, sexual or emotional abuse; physical, emotional or medical neglect)
- Domestic violence/interpersonal violence
- Sexual assault
- Human trafficking
- Accident or medical trauma
- Natural disaster (flood, tornado, hurricane, fire, drought)
- Terrorism, war, detention
- Race-based, historical or structural trauma
- Refugee trauma, forced migration
- Community violence
- Parental incarceration

A traumatic event may create a traumatic **experience**: the actual or perceived threat of death, serious injury or sexual violation created by exposure to the traumatic event.

Traumatic events are experienced uniquely by different people, and in different contexts. Thus, two children exposed to the same traumatic event, even in the same family, may experience the event quite distinctly: one child may find it highly threatening, while the other child perceives it as manageable.

Differences in perception and experience of traumatic events may be related to age and developmental level, available family and community supports, individual coping capacity, concurrent or past behavioral health status, past exposure to trauma, and the nature of the event itself. The same individual may even respond to the same type of trauma exposure differently at different times in their life, depending on these contextual conditions. The experience of trauma differs according to the individual, the traumatic event and the context of that particular moment.



Trauma may be experienced personally or witnessed; both may elicit the perception of threat and create a traumatic experience.

The **effects** of trauma will vary widely: they may occur immediately or have a delayed onset, be short-lived or long-lasting, and range from mild to severe. Some people may have a period of distress which resolves on its own over time; others may require professional support to recover and return to prior levels of functioning; others may experience long-lingering effects. Responses to trauma also can wax and wane over time, or even be reignited long after the traumatic event is over and the experience appears to have ended.

Our natural response to trauma elicits a physiological brain and body response that can impact development and functioning across all domains: physical, cognitive, emotional, social

and behavioral. Trauma exposure in early childhood may be particularly deleterious to the developing brain and subsequent functioning. The detrimental effects of trauma often manifest in the school environment as challenges in learning, difficulty regulating behavior and emotions, erratic social interactions and poor physical coordination and abilities.

It is important to recognize that these negative effects are a response to trauma exposure and can be mitigated through healing and recovery supports that recognize the causal role of trauma. The effects of trauma do not result in immutable and permanent damage to youth. It is up to the adults in a child's life to provide the supports necessary for healing and recovery, and up to systems to ensure their practices and policies do not cause trauma or re-traumatize youth. Educators and educational systems must actively and intentionally implement the trauma-informed strategies described in this toolkit to guard against unintentionally traumatizing or re-traumatizing students, families and staff.

Some effects of trauma among school-aged youth include:

- Difficulty getting along with others, extreme reactions, hypersensitivity, challenging or defensive towards authority, social withdrawal
- Difficulty with concentration and focus, physical or mental agitation, hypervigilance
- Problems with memory, decision-making, following directions
- Moody, tearful, anxious, clingy, depressed, negative, numb, withdrawn, disengaged, suicidal

Youth may have one, several or many of these responses to trauma exposure. The effects may change over time, at different developmental phases or in response to changing environmental contexts and stressors. The impact of trauma also may be difficult to spot in students who work to “mask” their very difficult inner struggles. Thus, it is important to always use a “**trauma lens**” to understand the source of challenging school behavior and performance. Using the trauma lens means asking, “What happened to this student?” rather than “What’s wrong with this student?”

WHAT IS THE PREVALENCE OF TRAUMA AND ADVERSE CHILDHOOD EXPERIENCES AMONG YOUTH IN OUR SCHOOLS?

Rates of trauma among students are difficult to measure and generally believed to be imprecise. Few systematic means of surveillance capture the prevalence or incidence of child maltreatment across all populations. Those systems often count only reported incidents of maltreatment or rely on reporting after the fact. Much child maltreatment is interpersonal and private when it occurs, and both survivors and offenders often are not inclined to disclose what is happening. Culture, ethnicity, race, religion and gender also influence willingness to report child maltreatment.

Lack of clarity around definitions and conceptual understanding, as well as wide variation in methodology including respondents (youth, caregivers, professionals, records) and time frame (lifetime versus last year) make aggregating or comparing data difficult. For these reasons, it is generally assumed that reported rates of child maltreatment (both prevalence and incidence) underestimate the actual rate (Fallon et al, 2010; Saunders & Adams, 2014).

However, certain indicators and trends can be gleaned from existing data. Retrospective reports from the Adverse Childhood Experiences Study and similar studies indicate approximately two-thirds of adults experienced adverse events in childhood. Child maltreatment reporting records indicate 38% of youth in the United States have been the subject of a child abuse investigation, with higher rates (53%) for African American youth (Kim, et al, 2017). The American Psychological Association, citing a 2008 Presidential Report, states that between 39% and 85% of youth have witnessed community violence, while studies indicate a range from 25%-43% of youth experienced sexual abuse. Exposure to natural disasters and serious motor vehicle accidents have been reported at 20%-25% of youth (Saunders & Adams, 2014). Polyvictimization, the exposure to more than one type of trauma, is estimated at 20% of all youth (Saunders & Adams, 2014).

WHAT ABOUT KENTUCKY?

America's Health Rankings, using a number of national surveys and datasets, estimate that 25.8% of Kentucky youth ages zero to 17 experienced two or more of the following adversities between 2017 and 2019:

- *Witnessing domestic violence*
- *Witnessing community violence*
- *Living with someone with a substance use disorder*
- *Living with someone with mental illness*
- *Having a parent spend time in jail*
- *Death of a parent*
- *Economic hardship*
- *Parental divorce*
- *Racial/ethnic discrimination*

This was higher than the national estimate of 20.8% with notable differences in living with someone with a substance use disorder (Kentucky at 11.5% compared to the national rate of 8.5%) and having a parent spend time in jail (Kentucky at 12.6% compared to the national rate of 7.7%).

In general, schools may operate on the assumption that 25% of students have been exposed to trauma, knowing that is likely an underestimate. Variations based on student demographics, community violence rates and student age should always be considered. Because precise prevalence and incidence rates are difficult to ascertain, and because schools often don't know who specifically has experienced trauma, a widespread, systematic public

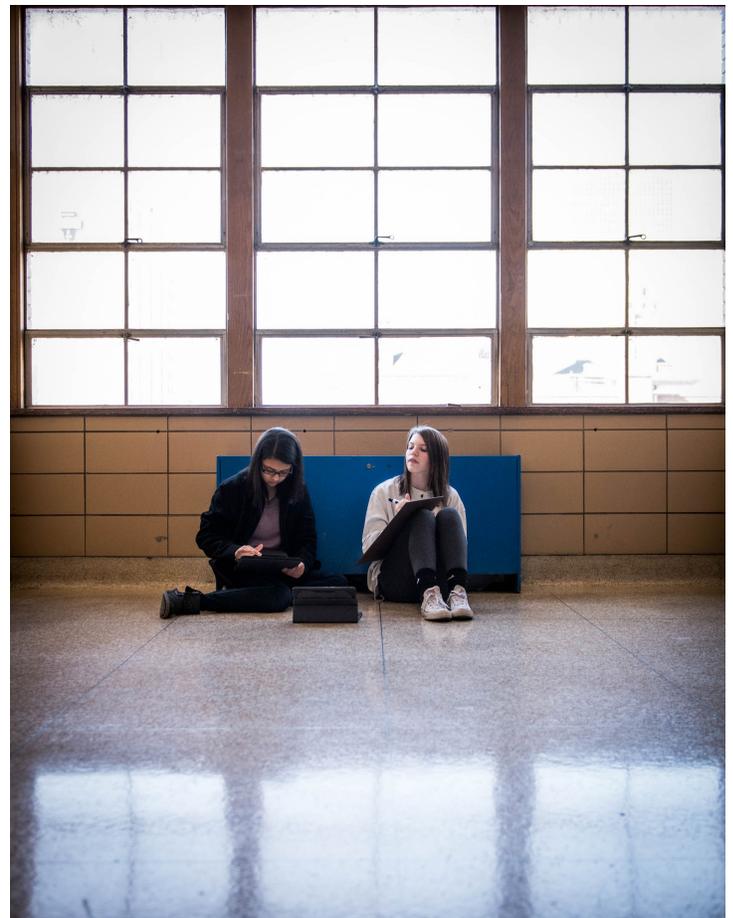
health approach to trauma-informed practices is recommended.

This public health approach is grounded in universal trauma-informed response and intervention to ensure benefit for students who most need trauma-informed supports. Students who have not been exposed to trauma will not be harmed, and, in fact, also may benefit.

WHAT ARE ADVERSE CHILDHOOD EXPERIENCES?

The Adverse Childhood Experiences (ACEs) Study is a seminal study conducted in the 1990s by the U.S. [Centers for Disease Control and Prevention](#) (CDC) and Kaiser Permanente involving more than 17,000 adults in California, primarily white, middle class and college-educated. The study examined the rates and types of adversity adults recalled experiencing in childhood, and then explored the connections between childhood adversity and adult physical and behavioral health. Findings demonstrate several key tenets of our understanding of childhood trauma and adversity:

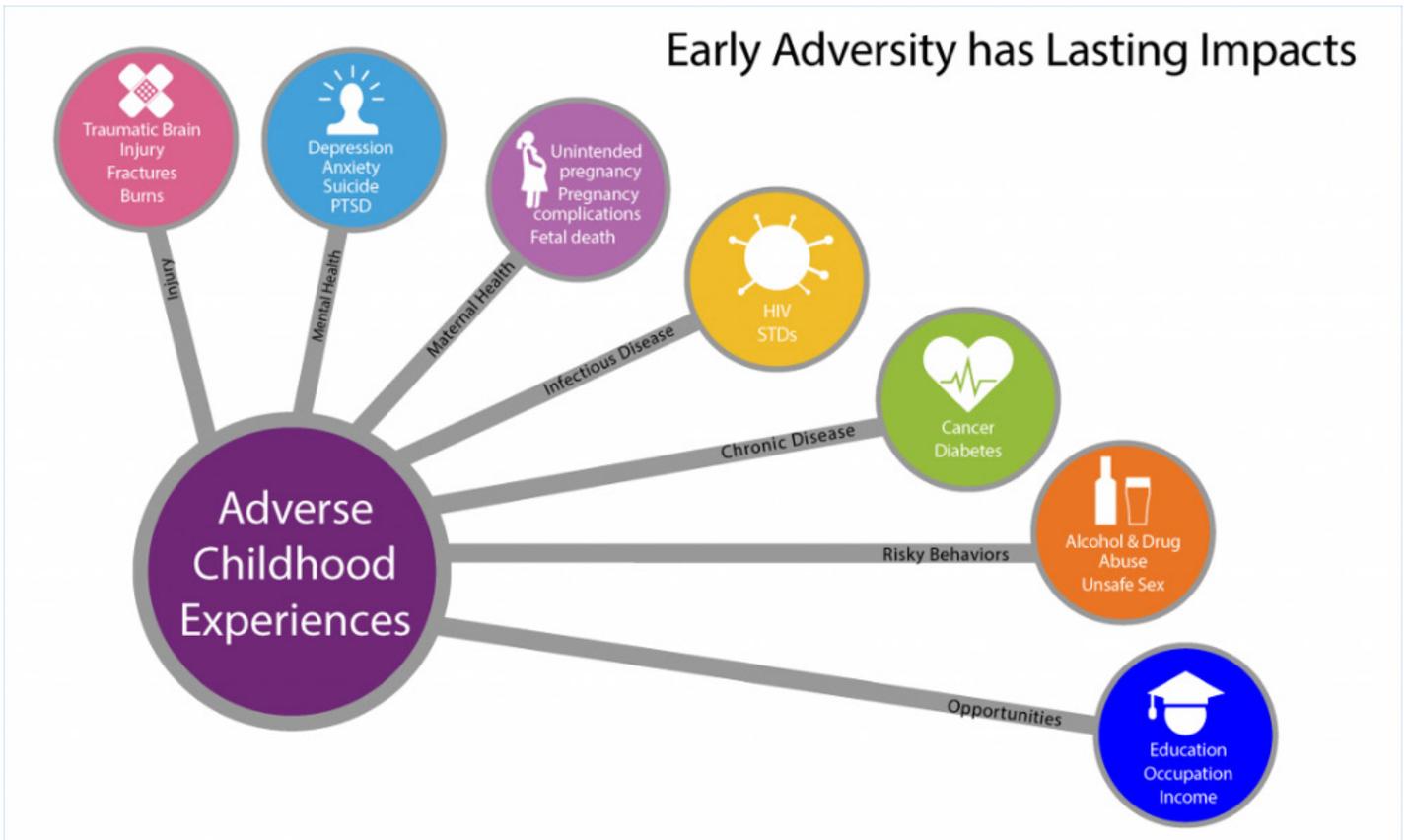
1. **Adverse childhood experiences are not uncommon:** Nearly two-thirds of respondents reported having faced at least one of 10 adverse experiences, and one in five reported experiencing three or more.
2. There is a **dose response** between exposure to childhood adversity and the ongoing risk for negative health and behavioral health effects. That is, the higher the amount of exposure to ACEs, the more detrimental the effects; exposure to four or more ACEs in childhood significantly increases risk for persistent negative effects on health and well-being.
3. Early exposure to adverse childhood experiences **disrupts neurodevelopment** which sets up a cascade of risk for subsequent health and well-being including obesity, diabetes,



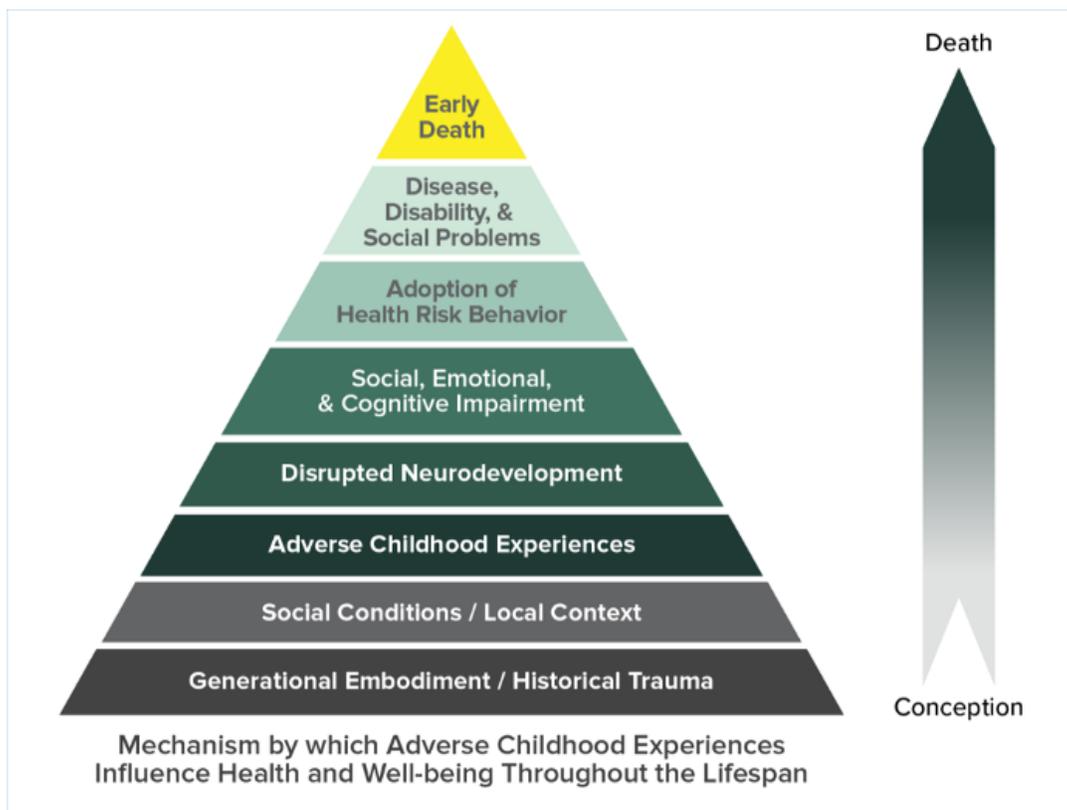
lung disease, cardiac disease, depression, substance use disorder, suicidality, domestic violence, homelessness and economic instability.

4. **Early intervention is critical** to interrupt the consequences of risk and health and behavioral health complications that can follow adverse childhood experiences.

Early Adversity has Lasting Impacts

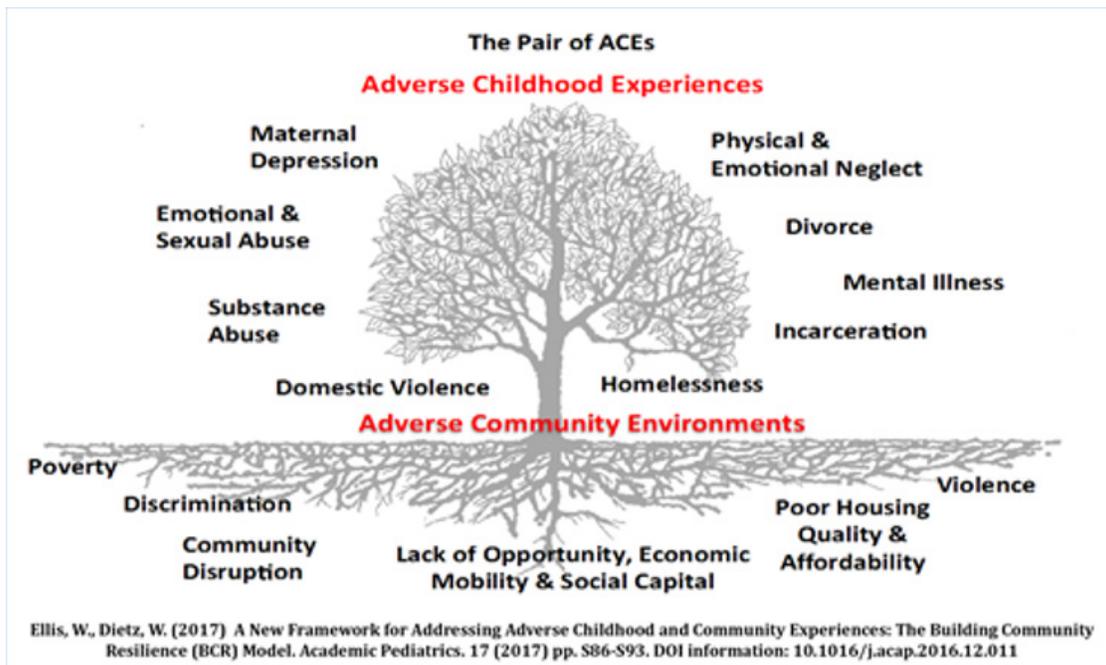


The original ACE study led to the development of the ACE Pyramid to understand the effects of childhood exposure to adversity and trauma:



Replication studies across many different populations confirm the findings of the original ACE study and extend our understanding of the impact of exposure to childhood adversity and trauma. Specifically, recent studies indicate that Black

persons and other persons of color have even higher rates of ACE exposure, informing the development of the “Pair of ACEs” model that examines the impact of Adverse Community Environments as well as Adverse Childhood Experiences.



Additional items have been added to the original ACEs questionnaire to include other types of adversity and trauma. The ACE Questionnaire is not a diagnostic tool; it was developed to understand the prevalence of childhood adversity

across groups, and it is not intended to guide individual diagnoses or intervention. The ACE Questionnaire is not recommended for use as a screening tool since it does not assess impact, only exposure.

WHAT IS COMPLEX TRAUMA?

Complex trauma also is a multifaceted term, as it refers to both exposure to multiple traumatic events and the adverse effects of such exposure. Complex trauma exposure usually begins early in life with persistent or chronic trauma of an interpersonal nature (child abuse or neglect) that interrupts the child’s secure attachment to a caregiving adult. As a result, the child develops coping mechanisms for survival that impact subsequent development and functioning across all areas.

The child often develops a negative view of themselves (as unworthy), others (as unreliable) and the world (as unsafe).

Complex trauma often results from maltreatment at the hands of a caregiving adult, causing a profound betrayal of what should be a caregiving bond. Common effects of complex trauma exposure include:

- **Social problems** including difficulty with friendships, authority figures and romantic relationships. In older youth this may manifest as being drawn to peers who appear to have deviant behaviors or being connected to gangs. This also manifests as difficulty forming trusting relationship with others.
- **Emotional difficulties** including trouble regulating and

expressing emotions; sudden and extreme emotional swings; hypersensitivity and easily triggered into fight, flight or freeze mode; over-reacting or under-reacting to normal events.

- **Physical or medical ailments**, sometimes of a vague but persistent nature or sometimes seemingly unrelated to the traumatic event, but the onset appears to be in response to the trauma exposure.

- **Challenging behaviors** that often are described in extreme terms including deviance, sociopathy, psychopathy or are characterized as willful aggression, defiance, disengagement, lack of empathy, hopelessness or lack of motivation.

Youth who experience complex trauma are at risk for becoming engaged in school and community disciplinary or juvenile justice systems. Unfortunately, the role of trauma in their challenging behaviors is unnoticed at best, overlooked or dismissed as irrelevant at worst.

Sometimes these caregiving systems can themselves become sources of trauma and become another powerful source of complex trauma. Often in our systems, youth who experience

complex trauma are offered purely punitive consequences. Such approaches are not only unlikely to be successful in supporting youth but re-traumatize youth and exacerbate behavioral and emotional symptoms.

Understanding the impact and role of complex trauma in the lives of youth is imperative to achieve healing and recovery for them as individuals, and for their family, school and neighborhood communities.



WHAT IS RACIAL TRAUMA?

Racial trauma refers to trauma experienced as a result of exposure and re-exposure to racism, discrimination and marginalization, rooted in chronic historic and structural racism towards Black people, Indigenous people and other persons of color that permeates all areas of society.

This structural and systemic racism is seen in police brutality and chronic discrepancies in the arrest and incarceration of Black and Brown people; poorer health status and poorer health service responses to Black and Brown patients; and a myriad of educational discrepancies in educational achievement, retention, graduation, disciplinary interventions and pursuit of post-secondary opportunities.

Racial trauma also may result from the cumulative impact of microaggressions - small, often unintentional, acts of racism that erode psychological safety, self-value, competence and resilience.

Racial trauma can interfere with healthy physical, cognitive, social and emotional development in youth. Frequent effects of racial trauma in youth include hypervigilance and suspicion, hypersensitivity to perceived threat; perception of foreshortened future; nightmares and flashbacks; defensive and aggressive verbal and physical behaviors; and substance abuse.

In school settings, these traumatic stress symptoms may be mischaracterized as aggression, deviance, violence or

disengagement, limiting opportunities for healing and support. Trauma-informed schools must acknowledge the presence of racial trauma to implement effective prevention, identification

and response strategies that support students, families and staff experiencing racial trauma.

WHAT IS TRAUMATIC GRIEF?

Grief is a normal occurrence in the lives of children, and adults must teach children how to manage grief and loss. Traumatic grief occurs when a child is unable to move beyond the grief response and experiences prolonged symptoms of trauma as part of that grief. Traumatic grief may be more likely to occur if the loss is sudden, violent or unexpected; if the child witnesses the death or sees the evidence of the death; or if the loss is of a protective caregiver leaving the child vulnerable to trauma exposure or causing a cascade of changes and instability in the child's life.

Youth who experience traumatic grief often have nightmares or intrusive thoughts about the loss, avoid anything that reminds them of the death or the person, may demonstrate regressed behaviors, may deny that the death occurred, and are easily triggered into a physiological stress response that can manifest as shortness of breath, muscle tension or even intense anger and aggression.

WHAT IS TRAUMATIC STRESS?

The majority of people who experience traumatic events recover over a period of time. However, some experience ongoing or intense reactions to the trauma exposure, particularly if the trauma is experienced during critical developmental stages.

Traumatic stress refers to the constellation of symptoms that may occur in response to the experience of trauma. Traumatic stress responses may be significant and interfere with daily functioning and be diagnosed as Acute Stress Disorder (less than one month since the trauma exposure) or Post-Traumatic Stress Disorder (more than one month after the exposure).

Even if a student or other individual (including caregivers or staff) does not meet criteria for a clinical diagnosis such as Acute Stress Disorder or Post-Traumatic Stress Disorder, they still may be experiencing some symptom of traumatic stress. It may be that the severity of the symptoms does not

meet clinical criteria, or they only have symptoms in one area rather than several. Any symptom of traumatic stress should be treated with a trauma-informed intervention, even without a trauma-related diagnosis.

Signs of traumatic stress in students include:

- Poor sleep, nightmares, intrusive thoughts
- Anxiety, fearfulness, hypervigilance, rigid need to be in control
- Depression, suicidality, withdrawal
- Poor concentration, difficulty staying on task, impaired memory, difficulty learning
- Moodiness, extreme emotions, mood swings
- Anger, aggression, easily distressed over something small
- Agitation, difficulty staying still
- Avoidance of people, places or things associated with the traumatic event; avoidance of emotions, thoughts or body

sensations connected to the traumatic experience

Schools can help mitigate the impact and persistence of traumatic stress responses through implementation of universal (tier 1) trauma-informed practices focusing on creating a safe and supportive school climate and culture.

Universal, developmentally appropriate mental health literacy

for all students also is critical to help youth understand responses to stress and trauma and learn coping strategies. Schools may employ targeted and/or intensive interventions (tiers 2 and 3) for students who exhibit persistent or intense traumatic stress symptoms, even after tier 1 supports. These tier 2 and tier 3 responses may include additional academic, social and emotional supports; mentoring; skill-building groups; and individual trauma-focused therapy.



ADDITIONAL RESOURCES:

- U.S. Centers for Disease Control and Prevention: [Adverse Childhood Experiences](#)
- George Washington University Center for Community Resilience: [The Pair of ACEs Tree](#)
- Nadine Burke Harris, M.D., TED Talk: [How Childhood Trauma Affects Health Across a Lifetime](#)
- National Child Traumatic Stress Network:
 - [Addressing Race and Trauma in the Classroom](#)
 - [Complex Trauma](#)
 - [Traumatic Grief](#)
 - [Understanding Traumatic Stress in Adolescents](#)
 - [What is Child Traumatic Stress?](#)
- Substance Abuse and Mental Health Services Administration: [Concept of Trauma and Guidance for a Trauma-Informed Approach](#)

REFERENCES:

- America's Health Rankings (2020). *Adverse Childhood Experiences in Kentucky*. <https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/KY>
- American Psychological Association (2011). *Children and Trauma: Update for Mental Health Professionals*. <https://www.apa.org/pi/families/resources/children-trauma-update>
- Fallon, B., Trocme, N., Fluke, J., MacLaurin, B., Tonmyr, L. & Yuan, Y-Y. (2010). Methodological challenges in measuring child maltreatment, *Child Abuse and Neglect*, 34.
- Kim, H., Wildeman, C., Jonson-Reid, M. & Drake, B. (2017). Lifetime prevalence of investigating child maltreatment among US children, *American Journal of Public Health*, 107(2), 274-280.
- Saunders, B.E. & Adams, Z.W. (2014). Epidemiology of traumatic experiences in childhood, *Child and Adolescent Psychiatric Clinics of North America*, 23(2), 167-184.
- Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf



300 Sower Blvd., 5th Floor
Frankfort, KY 40601
(502) 564-2000
Fax (502) 564-5680
education.ky.gov