# Trauma Matters

SPRING 2019

A quarterly publication dedicated to the dissemination of information on trauma and best-practices in trauma-informed care.

## Inside this issue:





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www.womensconsortium.org

## Hidden Wounds of Male Trauma

Males are born into a society that is harsh and violent towards them and one that sets them on a path for emotional detachment from birth. Shockingly, studies have shown that a newborn baby covered with a blue blanket will be touched less and spoken to more firmly than a newborn in a pink blanket and that this happens regardless of the biological sex of the baby (Newman, 2008). The socially constructed colors we associate with gender, are so ingrained that they affect the way we respond to newborns. Unconsciously, newborns associated with male gender are treated harsher and more detached than newborns associated with female gender.

This impact of gender detachment for males undoubtedly continues to perpetuate as boys grow into men and begins so early that many do not recognize its existence. Other common cultural myths like, "men don't cry" or "men don't show their emotions" (except anger as it has been the only emotion deemed socially acceptable for them to show), have resulted in many men feeling "out of place" or "less than" in the context of our society when they are confronted with a situation in which they become emotionally vulnerable. Many males begin to question, "Do I allow these feelings and compromise my socially constructed identity as a man?"

The unhealthy social expectations of males create a need for many men to numb intense feelings to remain consistent with rigidly prescribed gender norms, which often sets the stage for continued cycles of addiction, violence, and re-traumatization. It is no secret that men are often perceived as perpetrators of violence and abuse and have frequently been re-traumatized during treatment by having to accept their place as "abusers" or "perpetrators". We teach that men are scary and should be feared but as we look at the facts these "scary" men are often abused or victimized themselves. Here are just a few facts surrounding abuse and trauma experienced by men:

- A large majority of the children who are neglected, abused, or murdered are boys (Kipnis, 2009).
- The majority of children in foster care and group homes are boys (Kipnis, 2009). Seventy five percent of suspensions, expulsions, grade failures, and special education referrals go to boys (Kipnis, 2009).
- Seventy nine percent of suicides are males (Centers for Disease Control and Prevention, 2010). Seventy two percent of homeless are males (US Department of Housing and Urban Development, 2009).
- Ninety three percent of prison inmates are men (US Department of Justice, 2010). Ninety nine percent of executed prisoners are men (US Department of Justice, 2010).

For many males this violence becomes a socially acceptable reality; boys are taught that violence is the norm and is part of "being a man." For many men violence has become so normalized they often do not even recognize it, yet the impact is still traumatic and cuts to the core of their identities.

In a therapy session a few years ago, I remember a man in his fifties describing his experience with family violence as a boy. He talked about watching his mother beaten and bloodied; then he looked at me with a demeanor of honor describing how at the age of 5, he had the courage to provoke the man who was hitting her only to have

the violence turned his way. He talked to me about how hard and traumatic that was for his mother and how he could see how, for her, that abuse was traumatic. When I turned the conversation and asked, "Could it have been traumatic for you?" he coldly stated "No, I got used to it. It wasn't bad for me. It was how we (the boys in my house) grew up."

Another often overlooked factor, for male trauma is how the experience of being a man in many cultures has been influenced by the war system. Though not all men become soldiers, all men must face the societal expectation of being called to kill as soldiers or warriors. Since the beginning of time, across all cultures, men have been consigned the societal expectations of protection of the ones they love by means of violence. In his book *Fire in the Belly: On Being a Man*, Sam Keen (1992), describes how the warrior culture has created a view of men as being expendable.

"Traditionally the murder of women and children has been deemed unacceptable and was protected under the shield of innocence…The point is, that no one even suggested that men's lives have a claim to the sanctity and protection afforded, in theory, to women and children (p.46)." The culture of the war system creates a society in which men endure physical, emotional, and spiritual scar tissue either from battle, expectation of battle, or blood guilt as perpetrators of violence. We must look beyond what men have done but also what they have endured. For men to be able to change who they are, we as a society must change how we view them.

If we hope to implement real change for men, we need to change both the way we view them and treat them in the world of healthcare. Male trauma must be assessed throughout the continuum of care in addiction treatment. Ancillary providers, such as emergency room clinicians, primary care providers, community health workers, criminal justice workers, and other behavioral health providers, need to be informed and trained to recognize male trauma to apply appropriate referrals and interventions. Clinicians must be trained in male-responsive, trauma-informed approaches to recognizing and treating trauma in males.

It is imperative that we as clinicians implement appropriate interventions that help men to build emotional competence, develop healthy relationships, and understand the impact of the trauma they have both experienced and perpetrated. If we hope to allow males to be comfortable in expressing and experiencing a full range of emotions despite the impacts of their trauma we will need to create a social norm where men learn to cope without the use of drugs, alcohol, or violence.

**Submitted by Chris Dorval, LICSW, LCDCS, LCDP**

## Ask the Experts: An Interview with Deborah Korn, PsyD

**by Emily Aber, LCSW**

***Debbie Korn, PsyD,*** *maintains a private practice in Cambridge, MA, and is an adjunct training faculty member at the Trauma Center in Boston. She has been on the faculty of the EMDR Institute for the past 25 years and is the former Clinical Director of the Womens' Trauma Programs at Charter Brookside and Charles River Hospitals. Dr. Korn has authored or co-authored several prominent articles focused on EMDR, including a comprehensive review of EMDR applications with Complex PTSD. Dr. Korn is an EMDRIA-approved consultant and is also on the Editorial Board of the Journal of EMDR Practice and Research. She presents and consults internationally on the treatment of adult survivors of childhood abuse and neglect. As a clinician, teacher, researcher, and consultant, Dr. Korn is known for her knowledge and integration of many different clinical models. In treating and consulting on complex, chronically traumatized cases, she believes that it is important to carry a large toolbox and to remain flexible, practical, and integrative.*

**Check out the latest Trauma Matters podcast featuring Deborah Korn at womensconsortium.org/trauma-matters**

**1). How did you become interested in the field of trauma treatment?**

I attended graduate school at the School of Professional Psychology at the University of Denver in Colorado. While I was in school, I had the opportunity to see clients –individuals, couples, and families during my field placements at the local community mental health center, the Denver Police Department Employee Assistance Program, and the Disabled American Veterans (DAV) Outreach Center. I saw veterans, domestic violence and sexual assault cases, survivors of childhood abuse and neglect, clients dealing with medical trauma, police officers and their families following critical incidents.

I received excellent supervision and tremendous emotional support in working with traumatized individuals and families and lo and behold, many, if not most, of my clients significantly improved. I loved that I could help folks finally put their past in the past. I loved that I could help them move from feeling like a victim to a survivor with dignity and power, to someone who could thrive in relationships and in the world. From the beginning, I loved the challenge of working with very complex cases and found psychotherapy with this population to be incredibly rewarding and hopeful. I was deeply moved by my clients' stories and experiences and could always see their potential for healing and post-traumatic growth.

I completed my pre-doctoral internship at the Brockton VA Medical Center, working with Vietnam veterans and their families, and knew at that point that I wanted to devote my career to working with trauma survivors.

A small side note to this story…one of my dearest uncles was a Holocaust survivor and I always felt like choosing to work with survivors of trauma was a way to somehow honor him and his suffering at the hands of the Nazis.

**2). What do you consider to be core competencies or skills that are essential for a trauma therapist?**

A competent, effective trauma therapist looks through many different lenses when treating clients. They work experientially and track many different phenomena: affective, cognitive and behavioral, sensorimotor, defensive, dissociative and ego state or parts phenomena.

They attend to relational or attachment dynamics, including re-enactments within the therapeutic relationship. They look through the lens of interpersonal neurobiology and affective neuroscience and think about the concept of co-regulation or dyadic regulation, at times, serving as the client's auxilary cortex, keeping them within a window of tolerance.

An effective trauma therapist uses a phase-oriented approach and prioritizes safety and stabilization prior to moving into any trauma-focused work.

They help clients develop self-regulation strategies and, work moment to moment, through interactive regulation, to make sure that the client does not get emotionally overwhelmed or flooded and does not, in turn, dissociate or shut down.

They provide relevant psychoeducation about trauma, emotions, attachment, dissociation, emotional needs, and the recovery process itself. They are ready to serve as a True Other, sitting in as a "good enough" parent, providing corrective emotional experiences and offering relational security and consistency, validation and respect for the person's defenses, resilience, and resources. They guide and responds to clients from a Self with a capital S, with presence, empathy, persistence, and playfulness.

They welcome all parts of the person and invite opportunities to process past experiences, imaginally, welcoming the client to say or do what couldn't have been said or done in the past, offering opportunities to bring one's child self the comfort or recognition that was missing in childhood. They aim to bring the client to a place of completion, of adaptive resolution, and are always focused on integration, helping the client to achieve a felt sense of wholeness, with a cohesive narrative and a connection to feelings, thoughts, and somatic experience.

One final point – I think that it is incredibly important for trauma therapists to be educated about dissociation so that they are able to identify when they are treating someone with a dissociative disorder, like DID, and develop an appropriate treatment plan. I can't begin to tell you how often I discover that colleagues have failed to diagnose a dissociative disorder and once they begin to see their case from this perspective, their work takes off as they intervene in more appropriate and effective ways.

**3). How do you integrate different trauma-informed clinical models in the treatment of complex trauma treatment?**

Personally, EMDR therapy is my primary treatment model but I regularly integrate other trauma-informed models into the standard EMDR framework.

For example, I use Internal Family Systems language, concepts, and interventions during the early stages of EMDR in preparing a client to process traumatic memories. I work to identify the "protector parts" of the person who hold concerns about the proposed work, parts who may block access to memories or affect or introduce substances, dissociation, self-injury, or even suicide in an effort to manage or distract from emotional pain or knowledge. In approaching these parts with curiosity, compassion, and appreciation, it is often possible to get them to "step back", allowing access to traumatic memories or "exiled traumatized parts". Only then is a client able to safely and effectively proceed with the Desensitization or processing phase of EMDR therapy.

Similarly, during the early phase of treatment, I might use strategies borrowed from AEDP (Accelerated Experiential Dynamic Psychotherapy) to strengthen the sense of safety within the therapeutic relationship, making it possible for the client to lower their defenses and then, explore their internal world and traumatic past. AEDP offers a beautiful framework for addressing attachment, building trust, and moving clients to a place where they are able to relinquish their maladaptive defenses.

Early on in the work, I may also engage in some biobehavioral or somatic resourcing exercises with my clients, borrowed from Sensorimotor Psychotherapy (SP) or Somatic Experiencing (SE), to help them feel more regulated or grounded, more empowered, and more prepared to handle triggers in their day to day life and more prepared to process traumatic material in sessions.

Similarly, I might introduce some hypnotic ego strengthening interventions to strengthen clients' capacities for affect regulation and dual attention (observing the past while staying grounded in the present).

Sometimes, I simply teach coping or self-regulation skills borrowed from more cognitive behavioral models like Dialectical Behavior Therapy (DBT) or Seeking Safety.

Once I begin to access traumatic material at a somatic, emotional, cognitive and imaginal level, I continue to call upon these other models as needed. In EMDR, we utilize interventions called "interweaves" when a client's processing is blocked or when a client needs more information or a new perspective. Sometimes, I may intervene with an IFS interweave, sometimes with an AEDP interweave, sometimes with a Sensorimotor Psychotherapy interweave, so on and so forth.

The EMDR model dictates that I use an interweave but the language or form of the interweave can certainly be borrowed from other models. So, with interweaves, I may ask a part to step back or not overwhelm the Adult Self to address blocked processing (called unblending in IFS) or I might use the language of secure attachment (I've got you. You're not alone now. I can see that you are scared but I'm not going to let you down.) to help modulate anxiety and the desire to avoid/flee (that's AEDP), or I might encourage a client to stand up and push against a wall to feel her muscles and move out of a frozen state associated with a memory of past abuse (that is something that I learned from SP, reorganizing from passive to active defenses).

So many of the trauma-informed models share common goals and emphasize similar concepts and interventions. What's important is to be clear about what you are trying to do in any given moment, to be clear about the clinical goal or need at an impasse or at a

particular stage of treatment.

Does the client need a relationally-focused intervention or a mindfulness-focused intervention or a regulation-focused intervention?

Does he/she need information or a different perspective, defense work, or an ego state or parts intervention?

Is the client ready for processing work and if so, does he need to focus on completing truncated actions (like expressing anger or fighting back), developmental repair (like comforting a traumatized child part), or simply sequencing or processing through the traumatic experience to lower the fear or distress associated with PTSD.

Again, many trauma-informed models offer interventions appropriate for these tasks. Depending on what you are trained in, what you are most comfortable with, and what kinds of interventions seem to resonate most for your client, you can choose what intervention to use with a particular client or at a particular moment in time.

**4). What stabilization tool(s) do you find most helpful to teach trauma survivors?**

I offer clients a wide array of tools over the course of treatment with an emphasis on self-regulation skills that are designed to be used to down-regulate hyper-arousal or up-regulate hypo-arousal.

I emphasize self-soothing skills like diaphragmatic breathing, safe place exercises, and other imaginal resourcing strategies (images or words associated with nurturing or protective figures). I introduce distancing and containment skills, like putting intrusive memories, images, sensations, or emotions up on a screen, behind a protective barrier, or in some kind of container.

I offer grounding and orienting strategies to help the client stay present, embodied, and connected to the current moment. I also teach skills to facilitate modulation and titration of affect, like the use of an affect dial, a remote control, or imagery that allows the client to tackle just one feeling or drop of feeling at a time or whatever he/she can handle. I might also teach folks to pendulate between safe place imagery or a calm, safe place within their body and upsetting, challenging material.

Perhaps, most importantly, I teach clients how to unblend from overwhelming states and traumatized or protective parts of self and how to maintain a witnessing, mindful stance, observing their parts, emotions, sensations, memories, from a distance and with compassion and curiosity.

I also tend to work on practical self-care (like appropriate sleep, exercise, and nutrition), boundary-setting, and assertiveness or interpersonal effectiveness skills with clients early in treatment in helping them establish safer and more stable relationships and practices in their day to day lives.

## From ABCs to ACEs: The Impact of Childhood Trauma Across the Lifespan

Children and adolescents are uniquely susceptible to a variety of traumatic and potentially traumatic events (PTEs) including maltreatment, victimization, and abuse. By adolescence, about 60% of individuals have experienced or witnessed a PTE (Berkowitz, Stover, & Marans, 2011). Oftentimes noted as adverse childhood experiences (ACEs), these traumatic experiences in childhood have lasting effects on an individual, ultimately affecting more than 60% of adults (American Academy of Pediatrics, 2014). Childhood trauma affects more than half of the population and impacts both physical and mental health across the lifespan, thus, ACEs are a public health crisis and should be researched and treated as such.

Trauma occurs when extreme stress overwhelms an individual's ability to cope; it is the result of an event or set of circumstances perceived as physically or emotionally harmful, and/or life threatening. Trauma has a lasting impact on an individual's functioning and overall well-being and can be caused by a variety of experiences including but not limited to violence, hate crimes, and sexual abuse. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 61% of men and 51% of women have experienced at least one trauma in their lifetime (2018).

A potentially traumatic event (PTE) includes any exposure to an event that is life or physically threatening to oneself and/or witnessing such an event happening to another individual (Berkowitz, Watson, & Brymer, 2011; Wethington et al., 2008). An alarming percentage of children and adolescents experience a PTE prior to entering adulthood – approximately 25 to 60% in total (Berkowitz, Stover, & Marans, 2011; Kowalik, Weller, Venter, &Drachman, 2011; Wethington et al., 2008). While some children and adolescents are considered to be at a higher risk for trauma and violence exposure than others, there is still an approximate one in six children considered "low-risk", and even these children will likely experience at least one PTE before entering adulthood (Costello, Erkanli, Fairbank, &Angold, 2002).

An estimated one in every eight children under the age of 18 will experience some type of maltreatment, one in twelve will be sexually abused, and at least one in every three will experience direct or indirect violence (Wethington et al., 2008). PTEs, and ACEs can have a negative impact on an individual's ability to function properly and an experience of even one of these events can be severe and disabling in children and adolescents (Kowalik et al., 2011). According to several research projects, ACEs are a significant risk factor for substance use disorders and wide range of health problems throughout a person's lifetime (SAMHSA, 2018).

These statistics highlight just how vital it is to implement a trauma-informed approach to treatment; this is particularly important for adolescent care. Trauma-informed care is becoming more well-known and prevalent, and for good reason. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2015) any entity practicing trauma-informed care "realizes the widespread impact of trauma and understands potential paths to recovery; recognizes the signs and symptoms of trauma in clients,

families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."

The more severe the childhood trauma, the higher the risk for negative physical and mental health effects that can continue across the life span. Recently, University of California San Francisco (UCSF) has focused on undoing the harm of childhood trauma and adversity; Alicia Lieberman, PhD, Director of the Child Trauma Research Program stated: "children do not outgrow the impact of ACEs" rather the risk of them worsening over time increases unless the conditions in which they live are effectively changed (Baker, 2016). One way to help change said conditions is to offer support to parents and provide them with strategies to handle the trauma and stress, not only of their children but themselves. Edward Machtinger, MD, a professor of medicine and director of the Women's HIV Program at UCSF, suggests that an awareness of available tools to address the impact of trauma in adults is what is lacking (Baker, 2016). In Dr. Machtinger's clinic, they are using trauma-informed methods to more effectively treat conditions in parents that may predispose their children to ACEs.

Additionally, Dr. Lieberman created an assessment and treatment program designed to decrease the impact of ACEs on children's physical and mental health. Following an initial assessment of a child and his or her caregiver, Lieberman's team creates an individualized treatment plan for them. The plans can include forms of psychotherapy, crisis intervention, and practical assistance for living situations. Intervening early in a child's life can help protect them from the impact of ACEs and changes their developmental trajectory while also helping to ensure that their illnesses do not become chronic (Baker, 2016).

While early intervention is ideal it is not always possible; one of the best things health professionals can do is to simply give parents and children an opportunity to share and discuss any traumatic events they have experienced. It is immensely important to focus on adults when it comes to ACEs as there is potential risk that adults who grew up with unresolved trauma may transmit ACEs to their own children through a dysfunctional home life (Baker, 2016). As Dr. Machtinger suggests, you have to help the adults heal if you want to interrupt ACEs. His trauma-focused care model focuses on the impact of lifelong abuse and incorporates proven strategies, including creating a safe and supportive clinical environment, empowering patients, and combating their social isolation and screening for treatment for post-traumatic stress disorder, chronic pain, substance abuse, and mental illness (Baker, 2016).

Based on research conducted by Laurie Leitch, a resilience-oriented approach to trauma-informed care is recommended. This approach moves from trauma information to neuroscience-based action with practical skills that build a greater capacity for self-regulation and self-care in both service providers and their clients (Leitch, 2017). Greater attention to strengths and protective factors, as well as challenges, can reorient the way that researchers and practitioners collect information, design interventions, conduct data analyses, and support the dignity and trust of clients. By using non-clinical, skills-based approaches, individuals can learn to assess the state of their nervous systems and direct their attention using practical skills that promote self-regulation and deepen resilience (Leitch, 2017).

Another approach that has shown to be beneficial when working with children who have experienced traumatic events has been alternative schooling and using these schools as a safe space for them. In New Orleans, where children display symptoms of PTSD at more than three times the national average, there is a nonprofit K-8 school called the New Orleans Center for Resilience (Jewson, 2018). There are 27 children enrolled in this program and all have some of the most extreme behavior needs in the city, more often than not stemming from trauma or mental illness. It is common that the students here have exhibited verbal and physical aggression, caused property damage, or refused to do coursework and have been asked to leave their other schools. The center's director, Liz Marcell Williams, states that many of these students have suffered significant complex trauma. The school offers a blend of traditional classes like English and math but also places emphasis on therapy and counseling (Jewson, 2018).

When the students begin at the center they are usually three grade levels behind in math and reading. Williams' goal is to get the kids back into the mainstream school system. Students attend the center for an average of 15 months and class sizes are much smaller than the traditional public-school classroom size, some having only two students (Jewson, 2018). They receive one-on-one attention while the school regularly contacts parents with updates. In the last year, the center began assigning students a home base room, where they are provided with breakfast every morning. The home base room is there for students to return to during the day if they feel they need to opt out of a class or activity, which is not usually an option in traditional schooling. The center has had 45 children attend since its opening and is working to expand so they can benefit children with intellectual disabilities as well as behavior disorders. They also wish to be able to enroll high school students and open a trauma-informed early childhood program in the future (Jewson, 2018).

With the increasing prevalence of PTEs and ACEs, and their effects on an individuals' development and quality of life, it is more important than ever to be mindful of such events and integrate trauma specific treatment in practice with both children and adults. These approaches have been shown to be extremely beneficial and there are even more in the process of being developed and evaluated for effectiveness. The most important step to take right now though, is to simply address the existence of these traumatic events and their effects, and offer support to the parents of these children and adolescents so we can begin to break the harmful cycle of ACEs.

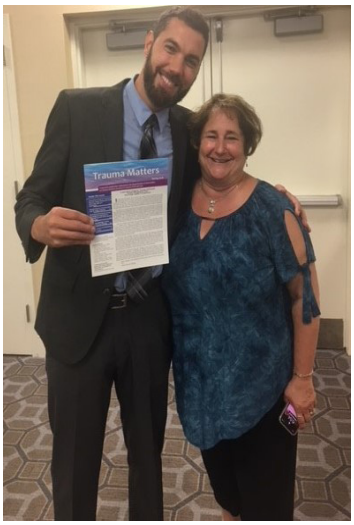
**Submitted by Sophie Caldwell, MSW Intern and Art Woodard, MSW**

# Featured Resource:

## Connecticut Women's Consortium Community Film Series

The Connecticut Women's Consortium's Community Film Series (CFS) is open to the public and endeavors to stimulate connections, raise awareness, increase knowledge, and encourage dialogue about current issues impacting our communities through film and panel discussion. CFS launched in November of 2017 with the film *Thank You For Your Service,* a documentary addressing veteran's behavioral health care and the struggle of returning home after combat. Since then, CFS has featured a variety of films on pertinent topics including paid family leave, criminal justice and re-entry, self-care, recovery and substance use, the opioid crisis, human trafficking, and adverse childhood experiences. Films are shown bi-monthly (January, March, May, July, September, and November) and each is followed by a panel including experts in the field, clinicians, peers, advocates, and more. Many panel discussions are livestreamed so check out the Connecticut Women's Consortium Facebook page often to watch.

Please visit www.womensconsortium.org/communityfilmseries for more information on upcoming films. For questions, comments and suggestions please email cfs@womensconsortium.org.




## Who's Been Reading Trauma Matters?

Pictured at left is Kane Smego with Connecticut Women's Consortium Executive Director, Colette Anderson at the 2018 National Association of Social Workers Conference in Washington DC.

Kane is an international touring spoken word poet, Hip Hop Artist, educator, and National Poerty Slam Finalist. He is the Associate Director of Next Level, a cultural diplomacy program that uses music and dance to promote cultural exchange, entrepeneurship, and conflict prevention. Kane's work as a teaching artist has led him to perform and facilitate workshops at dozens of colleges and K-12 schools across the country.

Kane Smego is presenting at Spotlight on Men & Gender Equality alongside international gender violence expert, Jackon Katz, PhD, on April 3rd, 2019.
Visit www.womensconsortium.org/spotlighton for more information.

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**A publication produced by The Connecticut Women's Consortium and the Connecticut Department of Mental Health and Addiction Services in Support of the Connecticut Trauma and Gender Initiative**

**www.womensconsortium.org**

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