Assessing Trauma Exposure and Its Impact on Children

1. Introduction

1.1 Introduction

Welcome back to the National Adoption Competency Mental Health Training for Mental Health Professionals. This lesson is: Assessing Trauma Exposure and Its Impact on Children.

Assessment is a critical part of understanding and addressing the needs of children and adolescents exposed to trauma. Developing a comprehensive framework for assessing both the exposure to, and impact of, complex trauma is vital.

1.2 Section 1: Lesson Objective

At the end of this lesson, you will be able to describe adoption competent clinical assessment practices and tools to assess trauma history and its impact on functioning in order to assure appropriate diagnosis and treatment.

2. Trauma Assessment is Essential

2.1 Trauma Assessment is Essential

As we have discussed, trauma can have such a pervasive impact on developmental trajectories that children and youth often end up with problems across many domains of functioning. A child's or youth's self-image is also profoundly affected.

2.2 Failure to Address Problem

Many children and youth end up feeling like they are "bad kids" who cannot change no matter what they try. They may be diagnosed incorrectly with a range of disorders and, consequently, treated with multiple medications and therapies that are ultimately ineffective because they fail to address the underlying problem and do not reflect a trauma-informed approach to assessment and treatment.

2.3 Impact of Trauma Video

Let's begin this lesson with a video that makes key points about the impact of trauma on children's behaviors and the importance of trauma screening and assessment. Please note that this video recounts a child witnessing domestic violence and may be upsetting to some.

[Video Transcript]

ALLISON SAMPSON JACKSON, PhD, LCSW, LICSW, CSOTP: I'd like to start with a story that was developed by the NCTSN. This story will be used to give you some perspective on the lived experience of many children and families with whom we all work.

Henry is five years old. He's heard and seen his parents fighting for his entire life. He feels scared and confused when they fight, but he loves his parents dearly. One night, he woke up to the sound of screaming, coming from the kitchen. He became frightened and wondered if they were fighting because he'd gotten in trouble at school earlier that day. He crept downstairs to find his mommy bleeding on the kitchen floor.

Moments later, three big police officers burst through the front door with their guns raised. Henry heard a lot of yelling and then one of the police officers was leading his dad out of the front door in handcuffs. Another officer took Henry to the police car and began to drive away. Henry did not get to say goodbye to his mom; did not know if she was okay and had no idea what was happening, or where he was being taken.

After spending a few long hours at the police station, a lady came to take him to a house, where he was met by a man and a woman he had never met before. The lady dropped him off and the man and the woman put him into a bed that felt big and unfamiliar. He cried himself to sleep.

The next day, the woman took him to a new school for kindergarten. He had to wear someone else's clothes that were a little too small. He didn't know anyone at the school and he felt scared and shy.

At school, he had a hard time concentrating on the teacher and following the class rules. Sometimes he got in trouble for this, became really scared that his teacher would become angry at him and yell, just like his daddy used to.

A few days later, a new lady came to the house and asked him a lot of questions. Henry asked about his parents and was told his mommy was in the hospital and his daddy was in jail. Henry did not get to talk to his mom or dad or see them for what felt like a very long time. He felt angry and confused.

He had a hard time sleeping, and when he did sleep he had bad dreams and he wet his bed at night. The man and the woman would yell at him for this, which reminded him of when his daddy would yell at his mommy. He felt scared when they yelled, and would hide under the table.

Soon the lady came back and took him to a new house. He didn't know if it was because he had done something bad. Henry wondered how many different houses he'd have to go to, and if he'd ever get to see his parents again. If we continue to follow Henry, we

witness the termination of his parents' parental rights. Yet given his age of eight now, his adoption process is slow.

At the age of twelve, in his eighth foster care placement, he witnesses his foster father yelling at his foster mother. Reminded of his childhood experience with family violence, he inserts himself between the two of them, determined now to stop this kind of verbal violence, which he fears will lead to physical violence. He takes a swing at his foster father; his foster mother calls the police. Henry is charged with simple assault, and is now introduced into the juvenile justice system.

As we listen to this story, we hear the violence in Henry's family that led to their initial engagement in our system of care, via the police. Yet if we really explore this story we notice that five sentences of the story is the familial violence Henry experiences. This is significant, and certainly has an impact on Henry's lived experiences of families and safety. Yet the next three to four paragraphs of this story involves trauma from the systems of care designed to support Henry and his family, in recovery.

Henry and his family must navigate these systems successfully in order to be reunited and to heal. Yet if our systems of care are not trauma informed we actually re-traumatize Henry and his family. We actually prevent recovery, instead of fostering it.

[End of Video]

2.4 Henry's Trauma Reflection

Think about the multiple traumas to which Henry was exposed – within his birth family, at the hands of the systems that intervened in his life, and with the subsequent families with whom he lived. Write down the different traumatic experiences in Henry's life.

2.5 Henry's Trauma Response

Henry was traumatized by the violence in his home and by the systems of care that intervened to protect him and work with his family.

Click each image to hear some of Henry's traumatic experiences.

1. At home, Henry witnessed fighting between his mother and father and his father's violence, resulting in injury to his mother.

2. Once the police intervened, Henry was repeatedly re-traumatized: separated from his mother without saying goodbye or knowing how she was, placed in a home that was unknown to him, sent to a new school in someone else's clothes, and not allowed to talk with, or see, his parents.

3. He lived in eight different foster homes, repeatedly feeling fear and uncertainty about his life. He was again re-traumatized when, upon seeing a foster father yelling at the foster mother in the ways that his father yelled at his mother, he intervened, was charged with assault and entered the juvenile justice system.

4. Henry likely experienced self-blame, loss and betrayal, and powerlessness.

2.6 Trauma Screening and Assessment

When working with children and youth who have experienced trauma, it is important to look beyond the behavior and understand what needs they are trying to meet and how their lived experiences taught them unhealthy ways to get their needs met.

Trauma screening and assessment play a critical role in guiding clinicians to understand what the child's or youth's needs are and to develop a treatment plan to begin the healing process.

2.7 Addressing Trauma First

Mental health professionals should not diagnose a child with a mental illness without first addressing the impact of trauma.

When a child or youth exhibits symptoms that could be diagnosed as either trauma or mental illness, and when symptom onset is subsequent to a traumatic event, mental health professionals should begin by developing a treatment plan to address trauma issues before diagnosing mental illness.

If the trauma treatment approach is effective, it may not be necessary to diagnose a mental illness.

2.8 Developing a Complex Trauma Framework

Developing a comprehensive framework for assessing both the exposure to, and impact of, complex trauma is vital. Unaddressed complex trauma can have such a pervasive impact on developmental trajectories that children often end up with problems that lead to a psychiatric diagnosis.

3. Trauma and Mental Health Symptoms

3.1 Trauma and Mental Health Symptoms

Let's consider the relationship between trauma and mental health symptoms.

3.2 Screening and Assessment

Screening and assessment for trauma symptoms, especially when determining how trauma affects healthy functioning, are essential in understanding a child's or youth's overall social and emotional well-being.

It is useful to think of child trauma as incorporating traumatic events, basic trauma symptoms, and specific constellations of events and symptoms, such as PTSD, and complex trauma.

3.3 Co-Occurrence of Child Trauma and Mental Health Problems

Child trauma and mental health problems can co-occur.

Trauma can exacerbate an underlying mental illness, resulting in greater symptoms. A child or adolescent may be traumatized and be diagnosed with a mental health problem.

In a study of children in foster care in Illinois, researchers found that the incidence of overlap of trauma and mental health symptoms varied based on the age of children entering foster care.

3.4 Research Findings on Co-Occurrence

Consider the following information from the study by Griffin and colleagues.

Some key points from the data on this chart are:

- More than one-quarter of all children and youth entering foster care have both trauma and mental health symptoms.
- The age group 17+ years represents the largest percentage of young people entering foster care with both trauma and mental health symptoms.
- For two age groups – 0 to 6 years and 7 to 12 years -- the incidence of trauma symptoms is greater than the incidence of mental health symptoms.

The key takeaways are the increased incidence of both trauma and mental health symptoms among children and youth with early adverse experiences and the likelihood that these will be co-occurring as children and youth age. Without an assessment and understanding of these early traumas, children's and youth's symptoms can be misdiagnosed.

Source: Griffin, G., et al., (2011). Addressing the Impact of Trauma Before Diagnosing Mental Illness in Child Welfare. Child Welfare, 90(6), pp. 69-89.

3.5 Case Study: Jack

Let's look at this brief case example: A Toddler Who Has Been Traumatized - Internalizing Behaviors. Click on the bottom right corner of the page to hear about Jack.

1. Jack, age 3, was an active spirited boy with a large extended family. Jack's mother was diagnosed with bipolar disorder and had a substance abuse problem. As she went deeper into her meth addiction, she began to isolate herself and keep Jack away from his aunts, uncles, and cousins.

2. One very cold winter night, high on meth and in an agitated depression, she got Jack out of bed, drove to a remote location and attacked him with a knife. Believing that he was dead, she cut her own throat and died within minutes. The car cooled very quickly and Jack was saved when his wounds froze shut.

3. The police spotted the vehicle because Jack's mother had left the lights on. Jack spent many months in the hospital and was placed with a foster family whom he did not know. He had no contact with his extended family.

4. Jack has not spoken since the events of that night. He refuses to eat much of the time. He is not responsive to his foster parents' affection toward him.

5. Jack's trauma manifests in internalizing behaviors, including mutism and social withdrawal. He will need therapy to begin healing and his foster parents will need support to learn the most effective ways to help him.

3.6 Research on Impact of Trauma in Childhood

Research shows that the adverse impact of trauma exposure on risk of developing internalizing and externalizing behaviors may begin early in childhood.

One longitudinal study of toddlers by Copeland, et al., for example, found that almost a quarter of the children had already experienced a potentially traumatic event. Those children who were exposed were more likely than non-exposed children to exhibit internalizing and externalizing behaviors. Additionally, approximately 20% of those exposed had PTSD.

3.7 Overlapping Symptoms Reflection Part 1

Research also tells us that trauma and mental health symptoms can overlap.

Here are some symptoms that overlap child trauma and various mental health diagnoses. Choose from the list the mental health diagnosis that matches each group of symptoms. Click "Submit" when you are finished.

Symptoms:

- Striking anxiety and psychological and physiologic distress upon exposure to trauma reminders, avoidance of talking about the trauma
- A predominance of angry outbursts and irritability; resistant or defiant behavior; dysregulation and dissociation
- Restless, disorganized and/or agitated activity; difficulty sleeping, poor concentration and hypervigilant motor activity
- Avoidance of feared stimuli, physiologic and psychological hyperarousal to feared stimuli, sleep problems, increased startle reaction

Mental Health Diagnosis:
- Panic Disorder
- Oppositional Disorder
- Attention Deficit/Hyperactivity Disorder
- Anxiety Disorder

3.8 Overlapping Symptoms Reflection Part 2

Do the same thing with these groups of symptoms. Choose the mental health diagnosis that matches each group of symptoms.

Symptoms:
- Drugs or alcohol used to numb or avoid trauma reminders
- Self-injurious behaviors, social withdrawal, affective numbing, sleeping difficulties; sadness, feelings of helplessness; irritability
- Severe agitation, hypervigilance, depersonalization, sleep disturbance, numbing, unusual perception, fluctuating levels of consciousness

Mental Health Diagnosis:
- Major Depressive Disorder
- Substance Abuse Disorder
- Psychotic Disorder

3.9 Overlapping Symptoms Response

Here is the complete chart, showing which symptoms can overlap with various mental health diagnoses and child trauma. A trauma screening can provide greater clarity about the origins of symptoms described above and their connection to early adverse experiences.

3.10 Revictimization

Another issue to consider when assessing for trauma is the increased likelihood of revictimization at some point in their lives. Click each column to learn about revictimization.

1. Revictimization occurs when a previously traumatized individual encounters later life circumstances, either a new trauma or a trigger that reminds them of a previous trauma, that overwhelms the capacity to cope, leading to one or more trauma symptoms.

2. This pattern is common in maltreated children and adolescents. For example, studies have found that sexual victimization in childhood or adolescence increases the likelihood of sexual victimization in adulthood between 2 and 13.7 times.

3. Studies show that revictimization is associated with increased risk for PTSD and other co-morbidities, such as depressive and substance use disorders.

4. Conducting a Comprehensive Assessment of Complex Trauma

4.1 Conducting a Comprehensive Assessment of Complex Trauma

Now that we have considered the relationship between trauma and mental health, we must consider the implications for effective assessment of complex trauma. This involves assessing children's and youth's exposure to multiple traumatic events, as well as the wide-ranging and severe impact of trauma exposure across domains of development.

4.2 Steps for Conducting a Comprehensive Assessment

The National Child Traumatic Stress Network (NCTSN) lists six key steps for conducting a comprehensive assessment of complex trauma. We have added one more step for a total of seven.

1. Assess for a wide range of traumatic events. Determine when they occurred so that they can be linked to developmental stages.
2. Assess for a wide range of symptoms, risk behaviors, disabilities, and developmental delays.
3. Gather information using a variety of techniques.
4. Gather information from a variety of perspectives.
5. Try to make sense of how each traumatic event might have impacted developmental tasks and derailed future development.
6. Try to link traumatic events to trauma triggers that may trigger symptoms or avoidant behavior.
7. Determine if the child or youth is from a group or population that has experienced historic or collective trauma or unjust treatment based on their physical or social characteristics.

Let's look at each step in more depth. Click on each one to hear more.

4.3 Step One

Step One is to assess for a wide range of traumatic events. Determine when they occurred so that they can be tied to developmental stages. In your resources, there is a link to the Traumatic Events Screening Inventory for Children (TESI-C). This instrument provides questions for a clinical assessment of trauma.

Here are some examples of the primary types of trauma assessed:

- Neglect
- Physical abuse
- Sexual abuse
- Emotional abuse
- Accident
- Medical trauma
- Natural disaster
- Traumatic loss or separation
- Domestic violence
- School violence or bullying

- Community violence
- Physical assault
- Sexual assault
- Kidnapping
- Incarceration
- Impaired caregiver due to addiction or mental illness

4.4 Dimension of Trauma Exposure

As part of the assessment, it is also important to determine the dimension of trauma exposure:

- When the trauma occurred
- The severity of the trauma
- The frequency and duration of the trauma
- What specifically happened
- The relationship with the perpetrator
- Messages received from others about events
- Child's perceptions and beliefs

Click the Return to Main Menu button to go to the next step.

4.5 Step Two

Step Two is to assess for a wide range of symptoms, risk behaviors, disabilities, and developmental delays.

Review the list of possible behaviors, emotions and moods, and relational or attachment difficulties that should be considered in an assessment for trauma and complex trauma.

Some behaviors include:

- Aggression toward self; self-harm
- Explosive behavior
- Excessive shyness
- Oppositional and/or defiant behavior
- Sexual behaviors not typical for age
- Difficulties with sleeping, eating, or toileting
- Social and/or developmental delays in comparison to peers
- Repetitive violent and/or sexual play (or maltreatment themes)
- Unpredictable and sudden changes in behavior (such as attention or play)

4.6 Emotions and Moods

Some emotions and moods include:

- Excessive mood swings
- Frequent, intense anger
- Chronic sadness; does not seem to enjoy activities; depressed mood
- Flat affect; very withdrawn

4.7 Relational or Attachment Difficulties

Some relational or attachment difficulties include:

- Sad or empty eye appearance
- Overly friendly with strangers
- Alternates between clinginess and disengagement and/or aggression
- Has difficulty in daycare/preschool
- Has difficulty in school
- Lack of eye contact or avoids eye contact

4.8 Behavioral Context

It is essential to view any of these symptoms in the broader context of the child's or youth's background, family, and community to avoid misdiagnosis.

Some children, for example, are taught that eye contact is impolite, especially with adults in positions of respect or authority.

Please see Handout: *Immediate and Delayed Reactions to Trauma* in the Resources tab for additional information on immediate and delayed symptoms of trauma exposure.

4.9 Neuropsychological Assessment

Since complex trauma impacts brain development and executive functions, trauma experts recommend a neuropsychological assessment when indicated.

Youth with significant damage to the brain do not respond positively to cognitive therapies, and other types of intervention may be needed initially.

Click the Return to Main Menu button to go to the next step.

4.10 Step Three

Step Three is to gather information using a variety of techniques.

When considering techniques to gather assessment information, the following are recommended: clinical interviews, standardized measures, social histories, and behavioral observations.

Click through the numbers listed on the left-hand side of the screen to learn more about clinical interviews.

1. A mental health professional best approaches trauma assessment in a clinical interview from a position of supportive neutrality. Depending on the child's or youth's developmental level and the defenses they employ in order to cope, supportive neutrality can pave the way for disclosure and openness to treatment.

2. A mental health professional should always be sensitive to the likelihood that a child or youth may have experienced danger and intrusion at the hands of others and will regard the interview as threatening. Particularly when traumatization has been recent and severe, the interview may seem to some victims as an unwarranted intrusion and another experience of victimization.

3. The assessment process itself is quite stressful for some trauma victims irrespective of how gently or sensitively it is conducted. It is essential to create assessment conditions that are as safe as possible. When working with children and youth, additional time may be needed to first build rapport and trust.

   Remember, many children and youth you work with from the foster care system may have had multiple clinical interventions before they see you. They may see helping professionals as they do other adults - not to be trusted. Mental health professionals should be aware that a request to describe traumatic events in some detail can re-stimulate unsettling and painful material and produce additional distress.

4. It is essential that you closely monitor the child's or youth's reactions and, as needed, change the pacing or suspend the assessment when it becomes unsettling.

4.11 Standardized Measures

Click on each number to learn about standardized measures.

1. A number of standardized measures related to trauma have been developed. The strength of standardized measures is that there has been a careful selection of test items and research to validate the measures.

2. The limitation is that standardized measures alone cannot provide a holistic picture of the child's traumatic experiences and responses. Therefore, they should be used in conjunction with clinical interviews and observations and considerations of contextual significance in the child's or family's life.

3. The National Child Traumatic Stress Network has compiled a list of various standardized tools for assessing trauma in children and adolescents. Please see *Complex Trauma Standardized Measures* in the Resources section and consider which tools you might add to your practice or explore further.

4.12 Social History and Behavioral Observations

Click on each tab to learn about social history and behavioral observations.

Social History: It is important to have a social history outlining as much about the child's lived experience as possible. Without a social history, much of a child's trauma history will not be evident. Trauma-related history will emerge from collateral contacts, interviews with caregivers, and record reviews.

Behavioral Observations: Best practice is that mental health professionals observe the child's or adolescent's behaviors as part of the clinical assessment.

4.13 Step Four

Step Four is to gather information from a variety of perspectives.

In addition to the child, it is important to interview adults and other significant individuals who are close to the child or youth and who know them well.

Initially, children and youth may not be able to communicate their own trauma histories and current caregivers may have little to no knowledge of what happened to them, which can further complicate your gathering of information. However, with a supportive approach from a therapist, the discovery and understanding of the child's trauma can be revealed and explored.

Some of the information gathered may be difficult for the parent or caregiver and they may deny the reality or question the honesty of the child. It is important for therapists to have conversations with caregivers so they can support this exploration.

Click the Return to Main Menu button to go to the next step.

4.14 Step Five

In Step Five, try to make sense of how each traumatic event might have impacted developmental tasks and derailed future development.

For many of the children and youth who have been in foster care and/or in institutionalized care, the process of determining the impact of each traumatic event on their development may be challenging because of the number of pervasive and chronic traumatic events they may have experienced throughout their young lives.

Evidence suggests that certain types of abuse and neglect rarely occur in isolation and that children and youth who experience maltreatment often experience multiple types of abuse and neglect.

Click the Return to Main Menu button to go to the next step.

4.15 Step Six

Step Six is to try to link traumatic events to trauma triggers that may trigger symptoms or avoidant behavior.

Trauma triggers can be remembered both in explicit memory and out of awareness in the child's or youth's body and emotions. Dr. Theodore Gaensbauer has developed a framework for understanding the impact of trauma on development and future functioning.

In his article, *Developmental and Therapeutic Aspects of Treating Infants and Toddlers Who Have Witnessed Violence*, he describes seven levels of developmental impact from trauma.

Click on each check box to reveal the levels.

- Characteristic posttraumatic symptoms
- Associated feelings and psychological meanings connected to the particular circumstances of the trauma
- Disruptions in developmental issues being worked on at the time trauma took place
- Disruption in subsequent developmental phases
- Effects of the child's symptoms and behavior on interactions with others
- The impact of a trauma on other family members, independent of the child's reactions
- The extent to which a trauma may bring up memories and feelings related to previous traumas

4.16 Case Example

Here is a hypothetical case using his framework that can help illustrate how a traumatic event might impact a child's development and the link between traumatic events and trauma reminders.

Let's look at these development levels, using the hypothetical case of Belinda, a six-year-old who was sexually abused by her father, Adam, when she was four and five years old. She was subsequently placed with Amanda, her foster mother. Click on each level to hear more.

Level One: Posttraumatic symptoms include re-experiencing, avoidance of reminders, numbing of general responsiveness, and increased arousal. Belinda has frequent night terrors and has begun sucking her thumb. She is anxious and easily agitated, and she is irritable in response to minor conflict.

Level Two: Feelings and meanings connected to the particular circumstances of the trauma. Examples are depression and feelings of responsibility or guilt. Belinda refuses to go into the bathroom where much of the abuse took place. Adam told Belinda that she was a bad girl, and no one would believe her if she said anything. She has been told otherwise, but she continues to believe the abuse was her fault.

Level Three: Disruption in developmental milestones at the time that the trauma took place. Examples include self-regulation, successful toileting, cooperation with others, and independence. Belinda was growing in independence at age 4, but now she does not like to go into her fenced backyard alone and will not ride the school bus. She has begun wetting the bed.

Level Four: Early disruption in developmental milestones that has disrupted next level milestones, along with ongoing post-traumatic symptoms and themes. Belinda was happy as a preschooler and then in kindergarten. Now, she clings to her foster mother and refuses to go to school almost every day.

Level Five: Effects of the child's symptoms and behaviors on interactions with others. Belinda frequently is fearful and talks about scary images which make her classmates uncomfortable. She can be unpredictably angry and threatening with them.

Level Six: The independent impact of trauma on other family members, independent of the child's reactions. Belinda's foster mother, Amanda, was emotionally overwhelmed when she learned of the abuse and had very strong negative feelings toward the birth parents.

Level Seven: The extent to which a trauma may bring up memories and feelings related to previous traumas. Belinda did not have clear memories of her father abusing her mother, however, her father's threats to ensure her silence about the sexual abuse reactivated her sense of fear and lack of safety.

Click the Return to Main Menu button to go to the next step.

4.17 Step Seven

Finally, Step Seven is to determine if the child or youth has experienced collective trauma, unresolved intergenerational grief and loss, and experiences of unjust treatment.

Here is an example of trauma that has persisted over generations. When you are finished watching the video, click the Return to Main Menu button.

[Video Transcript]

GIRL 1: Almost mad all the time. Problems controlling my anger. Can't really think of just one time.

GIRL 2: I know most of my anger comes from pain.

GIRL 3: someone once told me the reason I have so much anger is for my dad and it comes from my grandpa. Which comes from his mom.

GIRL 1: That the anger is pain from so long ago.

GIRL 3: She says Indians are so full of pain. Causes them to drink it all away but instead it causes more pain.

GIRL 2: I have anger from pain. I have many generations of built-up pain.

GIRL 2: I hope that I can learn to forgive and heal. So I no longer carry the pain of my ancestors.

GIRL 1: I will forgive. I will heal.

[Chanting]

MALE: One point five percent of the U.S. Population is Native American. Historical events such as removal from homelands, sexual abuse, exposure to violence, boarding schools, massacres, forced relocation, homicide, suicide, and multiple victimization are ways in which trauma has affected native communities. Forty percent of Native Americans live below the poverty line. Thirty-nine percent have some form of a disability. Native children have 2.5 times greater risk of experience in a trauma, and thirty percent have some form

of depression, while ten percent have PTSD. The suicide rate is three times higher for Native Americans. Native American women are 2.5 times more likely to be raped or sexually assaulted than women in the U.S. in general. Native Americans are 2.2 times more likely to have diagnosed diabetes.

[End of Video]

4.18 Key Points

Some key points to remember when conducting a comprehensive assessment for trauma are:

- Suspend judgment and labeling at the outset
- Engage in an open, flexible ongoing process that addresses the traumatic stress reactions
- Monitor how symptoms and behaviors change in response to trauma-focused treatment
- Integrate parents or other caregivers into the assessment and treatment process

5. Conclusion

5.1 Wrapping Up

A comprehensive assessment of trauma is essential to accurately diagnose children and youth and develop effective and appropriate treatment plans that will help them to heal from their early adverse experiences.

Without this, children and youth will continue to experience significant trauma symptomatology and the healing process will be delayed.

5.2 Your Journal

Please click on the journal page to write down your reflections on this lesson.

5.3 Journal Reflection

Reflecting on this lesson, what are your key takeaways and how might you apply these in your practice?

5.4 Journal Response

Click the "Print Results" button to print and save your answers.

5.5 Conclusion

Congratulations! You have completed Assessing Trauma Exposure and Its Impact on Children.

In the next lesson, we will focus on remediating the consequences of trauma: treatment goals and practice models.