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Seeking Help for Children Who Have Experienced Trauma in Venezuela: A Literature Review of School-Based Interventions and Teacher Recommendations

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SEEKING HELP FOR CHILDREN WHO HAVE EXPERIENCED TRAUMA IN VENEZUELA: A LITERATURE REVIEW OF SCHOOL-BASED INTERVENTIONS AND TEACHER RECOMMENDATIONS

by

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ABSTRACT

The main purpose of this research synthesis was to determine recommendations that promote the development of a trauma-informed approach in Venezuelan schools to address the traumatic effects of political unrest in young children through a systematic review of existent intervention programs. After conducting an initial search, four studies were identified that studied the effectiveness of an intervention program in schools targeting trauma in children younger than 14 years old.

Results showed that there were four categories that all studies incorporated. All intervention programs used an assessment tool to determine PTSD presence and symptomatology, as well as other domains that could be impacted. The assessment was used to determine the need for extensive intervention and to record the effectiveness of the program. The development of the intervention program was carefully established. Approaches varied in length, intervention provider, curriculum used, and ages, yet all focused on either Cognitive Behavioral Therapy or Play Therapy as the foundation. Third, teachers were trained and received support throughout the study. Training included education on the repercussions of trauma, symptomatology, and ways to address the need of children. Clinicians provided ongoing classroom support to improve the environment. Finally, in three of the studies, parents received training on trauma symptomatology and the effects of trauma. Parents learned strategies to work with their children and were able to take part in the intervention.

Even though the understanding of trauma in childhood populations dates back to World War II, there is a lack of tiered intervention programs provided in schools for children at risk. In Venezuela today, children experience an ongoing environment of toxic stress paired with

systemic oppression trauma. Thus, there is a need for an intervention program to reach large groups of children that does not generate an economic burden on parents. This study provides a comprehensive analysis of effective methods that can be used for a further intervention program. New policies need to be established to ensure that the most vulnerable populations receive all the services needed to succeed in the future and that the socioeconomic gap is narrowed.

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INTRODUCTION

Peace is a privilege that not every country can afford. For the past 20 years, Venezuela has been living under a dictatorship characterized by oppression, marginalization and increased poverty. Adults have had to deal with the fear of not being able to bring food to the table, being killed in a queue to buy groceries, being robbed carrying bags to their homes, or dying because they simply cannot afford to buy food, formula, and medicine due to inflation close to the thousands in percentage. Added to this situation of extreme poverty, Venezuelans have had to deal with political oppression and uprisings. Every few years, Venezuelans take to the streets in protest to demand a change in the government. Year after year, they have to endure a repressive political system that uses its military to mitigate the actions of citizens who seek a ore democratic way of life and an opportunity to live in freedom. Yet, all the power that a regime with the biggest amount of oil reserves in the world has, the population of this country is time after time denied basic rights, tortured, killed, or silenced.

For some children, this context is the only reality that they know. Children are growing up seeing people killed by their own army. They have seen their mothers choose what child to feed and which ones to leave to die. Children have had to leave the schools and accompany their mothers in queues to buy food. Children have had to go through a school system that does not provide equal opportunities and that its own goal is to perpetuate the oppressive system. They have been taught that the only Messiah that they should follow, the one who changed how Venezuelans live, is the former president Hugo Chávez. Many Venezuelans feel they have had to become thieves, assassins, and kidnappers in an effort towards basic survival.

However, because this situation over time has become normalized because it is the only reality that exists in Venezuela, people fail to realize the many traumatic experiences that children have endured, often before they are even able to read. It is not until you are removed from the situation that you are able to understand how deeply the scars go. Children are a vulnerable population. They depend mostly on their caregivers. In Venezuela, the caregivers are also struggling to deal with traumatic events. This leaves children at an even greater risk.

Unless you grow up in Venezuela, people cannot realize how experiencing the atrocities of the government impacts young children. It is not until they change environments, that they are able to identify multiple symptoms that before seemed normal. Small moments like trying to read a book in a park can be stressful. People become aware of their surroundings and how the people walking by could pull a gun or a knife to rob them. Everyone seems suspicious, and mitigating those thoughts is a difficult task to accomplish for anyone, of any age. In Venezuela, the country with the third highest murder rate in the world (Pariona, 2018), this is part of survival. In some cases, that level of awareness and responsiveness can save you.

Santiago, was around five years old when he saw, from his home window, a police officer capture a child in school uniform during a political protest demanding basic human rights. The child was leaving his school, but he happened to be passing the street where the protest was occurring at the moment. Santiago's mother started to scream hysterically because the police officer was taking the child most likely to be tortured. There were rumors about the different forms of torture that police officers employed when they captured someone. At the moment, Santiago was asking what the police officer was going to do to the child. His mother lied, and said that the officer was just going to return him to his family. Nonetheless, a few months later,

Santiago passed by a police officer and was scared of what the officer might do. He was scared because the police could take him, and do bad things to him. This young child was confused, and the family kept telling him things that did not align their emotional and physical responses to the situation. Santiago's family probably did not know how to address the situation, mostly because they had to endure it. Santiago has had the privilege to grow up in a middle class family. Where many of the events that take place in the country are hidden from his eyes. However, this does not mean that he does not understand that traumatizing events are occurring every day.

In a very small coastal town in August of 2017, a sea of children, adolescents, and young adults walked across the street to sit in front of an army of police officers. Throughout the day, gas bombs were thrown from the police side to the young protesters' side. When any one of the children or adolescents were caught, they were taken into a container in which the police officers threw gas bombs. Officers would put all the captees inside the container, throw gas bombs, and close it to work as a gas chamber. The gas did not kill them, but it would make their throats and skin itch, and their eyes burn. They were left there for a few days before the officers decided to release them. This young group only had tools that they created for themselves, trash cans were used as shields, fireworks as bombs, and t-shirts as masks. They resisted all day to the police's use of extreme force, all day, for several months. A few months earlier one of their owns, probably in his late teens, was murdered near the protests by the same forces that they were resisting. Neighbors fed them, not entirely sure where the families were. This group of children and young adults came from the lowest socioeconomic level, from the poorest neighborhoods and were protesting. If they stayed at home, there was no way for them to eat. With the rate of inflation and food scarcity, they were unable to buy enough food to feed themselves. However, if

they endured the repression, the middle-class citizens provided food for them. It became a job. They did not fight only for a change in government, they fought to survive.

These two distinct examples, exemplify the advantages that a child like Santiago has, over children who are born in the poorest neighborhoods, called *barrios*. The social and emotional needs for both children are clearly negated, and they cannot be neglected. What is the future like for a child who grew up enduring repression or throwing bombs? What other traumatic events, like the one Santiago experienced, shape the way children develop their schemas of the world? How do these experiences impact future behaviors?

The study of trauma in children dates back to the end of World War II (Bodman, 1941; Carey-Trefzer, 1949). The both long and short term effects have been researched throughout the years. The general conclusion is that children who experience trauma during early childhood, will have repercussions that will not go away. Figley (2012) says, "trauma always leaves an imprint, and even if covered by extra defenses, a degree of compromised functioning, sensitivity, and vulnerability remain" (p. 678). Childhood trauma focuses on abuse, neglect, natural disasters, accidents, terrorism, war, and refugees. These types of trauma relate to the complex traumatic situations that children endure in countries with systemic oppression (Goodman, 2015), yet fail to fully address the ongoing aspects, such as Venezuela.

Teachers and administrators seek to provide the best education possible to children. In many cases, the traumatic experiences and difficulties of a child's daily life do not allow them to perform academically to the best of their abilities. The main purpose of this research synthesis is to determine recommendations for teachers and administrators that promote the development of a trauma-informed approach for children in Venezuelan schools to address the traumatic effects of

political unrest. Education of children should be aligned with their healthy development and well-being. It requires taking into account not only academic subjects, but also the socioemotional development of children. The recommendations derived from this study will have the potential to aid teachers and administrators to provide a safe environment for children to cope with the effects of trauma.

This research will serve as the basis for considering educational policies to address the needs of children in current Venezuela. It will also function as a resource guide for school administrators and teachers to become informed regarding the effects of trauma and the need to develop a trauma-informed approach in the schools. This analysis seeks to start a conversation that deals with the needs of children in trauma torn and developing countries that go beyond the basic physiological needs and identify an impact in socioemotional development. Finally, these researched recommendations would be beneficial for teachers and other professionals in the United States who are working with immigrant children who come from Venezuela, to generate an awareness of how the children's current behavior is related to previous traumatic experiences.

REVIEW OF LITERATURE

This review of literature examines research that revolves around childhood trauma with the intention to support the need for a trauma-informed curriculum in Venezuela. First, this section will define trauma taking into account different perspectives within the field. Second, the following will provide a view of historic research of childhood trauma that began after World War II. Third, this section will discuss studies determining the repercussions of childhood trauma across the lifespan of an individual. Fourth, the review of literature will establish the different types of trauma that children might experience in their lives based on how they are exposed to the traumatic events. Finally, this section will outline the current context in Venezuela that contributes to traumatic experiences in young children.

Defining Trauma

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), trauma can be defined in the following way:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s). (2) Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers. (3) Learning that the traumatic event(s) occurred to a parent or caregiving figure. (4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) (American Psychiatric Association, 2013, p. 271).

Researchers have debated that this definition is too narrow to cover the different types of trauma that people experience in their lives, and the role that the environment plays (Briere & Scott, 2006; Goodman, 2015; Karcher, 2017). Briere and Scott (2006) define trauma as an

"extremely upsetting" event that has psychological repercussions and overwhelms a person's internal resources for a period of time. This definition includes a better understanding of the societal and environmental aspects of trauma, but it fails to acknowledge the range that trauma has in humans. Figley (2012) states that "disruptions may radiate to any or all levels of human functions, ranging from anatomical and physiological to existential and spiritual" (p. 678). Thus, for the purpose of this study, trauma is an extremely upsetting event that disrupts the life of the human being at any level of functioning.

History of Childhood Trauma Research

Like adults, young children are also subject to the negative effects of trauma experiences (Figley, 2012). Research on the impact of trauma in children started during World War II. Bodman's (1941) research, focused on the impact of a particular air raid that happened while children were in the Children's Hospital in Bristol. The subject of the study was a group of 54 children between the ages of 2 months to 12 years. Data demonstrated that the children who exhibited the most persistent signs of trauma were those between the ages of 1 and 5.5. Of these, 80% still had disruptions in behavior even though they had moved to quieter areas. This demonstrates that development plays a significant role in the assimilation of traumatic experiences. Another researcher, Carey-Trefzer (1949), conducted a clinical study on children who lived in England during World War II. There were 212 participants between the years of 1942 and 1946. When examining the types of occurrences that children faced, results showed that children who were evacuated before the age of five presented more serious repercussions. Children who had to undergo life changes, such as bombings and family modifications, showed that, once the changes were removed, children's disruptions in behavior subsided. Finally, the

research indicated that disturbances caused by evacuation were more persistence than the ones caused by bombings. This supports the claim that the type of traumatic experiences has a correlation with the symptoms that children will experience.

Bloch et al. (1956) studied a group of children who were impacted by a tornado in Mississippi. Taken from parent interviews, children experienced involuntary urination, nightmares, avoidant behavior, phobic anxiety, dependency on others, and they replayed the occurrences during play over a period of time. These effects were correlated to the impact zone of the tornado in relation to where the child was at the moment, and the presence of an injury on themselves, or on a family member. This finding affirms Bodman's (1941) conclusion that external variables are not related to the type of trauma, and that they play an important role in the assimilation of events and the development of symptoms of trauma.

Terr (1981) studied a group of 23 children who had been kidnapped in a school bus and buried alive in Chowchilla, California. The ages of the children varied from five to 14 years old. Despite the age difference, their perceptions of the traumatic event and the post-traumatic symptoms were consistent. Terr classified the symptoms in three broad categories. The first category, initial signs of traumatic disruption, includes identifying omens that predicted the traumatic event, fear of future trauma in everyday or during the kidnapping, and disturbances in cognition such as hallucinations and distorted perceptions of when their behaviors started. The second category is repetitive phenomena that includes traumatic dreams, post-traumatic play in which anxiety was not relieved, reenactment of behaviors linked to the kidnapping, and an absence of flashbacks that are common in adults. The last category was fears, which every child exhibited. Fears took multiple forms, such as fear that the kidnapping would happen again, that

the incarcerated kidnappers would come back, as well as fear of mundane events, such as being left alone, darkness, vehicles, strangers, confined spaces, and open spaces. Fears associated with the kidnapping also resulted in attitudes towards everyday environments, and children remained in a state of alert on a regular basis. A major finding from Terr's research (1981) is the comparison between the responses of children to trauma and the responses of adults. Children did not experience amnesia, denial, or flashbacks, like adults do. However, they used play and reenactment in the way that adults use dreams, and they experienced major dysfunctions in cognitive processes.

Terr's study (1981) furthered the conversation because it compared adults' responses to trauma with children's. Like Terr, in one of the studies during World War II, Carey-Trefzer (1949) also explains that development plays a role on the manifestation of symptoms. These research provided the basis for the development of a criteria for Post-Traumatic Stress Disorder (PTSD) that considered age differences. In the DSM-IV, criteria for PTSD was defined without specific distinctions on how the disorder presents itself based on age. Due to increasing research, in the DSM-V, a criteria for children under the age of six was determined for PTSD that includes Terr's findings of dissimilar symptoms.

Traumatic Repercussions

Research has shown that exposure to toxic stress, such as the one resulting from traumatic experiences, can damage the brain's architecture. According to the National Scientific Council (2014), during the sensitive periods of children's brain development, chronic stress promotes the overproduction of neural connections in the regions that control fear, anxiety, and impulse, while the areas of planning, reasoning, and behavioral control has fewer connections.

As the stress response system is activated, the production of stress hormones and brain chemicals starts to prepare the body to address the situation. When high levels of cortisol remain, the functioning of the neural system is affected, the immune response is inhibited, and brain development in parts that relate to learning and memory change. The frequent response to stress is related to future susceptibility to physiological and behavioral disorders, and it can affect the expression of genes that control the stress response. Children who come from low-income families, especially those in chronic situations of poverty, and with mothers who experience depression, present higher levels of the stress hormone which negatively affects learning. However, positive experiences can compensate for some consequences by changing the brain's architecture and chemistry.

Undergoing toxic stress for a prolonged time lowers the threshold for the response system, leading to its activation with situations that others would not consider stressful, and to a more frequent and longer response (National Scientific Council, 2014). Perry (2008) states that the nature of dysfunction will be dependent on the neural networks and areas of the brain that are distorted. With ongoing trauma, the dysfunctional neural connections resulting from long lasting activation of the neural system, lead to a persisting state of fear that can later be considered anxiety. Studies have shown that the right amygdala is activated with a higher frequency for people who have experienced trauma (van der Kolk, 2003). When reminded of previous traumatic experiences by similar stimuli, the amygdala is activated resulting in inappropriate negative responses. The hippocampus has also been proven to be affected by trauma (van der Kolk, 2003). In some cases, it can even cause hippocampal atrophy, which presents as depressive

symptoms. Those with compromised functioning of the hippocampus have problems processing emotional information, such as sadness or disappointment.

In the socioemotional domain, children who undergo chronic stress lack self-regulation (van der Kolk, 2003). This presents itself by a distorted sense of self, poor impulse control, and uncertainty about reliability and predictability of others. They also have socialization impediments such as difficulty reading social cues and adapting arousal levels to meet social demands. They might be withdrawn, inattentive, and in a constant state of hypervigilance. This state of hypervigilance relates to further issues in social situations due to their extreme reactions to new environments. All these components complicate the normal functioning of children in schools and outside of it. Holmes et al. (2014) discussed how thoughts are distorted in children who experience trauma. Children believe that they are not safe, not good enough, or that things will not get better at all. When children are experiencing trauma, parents and caregivers can reduce the impact of trauma by providing soothing actions, such as holding and rocking (van der Kolk, 2003). Through soothing, adults are helping children develop biologic structures that help deal with future experiences by modeling coping strategies. Children learn that there is someone else to help them deal with a particular situation when they do not feel safe, and that sense of security is built on when soothing is consistently provided.

Felitti et al. (1998) provided significant information regarding the long-lasting effects of childhood trauma in the Adverse Childhood Experiences (ACEs) Study. Researchers classify ACEs in three categories: (1) abuse, (2) household challenges, and (3) neglect. In a sample of over 17,000 people, two-thirds of the participants reported at least one ACE, and findings demonstrated a dose-response relationship between ACEs and adult negative health and well-

being. Another major finding is the correlation between the amount of ACE and the increasing risk for alcoholism, chronic obstructive pulmonary disease, depression, fetal death, health-related quality of life, illicit drug use, ischemic heart disease, liver disease, poor work performance, financial stress, risk for intimate partner violence, multiple sexual partners, sexually transmitted diseases, smoking, suicide attempts, unintended pregnancies, early initiation to sexual activity, adolescent pregnancy, risk for sexual violence, and poor academic achievement.

The ACE study served as the basis for future researchers to build on the understanding of lasting consequences of childhood experiences and the importance of early interventions. Some of the ACEs are considered traumatic experiences; thus, the research provides a sample of not only repercussions on the short term, but also throughout an individual's life. This study demonstrated that adverse experiences in the early years brings future problems that go beyond the socioemotional domain and impacts humans' overall health over the course of their entire lives. Further research on ACEs has examined the consequences in the children of parents who have had these negative occurrences. Mason and Cox (2014) found that of parents who had experienced four or more ACEs, children had a higher presence of behavioral health problems such as hyperactivity, emotional disturbances, and scored higher in the Behavior Problems Index (BPI). Trauma, then, not only has short and long term consequences in those who undergo it, but also in the next generations by increasing the risk of behavioral problems.

Types of Trauma

Figley (2012) explains that childhood trauma could be due to the following causes: "an unstable or unsafe environment; separation from a parent; debilitating illness; intrusive medical and dental procedures; sexual, physical, emotional, and verbal abuse; emotional and physical

neglect; domestic violence; bullying; and the pressure to excel" (p. 675). Thus, due to the variety of probable causes, the National Child Traumatic Stress Network (NCTSN; Oseldman, 2018), classified childhood trauma in 11 categories that relate its nature. These categories are: community violence, complex trauma, disasters, domestic violence, early childhood trauma, medical trauma, physical abuse, refugee trauma, sexual abuse, terrorism and violence, and traumatic grief. However, according to Goodman (2015), it is necessary that mental health professionals take into account the sociopolitical context in which events occur.

Based on the studies of childhood trauma, children can also be affected by the environment in which they live. Bronfenbrenner (1977) proposes the Ecological Systems Theory, in which children's development is tied to the changing environment in which they grow up. Within the different levels that affect human development, Bronfenbrenner (1977) identifies the Exosystem. The Exosystem encompasses the impact that the contexts in which the immediate environment of the child is embedded has in development. Some of the contributing factors in this system are the community, government agencies, police practices, patterns of recreation and social life, health services, and socioeconomic status. If the environment plays a role in the development of children, then traumatic experiences can also come from situations or events in it. Thus, issues such as war or political unrest play a role in children's lives.

Complex trauma relates to events or experiences that happen over a period of time, mostly premeditated, and are usually against those of lower status (Figley, 2012). Within this type of trauma, ongoing community violence and human rights violation, are found to be experienced by different groups. According to Figley (2012), children can be born into this social context, and if that is the case, further traumatic situations will have greater repercussions.

Following the Ecological Systems Theory and the definition of complex trauma, the proposal of Systemic Oppression Trauma has gained grounds. Systemic Oppression Trauma acknowledges that the context in which individuals live and their culture can have an impact just as strong as experiencing a particular event. This trauma relates to the experiences that a group of people undergo as a result of a hegemony that perpetuates oppression, such as racism and discrimination (Goodman, 2015). However, most research in this area has only focused on the impact of this type of trauma in minority groups in the United States, such as African Americans and Latina/os, while failing to acknowledge the oppression that takes place in other countries.

Few studies have looked at the impact of political unrest and war in children living in countries with uprisings or dictatorships. Giacaman et al. (2007) studied the negative effects of exposure to violence in 3,415 adolescents in Palestine. They found that collective and individual exposure to trauma and violence have distinct effects in the mental health of adolescents. Children presented "depressive-like states," somatic and emotional outcomes. War and conflict not only have individual repercussions, but there are also effects on the sense of safety in the community. However, this research did not find a correlation between reduced effects from collective trauma due to social support. Another important finding from this study is the difference between the effects of trauma based on gender. In Giacaman et al. (2007), girls reported having experienced less trauma or violence, yet they present higher depressive-like symptoms. Violence due to war and conflict is common in other countries around the globe. However, studies do not address the impact that these events have in young children, in particular young girls.

Southivong et al. (2013) looked at the prevalence of PTSD among children who survived landmines or unexploded ordnance in Lao People's Democratic Republic. Results showed that those who were injured had a higher incidence of PTSD, yet the perception of social support reduced the presence of symptoms. This study demonstrates the impact that high levels of violence have in children. Southivong et al. (2013) also determined an impactful variant, community help, that was used to develop interventions to provide care to those children affected.

Even though some studies have shown the presence of trauma due to political reasons (Bodman, 1941; Carey-Trefzer, 1949; Giacaman et al., 2007; Southivong et al., 2013), there is still a gap in understanding pertaining to the effects that war and political unrest has in children who were born in this environment (Punamäki et al., 2018). According to aforementioned research (National Scientific Council, 2014; Perry, 2008; van der Kolk, 2003), children who come from chaotic, stressful sociopolitical contexts, would present different neural connections and areas of the brain would be less developed than those children who have lived in violence-free zones.

Venezuela's context contributing to traumatic experiences

In 1996, the United Nations General Assembly discussed the impact of armed conflict on children. Issues that were discussed at the time are still relevant to children living in Venezuela. Families who are living in poverty have had to deal with basic problems such as malnutrition. Malnutrition negatively impacts cognitive development in children and reduces the physiological abilities of children to attack childhood diseases (Machel, 1996). In Venezuela, these sociopolitical and economic uprisings are not a new phenomenon. Throughout the 20 years since

the Socialist Party United of Venezuela has been in power, political unrest is a constant. In certain years, such as 2002, 2014, and 2017, the violence escalated and made it into international headings. Unfortunately, due to the dictatorial government, valid and reliable information related to news sources stopped being issued by respected international NGOs for dissemination to international publications.

Across Venezuela, unofficial statistics say that 6 out of 10 children miss school due to malnutrition. In *Scarcity,* Mullainathan and Shafir (2014) discuss a study conducted with starving adults who did not provide military service during World War II. After closely observing 36 starving adults over the period of a year, results showed that the participants had become obsessed with the idea of food, not only to fulfill their needs, but also with discussing it as a career path, such as opening a restaurant. During the starvation period, adults lost an average of 25% of their body weight, and their minds oriented "toward unfulfilled needs." Similarly, in Venezuela, citizens have come together and created groups of support to provide meals for children whose families cannot afford it. In a *New York Times* article, the president of the Venezuelan Society of Childcare and Pediatrics stated that children are experiencing a level of malnutrition similar to those in refugee camps (Kohut & Herrera, 2017). In the same article, a doctor reported that children in emergency rooms die in their arms from dehydration. The same doctor mentioned that since 2017, toddlers started coming to the hospitals with the same weight and height as newborns. Further in the article, the authors bring examples of mothers who were unable to breastfeed their children and how finding and affording baby formula was impossible, leading to their newborns dying of malnutrition. Kohut and Herrera (2017) provide common examples of families rummaging through the garbage after they have spent days without eating,

children fainting in schools out of hunger, and mothers skipping meals often so their children can eat.

The aforementioned issue is part of the basic needs covered by Maslow (1943) in his Hierarchy of Needs. Maslow mentions that a person "who is lacking food, safety, love, and esteem" (p. 373) would be first concerned by food rather than safety. If all needs are unmet, then the body responds physiologically and all actions are directed towards fulfilling the hunger. Maslow (1943) states that all other desires, such as the desire to learn or the sense of future, are then forgotten until the body is satisfied. In Venezuela food is not ensured for everyone. Thus, children cannot be expected to concentrate in classroom or act in a way that deviates from what their physiological needs are. A child cannot think about solving a math equation, when all the thoughts go back to the amount of days gone without eating, how he or she will have to get the food to eat, and how much longer it will take to find something to eat. In a society where the amount of people who experience food insecurity is so high, its functioning level is also affected. It can become a vicious cycle in which parents are unable to provide food for themselves and their children, which leads to increased hunger, leading to a disruption in cognition, resulting in the inability to work, which in turn reduces the income necessary for food, and the cycle repeats itself.

Besides the shocking issue of malnutrition, children experience violence not only in the form of political protests turning into blood baths, but also in community violence. According to the *World Atlas* (Dillinger, 2016), Venezuela has five cities in the top 35 most dangerous cities of the world as established by homicide rate. The Venezuelan homicide rate was of 90 homicides for every 100 thousand habitants in 2015 (Venezuelan Observatory of Violence, 2016). The

Venezuelan Observatory of Violence identified six factors that contributed to the increase of violence. The first one is a higher presence of organized crime due to territorial fights, drugs, kidnappings, and extortions. Second, is the detrimental state of police with police officers becoming more corrupt, or being victims of violence. Third, privatization of security and justice by which the lack of state repercussion has lead to citizens taking justice in their own hands. Fourth, unnecessary use of force by the military against the people. Fifth, the increased levels of poverty leading to extreme measures to fulfill basic needs. Finally, institutional destruction of trust and lack of applied laws leading to extreme uses of force from the state and the citizens. All these factors are part of what children experience every day. With high crime rates, children lose family members and are witnesses of violent crimes. In order to survive, children have to be in constant state of alert by assuring that there is no imminent threat to their lives. There is an increased chance that children will also become part of gangs in order to fulfill their basic needs.

This problematic is part of Maslow's (1943) second basic need: safety. If the need for food is relatively fulfilled, then the body focuses on fulfilling the need for safety. Children need an organized world in which the outcomes are predictable and they feel in control. Also, the possibility of death in a particular situation causes the child to act in a way that ensures safety. Bailey (2015) discusses a brain state model in which children respond to stimuli by ensuring safety first, then by ensuring love, and finally with critical thinking. First, the body assesses the situation quickly to see if there is an imminent threat to safety. If there is, then it responds from the brain stem immediately with the intention to ensure the person survives. As mentioned in studies above (National Scientific Council, 2014; van der Kolk, 2003), the continuous activation of this part of the brain, leads to a distorted threshold of stress and response in which the body

reacts to smaller stimuli. If safety is assured, and children feel loved as established by the limbic system, then they can use the prefrontal lobe, which is in charge of critical thinking (Bailey, 2015). With the level of violence in Venezuela, children will often respond from the brain stem rather than the prefrontal lobe. They are unable to assess the situation by using critical thinking and their actions would be impulses lead by the desire to survive.

Taking into account the difficult situation, people are escaping this situation. The Migration Policy Institute in an article published that the Venezuelan exodus has become the "fastest-escalating displacement of people across borders in Latin American history" (Feline Freier & Parent, 2018). Numbers of immigrants range from 1.6 to 4 million by the beginning of 2018, which could surpass the Syrian migration movement. People are fleeing because the situation has become unsustainable. This in itself leads to a new problem in which people flee without having a plan or the legal status to do so. In that case, a variety of risk factors go beyond this study and have to be taken into consideration for the healthy development of children and families. Children are being subject to kidnapping and human trafficking as they cross the borders.

Aleman et al. (2017) conducted the only published study so far that deals with children in Venezuela. This study determined the behavioral differences between 2,914 children who received an extra semester of music instruction in the Venezuela's National System of Youth and Children's Orchestras. Those who received additional instruction presented reduced behavioral difficulties and improved self-control. Results were more significant for boys exposed to violence, having reduced aggressive behaviors, and children with mothers from less educated backgrounds. Even though this study did not focus directly on children who experienced trauma,

it establishes a connection between intervention and the violent everyday existent in the majority of Venezuela.

METHODOLOGY

Through a systematic review of existent intervention programs, the main purpose was to determine recommendations that promote the development of a trauma-informed approach in Venezuelan schools to address the traumatic effects of political unrest in young children. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), a trauma-informed approach require:s (a) the realization of the impact of trauma and the possible ways to overcome it, (b) recognizing the symptoms of trauma, (c) responding by incorporating information about trauma into practices, and (d) avoiding re-traumatization. Recommendations can be derived from research-based trauma interventions that could be adapted to fit into the current Venezuelan context and curriculum.

This literature review of current studies regarding childhood trauma included articles that met the following criteria: (a) was published in a peer-reviewed and scholarly publication; and (b) studied the effectiveness of an intervention program in schools targeting trauma in children younger than 14 years old. Studies included all methodologies, except literature reviews. Studies excluded include those that targeted populations of adolescents, or adults, interventions not provided in the school setting, and programs that did not address trauma as the underlying factor. Commentaries, book chapters, published abstracts, literature reviews, and letters to editors were excluded. Key words used for the literature search include trauma, political unrest, third world country, developing country, developing nation, early childhood development, young children, trauma-informed approach, Adverse Childhood Experience (ACE), toxic stress, and trauma intervention. Data bases used were PsycINFO, PsycARTICLES, PubMed, MEDLINE, PAIS Index, Education Source, and Education Resource Information Center.

After the initial search was completed, 2397 articles were retrieved. Articles were reviewed based on their titles and narrowed down to 371 for further assessment. Studies' abstracts were downloaded into Rayyan (Ouzzani et al., 2016) for further analysis. Rayyan is a free software that allows researchers to download article citations and abstracts into one platform for further review. The platform allows users to create categories to classify articles based on inclusion and exclusion criteria. After a review of abstracts and full articles, four articles were identified that met all the criteria. Data from included studies was extracted and classified in a data extraction sheet to include author's name, population targeted, assessments used, intervention design, and results.

RESULTS

The following section is divided in five parts. First, a brief summary of all the articles selected. Second, a description of the populations studied throughout the four selected articles is provided. Third, the assessments used for each particular intervention program. Fourth, the intervention design as established by the frameworks and theories used. Finally, the outcomes as measured by the different assessments implemented in each case.

Summary

Holmes et al. (2014) conducted a pretest/posttest study in a Head Start setting with a multicultural population ranging in ages from two to six. The study design was rooted in Cognitive-Behavioral Therapy (CBT) and the intervention was provided by licensed clinicians. Teachers were also trained and received support throughout the implementation of the program to improve the classroom environment to promote a trauma-informed approach.

Another study that was rooted in CBT was conducted by Kataoka et al. (2003). This program was targeted for Latino immigrants ranging in ages eight to 14. This intervention was a randomized controlled trial provided by school psychiatric social workers.

Berger et al. (2016) also designed their study on CBT. This study was conducted in Israel with Jewish Israeli children ages eight to 12. Besides targeting trauma, researchers looked into how stereotypes lead to discriminatory tendencies. The intervention was given by teachers during the homeroom class period. The program had a specific curriculum that teachers had to follow to ensure consistency throughout the study.

Finally, the only study that was not based on CBT, was conducted by Patterson et al. (2018). Researches developed the intervention design by incorporating child-centered play

therapy (CCPT) provided by registered play therapists. Teachers had the opportunity to consult with therapists to incorporate trauma-informed practices in the classroom and, unlike other studies, this intervention was a team effort with the after-care program and the school.

Population

The four studies included in this review varied on age ranges (Table 1). Only one of the interventions was targeted for early childhood, while two dealt with elementary grades, and one with elementary and middle school. The population also varied on race and type of trauma experienced. One study worked with a culturally diverse population, while the other three studies targeted Latino Immigrants, African American children living in poverty, and Jewish Israeli living in Israel respectively. The sample size also changed based on the study, ranging from 12 to 200. In two studies, there were control groups, while in the other two studies populations were assessed at the beginning and the end of the intervention.

Assessments Used

All four studies used a variety of assessments to measure PTSD, depression, anxiety, and other elements. Holmes et al. (2014) implemented the Childhood Trust Events Survey (CTES) - Caregiver Edition to collect historical information regarding the traumatic events that children have experienced; the Achenbach System of Empirically Based Assessment to assess clinical changes overtime in behavior aligned with the DSM; and the CLASS tool to assess the human interactions in the classroom taking into account the emotional support, classroom organization, and instructional support. Kataoka et al. (2003) used Life Events Scale to measure the level of violence that the children had been exposed to throughout their lives; the Child PTSD Symptom Scale (CPSS) to determine the PTSD symptoms within the month before it being administered; a

parent-report questionnaire about sociodemographic information; and cognitive interviews to ensure comprehension from the children due to possible language barriers. Patterson et al. (2018) administered the Impaired Rating Scale (IRS) for teachers to complete by reflecting on the child's external behaviors, level of functioning within the classroom, relationships within the classroom, academic progress, and overall functioning; and the Spence Anxiety Scale (SAS) to children about their internal behaviors and their perceptions of self. Berger et al. (2016) employed the Child Posttraumatic Symptoms Scale (CPSS) to assess the children's level of PTSD; the DISC Predictive Scales was used to determine functional problems and somatic complaints; the Screen for Child Anxiety Related Emotional Disorders (SCARED) to determine the level of anxiety; a measure developed by Berger et al. (2015) to establish discriminatory tendencies; and a scale developed by Teichman et al. (2007) to assess stereotypes in children.

Intervention Design

From the four included studies, three used practices from CBT, while two used CCPT, as reported in Table 2. One of the studies used the Attachment, Self-Regulation, and Competency (ARC) framework as part of the training for intervention providers. Another study included parts from the Pro-Social and Virtue programs. Three of the interventions provided individual and group sessions that were conducted outside the regular classroom, while one study focused only on in-class intervention. A range of dedicated time was seen with two studies lasting 12 weeks, one study lasting 16 weeks, and one study lasting 36 weeks.

All studies provided teacher involvement or education. The HSTS program gave teachers extensive training on the ARC framework which includes skills and competencies that are affected due to trauma. Teachers also had the opportunity to do classroom consultations with

Table 1

Intervention studies of child trauma in the school setting

Study	Age Range	Sample Size	Target Population	Study Design	Intervention	Outcomes
Holmes et al. (2014)	2.6-6.3	81	African American, non-Latino white, Latino/Latina, other	Pretest/posttest	Head Start Trauma Start (HSTS)	Improvements in the ability to pay attention, externalizing behavior, and oppositional defiance. Significant improvements in externalizing problems and attention/hyperactivity, and internalizing behaviors.
Kataoka et al. (2003)	8-14	192	Latino Immigrant	Randomized controlled trial	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Lowered levels of PTSD and depression.
Patterson et al. (2018)	5-9	12	African American living in poverty	Pretest-posttest	Child-Centered Play Therapy (CCPT)	Significant decreases in symptoms related to the subscales: separation anxiety, social phobia, physical injury fears, obsessive-compulsive, and panic.
Berger et al. (2016)	8-12	200	Jewish Israeli	Randomized controlled trial	Enhancing Resiliency of Students Experiencing Stress – Pro-Social (ESPS)	Reduction of PTSD symptomatology, anxiety, somatic constraints, level of stereotyping, and discriminatory tendencies. Improvements in the level of functioning.

therapists or peer mentoring to promote a classroom environment that addresses the need of children who have experienced trauma. CBITS teachers were trained to understand the effects of trauma in children and the symptoms that they would be observing in class. The CCPT teachers met with clinicians to discuss concerns about children or to report any changes in behavior. ESPS teachers had an intensive training before the study took place as well as throughout the intervention process. Teachers were also observed in every session to ensure consistency with the methodology.

In the four studies, parents were invited to participate as part of the intervention. For HSTS, parents were trained, in conjunction with teachers, other personnel, and interested community members, in the ARC framework. CBITS parents were invited in a voluntary basis to learn the effects of trauma in children and the techniques that children were learning during the individual and group sessions. In the CCPT intervention, even though parents were interested in being part of the program, due to external circumstances, such as lack of availability, meetings were unable to be conducted. ESPS parents attended psycho-educational sessions before the intervention started. They received training on ways to help the children complete the assigned homework, and were invited to participate in a total of two in-class intervention sessions.

Outcomes

For the Head Start Trauma Smart (HSTS) intervention, the study found improvements in the ability of children to pay attention to different tasks, reduced problems in externalized behaviors, and oppositional defiance. Significant improvements were observed in externalizing problems and reduction of attention/hyperactivity, and internalizing behaviors. In the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), lowered levels of PTSD symptoms and

Table 2

Intervention design in intervention studies of child trauma in the school setting

Study	Intervention theory	Teacher Education	Intervention Provider	Parent Education	Intervention Duration
Holmes et al. (2014)	Trauma Focused-Cognitive Behavioral Therapy based on the Attachment, Self Regulation, and Competency (ARC) model. Using strategies such as play therapy, bibliotherapy, and a sand tray focusing on cognitive distortions. Therapists could perform home visits if needed.	Training based on the 10 building blocks of ARC adapted for early childhood. Classroom consultations by therapists and peer based mentoring for classroom support.	Licensed clinicians and teachers	Training for parents or individuals close to the child based on the 10 building blocks of ARC adapted for early childhood.	12 weeks
Kataoka et al. (2003)	Group based Cognitive-Behavioral Intervention for Trauma in Schools (CBITS).	Teacher training provided by clinicians on the effects of trauma and symptoms.	School psychiatric social workers	Optional group sessions to discuss the effect of trauma and techniques that children would be learning.	36 weeks
Patterson et al. (2018)	Two phase individual and group child-centered play therapy (CCPT).	Teacher consultations for concerns about children or changes in behavior.	Registered Play Therapists (RPT)	Parents were unable to meet due to external circumstances.	12 weeks
Berger et al. (2016)	Enhancing Resiliency of Students Experiencing Stress - Pro-Social (ESPS): cognitive-behavioral techniques. Added parts of Pro-Social and Civil Virtue programs.	Teacher training before the intervention and throughout. Teacher observations in each session.	Homeroom teachers	Psycho-educational sessions, training on homework support, and involvement in two intervention sessions.	16 weeks

depression were determined for the children after the intervention took place. In the Child-Centered Play Therapy (CCPT), there was a significant decrease in separation anxiety, social phobia, physical injury fears, obsessive-compulsive behaviors, and panic after the intervention took place. In the Enhancing Resiliency of Students Experiencing Stress - Pro-Social (ESPS) intervention, results showed a reduction of PTSD symptoms, anxiety, somatic constraints, level of stereotyping, and discriminatory tendencies, as well as improvement in the level of functioning within the classroom setting for the children. Overall, all the studies showed an improvement in symptomatology related to trauma with increased ability to cope with daily activities.

As stated above, the four studies targeted different populations, were conducted over different periods of time, had different study designs, and used varied assessments. All studies incorporated research-based trauma interventions, such as CBT and CCPT. Teachers and parents received different levels of support, but all were included as an essential component of the design. In some cases, the teachers provided the intervention while in others specialized professionals did. Even with all these differences, all the interventions demonstrated positive outcomes, as measured by the individualized measures used in each study.

DISCUSSION AND CONCLUSIONS

The main purpose of this thesis was to determine recommendations to promote the development of a trauma-informed approach in Venezuelan schools in order to address the traumatic effects of political unrest in young children through a systematic review of existent intervention programs. This chapter includes a discussion of results in which recommendations are established, limitations for this study, educational implications, and future lines of research.

Discussion

Research regarding the impact of trauma has guided further studies into the development of interventions that address children's multidimensional needs. Many intervention programs have been developed to be implemented as therapies provided by clinicians in controlled settings. Few studies have included these services into the school setting (Berger et al., 2016; Holmes et al., 2014; Kataoka et al., 2003; Patterson et al., 2018). For environments, such as Venezuela, in which the amount of children who experience trauma is ongoing and substantial, it is important to develop programs that are available to everyone despite socio-economic status.

Developing an intervention program for children who have experienced trauma requires an understanding of the multiple ways in which children are impacted, how this is perpetuated in the everyday setting, and how creating a multidimensional team can benefit them. Across four identified studies, all interventions take into account four distinct variables: assessments, intervention design, teacher education, and parent education.

The assessments used serve to determine the need for services outside of the classroom that would be provided by clinicians and the effectiveness of the intervention program. The assessments not only identified the traumatic experiences that children went through, but they

also assessed the level of functioning that was impaired. Some of the scales were used to determine the levels of anxiety, depression, PTSD, and externalizing and internalizing behaviors. To choose assessments to implement in programs in Venezuela, administrators should select those for which the reliability and validity has been tested in their Spanish-translated versions (see Appendix A for a list of translated assessments), and are developmentally appropriate. Even though the intervention programs demonstrated an understanding on the impact of trauma in functioning, none of the studies used a measure to determine if the child's development was impacted, or if there were significant gains or losses in this aspect. The use of a development screening tool could provide further information regarding the effects in Venezuelan children.

The intervention design consisted primarily of CBT and CCPT programming. CBT works by identifying the negative automatic schemas and thoughts, and challenging them to promote cognitive reconstructing (Hagen and Hjemdal, 2012). Behavior is also addressed by promoting helpful actions, facing fears, building coping skills, and reducing physiological responses. Through CCPT, children explore, at their own pace, any issues that are affecting their current lives using play as the primary channel through which they externalize thinking (Brown, 2009). With CPT, children are in charge of their own growth and change. Even though in the studies, the interventions were only interrelated in one study, researchers have advanced Cognitive-Behavioral Play Therapy (CBPT) for children between the ages of 2.5 and 6 as a developmentally appropriate strategy (Knell, 1998). This could be a healthy alternative for early intervention programs in which children have yet to develop the language skills required for CBT. As far as the grouping, some designs provided group intervention, others individual, or a

combination. This could be determined by the resources available for the program or by assessment results.

In all cases, teacher education was also provided. According to SAMHSA (2014), this is one of the requirements for a trauma-informed approach in which an understanding of the impact of trauma and ways to overcome it is essential. Teachers were trained on the symptomatology of trauma to determine which children would benefit from further intervention, and to observe the advances. In one instance, human interactions in the classroom were assessed using the CLASS tool. This leads to the importance of establishing an environment in which children develop more effective ways to interact with each other through teacher modeling. Teachers should be trained to identify the ways in which their own traumatic experiences and stress levels affect their communication with children, and learn ways to manage such emotions or thoughts. Only one program provided a framework from which teachers could modify their approaches in the classroom. The Attachment, Self-Regulation, and Competency (ARC) framework provides ten building blocks that are applicable across different settings to provide services for children who have experienced trauma (Holmes et al., 2014). Even though no other programs were identified in the four studies, teachers and administrators can choose several programs to implement in their classrooms (see Appendix B) despite lack of research-based evidence as to their effectiveness.

Due to the important role that teachers play in the lives of children, and their position to detect and address issues, it is imperative that they are informed of the repercussions of trauma. They should also understand the ways in which they can address the diverse needs of children in their classrooms who present such concerns. Teachers should receive coaching throughout the

school year to ensure that they are improving the classroom environment through the use of informed practices. Some studies did this by implementing a series of classroom observations and consultations by clinicians in which teachers were able to express their concerns and questions.

A predominant interest in all the studies was the need to provide parent education. Even though in one study it was not possible, researchers stated the desire of the parents to participate in training. In some cases, this training was even available for community members and those individuals that are regulars in the lives of children. This training varied across programs. Some took the form of psychoeducation, while others were trained on ways to help children with assignments, or involvement in intervention sessions. Overall, the goal was to inform parents on the ways in which trauma was affecting children, and how they could provide a safe environment to support children. This fulfills the same requirement from SMAHSA's (2014) for a trauma-informed approach as teacher education. As with teachers, if parents understand the role of trauma in life, they will be able to address the experiences that they have had that dictate their actions towards children that contribute to a prolonged stress environment. By reducing the stress environment at home, hopefully children will have significant improvements in different aspects.

Overall, to implement a trauma intervention, teachers and administrators should start by educating themselves, and other staff members, on the effects of trauma. They should also determine ways in which their interactions with children can be improved and create a safe environment. As with teachers, parents should be educated on the same topics and learn different strategies and modifications that they can use to serve their children. Assessments should be used to understand the needs of a particular population in order to develop a more extensive

intervention in which caregivers, teachers, staff, clinicians, and community members are included. Clinicians should work with those children who require a more individual approach by using established trauma intervention practices such as CBT, CCPT, or CBPT. Clinicians should also provide consultations to teachers to ensure a positive classroom environment that incorporates any trauma-informed curriculum or framework. In order to succeed, the program needs to be a comprehensive approach in which all parts have some level of involvement.

Limitations

The limitations of the study were the following. Studies used targeted school environments in which traumatic repercussions were addressed, but only one study dealt with the repercussions due to political unrest and community violence. This makes the populations assessed in these four studies different from Venezuelan children. Second, assessments and programs used in the studies do not take into account the cultural differences for children in Venezuela. Third, the studies did not address the teacher practices that can be implemented to promote a trauma-informed curriculum. Fourth, none of the interventions took into account persistent and life-threatening malnutrition, which is a predominant issue in Venezuela.

Educational Implications

In the classroom, teachers are at the forefront to see different manifestations of trauma. Once teachers are aware that trauma has an impact in how children behave and their development, there are different implications on their approach to teaching and interacting with students. They will notice how experiences shape behavior, what triggers are present in the classroom, how to provide a supportive environment, and how they are also affected by trauma. Teachers will start to see reactive behaviors as a response to life experiences rather than

character traits. By doing so, teachers will be able to provide a more comprehensive approach to address the various needs of their students. For example, for children who have been kidnapped, emergency drills in which they have to hide might elicit aggressive behavior. In those cases, the teacher has to address the behavior not as a disruptive response, but as a need of safety that the child is trying to fulfill. If the teacher shifts to this thinking, then she will respond to the child in manner that better helps the child cope.

When teachers are aware of the traumatic life experiences of a child, they able to understand why the behavior is happening, and determine different triggers. After identifying triggers, teachers should reduce them and work with the child on developing appropriate responses. The teacher can incorporate new routines in the classroom to reduce the amount of triggers to which a child is exposed. If the child is being triggered by having one toy taken away from him, the teacher can incorporate a borrowing system in which the child knows who is the next person to borrow the toy and a timer to be reminded of how long he will be allowed to play with it. By doing so, the teacher is preparing the child to address the situation that generates the inappropriate behavior. Besides including this system, the teacher should help the child develop appropriate responses to different situations. This process can be done through the use of social stories, modeling, and recreating stressful situations. The teacher would provide the child with a situation that would elicit a reactive response, and then appropriate choices for the child to us. Afterwards, the child has to practice the responses with support and then the teacher would observe to determine further actions. Modeling should also occur when the child is triggered. The teacher can demonstrate soothing skills, such as reading and self-talk, that the child can later utilize when having to confront a difficult experience.

Besides reducing the triggers in the classroom, the teacher needs to provide a safe environment for children by allowing them to talk about their experiences. By providing a place for children to voice their concerns and talk about the events that bother them, the classroom becomes a coping environment. The teacher can provide support for children to develop strategies that will help them deal with future challenges. Also, the teacher will develop a bond in which children feel safe and supported enough to focus on their other needs, such as learning. To promote this sharing environment, the teacher can incorporate different routines in the classroom. The teacher can incorporate a classroom meeting daily in which children are encouraged to answer different questions and their peers hear them in a supportive manner. The teacher can also provide a modified play therapy in which children have different centers with multiple materials to elicit different types of dramatic play. This way children are able to express how they view the world and the teacher observes where more support is needed. Another mechanism is to include children's books that promote socioemotional emotional learning through diverse cultural backgrounds. For older children, the teacher can incorporate journaling sessions for children to express their needs. The journals could be private or the teacher can respond to children as needed. Art can be included in the classroom by having children use different mediums, such as paintings, drawings, drama, music, or dancing, to express their views. This way, children can develop a coping skills that works best for their characters and inclinations.

Finally, by having an understanding of how trauma impacts behavior, teachers will also be able to determine ways in which their own experiences shape their decisions in the classroom. Just like children are affected by what they have lived, teachers are impacted by their

environments. Teachers will start to identify different situations in which their responses are conditioned by their experiences and how to better address those needs. Moments in which teachers can be triggered are having conversations with parents that turn violent, a child acting aggressively, or a sudden loud noise. After identifying them, teachers can remove themselves from the situation and avoid them in the future. The teacher can also find help from different clinicians to address the behavior and schemas that lead to these reactions, and to develop other mechanisms to help them cope. If teachers and personnel collaborate in this matter, they will create a supportive school culture that generates a safe space in which teachers feel safe enough to provide the best care for children.

Future Research

Future action is required to address the needs of children experiencing ongoing trauma and toxic stress in Venezuela. This study serves as a basis to develop an intervention program that can be implemented as part of the curriculum to enhance the school environment and target the individual needs of children. This study showed that few intervention programs are designed to serve children in the schools who have experienced trauma. Considering the extensive research determining the negative repercussions and its prevalence, it is necessary to implement more programs to serve these traumatized children. Further studies are needed to determine the cultural implications and modifications needed in a trauma-informed program to better serve this population. Translated assessments need to be identified and their validity and reliability determined to be used as part of the program. Teacher training and parent education resources need to be developed to acknowledge the traumatic experiences that the adults have experienced.

Due to the lack of understanding of systemic oppression trauma, a need exists to identify its repercussions in populations around the world, specifically, Venezuela. Interventions that are not provided by public schools are only accessible to certain socioeconomic status populations. Thus, new policies need to be put in place in Venezuela to ensure that the most vulnerable groups are receiving all the services needed to combat the effects of chronic trauma and close the gap due to socioeconomic status to succeed in the future.

APPENDIX A: SPANISH-TRANSLATED ASSESSMENTS

Acute Stress Checklist for Children (ASC-Kids; Kassam-Adams, 2006)

The ASC-Kids is a self-report tool targeted for children ages 8-17 to measure acute stress disorder reactions.

Child PTSD Symptom Scale (CPSS; Foa et al., 2001)

The CPSS was designed to assess the severity of PTSD symptoms in children ages eight and older. It can be used as an interview guideline or as a self-report measure.

Post-Traumatic Stress Disorder Reaction Index (Steinberg et al., 2004)

The PTSD Reaction Index is a self-reported interview to determine exposure to traumatic events and existent PTSD symptomatology in school-aged children and adolescents.

Traumatic Events Screening Inventory for Children (TESI-C; Ford et al., 2002)

The TESI-C can be administered by clinicians as a structured interview or as a child questionnaire. It determines exposure to traumatic events and emotional reactions to particular situations. It is intended for ages 4 to 18.

APPENDIX B: TRAUMA CURRICULUM AND FRAMEWORK

Attachment, Regulation, and Competency (ARC, n.d.)

ARC is an organizational framework to support trauma-informed care for all children. It is component-based built upon four pillars: childhood development, attachment, traumatic stress, and risk and resilience. ARC establishes key skills that are impacted by trauma, and if targeted, promote resilience.

Conscious Discipline (Bailey, 2015)

Conscious Discipline is a trauma-informed socioemotional learning best practices for educators. It addresses the adult's internal states as the foundation for modeling the skills that children should develop. It builds on the Brain State Model to explain behavior, the Seven Powers for Conscious Adults to provide skills for adult regulation of behavior, creating a School Family to increase connections, and the Seven Skills of Discipline that transform everyday problems that children encounter into teachable moments.

The Neurosequential Model in Education (NME; Child Trauma Academy, n.d.)

Developed by the Child Trauma Academy and taught by Dr. Bruce Perry, NME is a developmentally appropriate approach to working with at-risk children. It is a way to assess the child's functioning, identification or problems, and the application of interventions to best meet the needs of children. This model is design to teach educators and school staff about brain development and the effects of trauma in development.

Creating, Supporting, and Sustaining Trauma-Informed Schools: A System Framework (National Child Traumatic Stress Network, 2017)

This framework provides a trauma-informed approach to address the needs of all the individuals that are part of a school. It touches on four core principles: understanding the impact

of trauma, recognizing the signs, responding to trauma at all levels of the school system, and avoiding re-traumatization.

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