This year’s theme, “Power Up! Be a Positive Charge,” aims to highlight the many ways that individual actions—large and small—that make positive connections can spark positive change. Throughout the week, schools across the country will be taking part in events and activities designed to generate energy and reinforce the connections that power thriving school communities.

“This year’s theme champions a willingness and resolve to be that positive charge,” explains NASP President Dr. John Kelly. “A key objective is to teach children that they have the power to bring about positive changes, both for themselves as individuals and for their communities as members of classrooms, peer groups, families, teams, and clubs.” In an effort to meet this key objective, all of the resources and activities designed to promote School Psychology Awareness Week emphasize a student-centered approach.

“The phrase Power Up!” emphasizes each individual’s ability to plug into the talents, skills, behaviors, and mindset that will help them grow and contribute to the quality of their school and broader communities,” adds Kelly. “By encouraging and valuing intentional, small, positive efforts, adults and students grow academically, build understanding, create compassion, and become more resilient—more energized to confront upcoming challenges.” (From www.nasponline.org)

**How did YOU celebrate SPAW this year?**

*Stare with us on our Facebook page!*

https://www.facebook.com/dasponline/
I am no longer an early career school psychologist. That thought hit me as I was driving this week. The National Association of School Psychologists (NASP) defines an early career school psychologist as someone who is in their first five years practicing as a school psychologist. I no longer qualify. This thought hit me the same day I was asked what was the best professional advice I have ever received. These two events led to me thinking about what I’ve learned during my early career years. I’ve learned a lot. I decided to share my top five in hopes that someone else can benefit from my experiences. So here they are:

1) Meet People Where They Are – I was given this advice from my internship supervisor and it is still the best advice I’ve ever received. If parents aren’t ready to hear difficult information about their child, that’s okay. Meet them where they are. Understand what they are willing to hear. Help them get to that next level of understanding. The same is true of teachers. If a teacher is struggling with classroom management. Don’t dump every single classroom management strategy on them at once. Especially if they are resistant. Pick one or two manageable things and work on them.

2) Eat Lunch – Even if it is only a 10 or 15-minute break. I each lunch 95% of my days. I’ve learned that I need to eat lunch before 11am-otherwise, I’ll get interrupted. I need to close my door and turn down my lights. I also need to put my computer away and not look at my work. I disconnect. I think of the vacations I want to take. I prioritize my self-care skills. After 10 or 15 minutes, I come back refreshed and ready to take on the second half of my day. If you are a non-lunch eater, I encourage you to try and eat lunch every day for a week. See how your energy levels and mood improve.

3) Find A Way to Disconnect (aka a hobby) – This one was extremely challenging during my first few years. I would work, eat, and do more work at home. A few years ago, I realized I needed to do something different or I was going to burn out. Since then, I have made a concerted effort… (Cont’d on pg. 3)
(Cont’d from pg. 2) …to develop hobbies outside of my professional world. I play softball, workout, and play with my dog, Paxx. These things allow me to disconnect, de-stress, and be more productive.

4) Professional Development – I am lucky enough to have a PD stipend built into my contract and I make sure to use it all. I’ve attended webinars, state and national conferences, and legal trainings. I’ve read books and I’ve learned. I’ve looked for opportunities to develop my areas of weakness as well as my areas of strength. This has expanded my knowledge base, improved my professional judgement, and made me more confident in my practice.

5) Develop A Professional Network – Another reason I find PD important is because it connects you with like-minded colleagues who know the challenges you face on a day to day basis. My first year, I didn’t know anyone and I felt like I was on an island. Fast forward five years and a move to Delaware, and I now have a great professional network. I have made connections with wonderful colleagues at the district, state, and national levels. These are people who I can vent to and seek advice from. For them, I am grateful.

This is my personal list, based on my personal experiences. It is by no means an exhaustive list. I’ve learned a plethora of things in my first five years and I’m sure I’ll learn even more in my next five. If you are someone who is no longer an early career school psychologist, I encourage you to share your personal experiences on our Facebook page, so that others may benefit from your experiences.

Sincerely,

Brittany J. Zehr, Ed.S., NCSP
President-Elect
Delaware Association of School Psychology
Letter from Your NASP Delegate, Emily Klein, NCSP

This year’s School Psychology Awareness Week is November 13-17, and the theme is “Power Up! Be a Positive Charge”. The idea is that a small spark—a new skill, a piece of knowledge, an extra effort, a kind gesture—can create the connections necessary for students to develop critical academic and social–emotional skills. This awareness not only helps bolster adults’ resilience, it serves as a model for students, who look to adults to see how they should interact and engage with the world. By encouraging and valuing intentional, positive efforts, adults and students can grow personally, build understanding, create compassion, and become more resilient. Ultimately, these strengths empower all to feel connected with one another and to take actions—both individually and collectively—to change lives for the better. This is a great opportunity to highlight the “sparks” that you see driving change in your school! Check out the resources at http://www.nasponline.org/research-and-policy/advocacy-tools-and-resources/school-psychology-awareness-week-2017.

Looking for a way to reenergize yourself and hone your professional skills? Come lose the blues with NASP in the US’s 3rd most populous city, Chicago! NASP takes over the Windy City (or at least the Hyatt Regency) from February 13-16, 2018. Early Birds who register before November 8th will receive a $50 discount on their registration fee, and will be entered into a drawing for a $500 Visa Gift Card! I know what you’re thinking – “Emily, I was on board with sunny San Antonio last year... but now you’re asking me to go to Chicago? In FEBRUARY? ON PURPOSE?” You bet your bottom dollar I am! There’s SO much to do to see and do in Chicago, even if the weather keeps you from Navy Pier. Chicago is home to world-class museums, a lively jazz scene, and Michelin-star/James Beard awarded restaurants! Fancy food not your style? Dig into one of Chicago’s famous deep-dish pizzas, or score yourself a real Chicago-style hot dog! Looking for adventure? Tilt 1030 feet over the city at 360 Chicago, or have the entire city beneath your feed when standing on The Ledge of the Willis Tower’s 103rd floor. If you’re a basketball fan, you can see the Bulls play at home on the 12th or the 14th. Still haven’t piqued your interest? Check out other tourist attractions at https://www.choosechicago.com/. Chicago… it’s my kind of town!

Register for the 2018 NASP Annual Convention!

Your registration for the Convention gains you access to more than 1,200 different sessions and events in the windy city-Chicago, IL!

DASP Membership Dinner (January 18th)

Frazier’s Restaurant in Dover, DE will host DASP’s annual membership dinner on January 18th from 5:00-9:00pm. As usual, this dinner will feature engaging speakers and outstanding networking opportunities for all attending Delaware school psychologists. Bon appétit!

DASP Annual Conference (May 10th-11th)

Join us on May 10th and 11th in Rehoboth Beach, DE for two days of conference activities! Don’t forget to also sign-up for networking opportunities with our Thursday night membership dinner and a Friday membership lunch!

The Program Committee is responsible for planning, organizing, and executing DASP conferences, workshops, and other professional development opportunities. If you are interested in finding out more or joining this committee, please contact Program Chairs, Gabrielle Koury, gabrielle.koury@redclay.k12.de.us, and Laura Wells, laura.wells@appo.k12.de.us.
Join One of Our Committees to Help Advocate for School Psychology in DE

Program Committee - This committee organizes and runs many of our events, such as: in-service day trainings, membership dinners, and the spring conference. If you are interested in finding out more or joining, please contact Gabi Koury (Gabrielle.Koury@redclay.k12.de.us) and Laura Wells (laura.wells@appo.k12.de.us).

Government and Professional Relations Committee (GPR) - This committee focuses on advocacy and outreach for both our profession and the students we serve. Policies and legislation impacting the practice of school psychology in Delaware are also a main focus for this group. If you are interested in finding out more or joining, please contact either Eric Pizzini (eric.pizzini@redclay.k12.de.us) or Courtney Chasko (courtney.chasko@irsd.k12.de.us).

Newsletter - DASP publishes two newsletters per year, one in the fall and one in the spring. If you are interested in contributing (and yes, please do!), please contact Laura Davidson (LDavids@UDel.edu).

Do you still need to apply for the 2017-2018 school year? It's easy!

1) Visit:  http://www.dasponline.org/membership
2) Complete the online application form
3) Pay online via PayPal
4) Enjoy your membership benefits!

Member benefits include:
- A forum for contact and professional development among colleagues
- Continued professional advocacy via the Government and Professional Regulations (GPR) Subcommittee
- Representation at NASP level meetings
- Reduced rates for professional development opportunities (such as our Membership Dinner and Spring Conference)

If you have any questions about our website, or have suggestions for additional content, please contact LDavids@UDel.edu!

Crossword Puzzle Answers

Across:
1.) Behavioral
2.) PIC
4.) SecondStep
6.) DataBased
7.) Baltimore
9.) Colonial
10.) Bear

Down:
1.) Behavioral
3.) CORE
5.) Cook
8.) Barta
Research-Based Practice: Understanding and Addressing Early Childhood Trauma

By Adrienne Garro, David Brandwein, Tara Calafiore, & Nicolette Rittenhouse

The notion that development influences children’s responses to traumatic stress is not novel. Chronological age and maturity level interact with environmental factors to mediate responses to trauma. Clinicians and researchers have confirmed that children can experience the full range of traumatic stress reactions seen in adults, and many youth meet criteria for DSM-IV diagnoses of either acute stress disorder or posttraumatic stress disorder (PTSD). However, many types of childhood trauma including psychological maltreatment, neglect, separation from caregivers, and inappropriate sexual contact are not fully accounted for by these disorders. Even when children experience events that are more commonly characterized as traumas (e.g., natural or manmade disasters, accidents, etc.), research indicates that their reactions are not fully congruent with the criteria provided in the DSM-IV, suggesting that these criteria may not adequately describe trauma responses in the pediatric population (Meiser-Stedman, Smith, Glucksman, Yule, & Dalgleish, 2008).

Several researchers have taken the lead in proposing that children exposed to chronic interpersonal violence often manifest a pattern of behaviors and emotional reactions that do not fit with DSM-IV criteria for PTSD. For example, van der Kolk et al. (2009) have advocated for a new diagnosis, developmental trauma disorder, encompassing the clinical presentations of children exposed to chronic interpersonal trauma. Currently, DSM-V, which is up for public comment, includes a diagnosis of PTSD in preschool children, which contains several of the criteria for developmental trauma disorder, such as dissociative reactions and increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, etc.; American Psychiatric Association, 2010). Recent research by De Young, Kenardy, & Cobham (2011) provides empirical support for the validity and developmental sensitivity of the new PTSD diagnosis for preschool children as proposed in the DSM-V. Other researchers, including Scheeringa, Zeanah, Myers, & Putnam (2003), have developed alternative criteria to more effectively address PTSD in this population. Due to the current gap in appropriate diagnostic categories related to pediatric trauma, it is not unusual for clinicians to inaccurately diagnose affected children with disruptive behavior problems, bipolar disorder, or other disorders. In addition, some clinicians are not attuned to the more subtle dynamics of trauma and, therefore, believe that trauma-related symptoms are best accounted for by one of these other disorders. These misdiagnoses, in turn, often remove focus from trauma-related problems, perpetuate misunderstandings, and limit development of effective interventions.

Physical Health Effects Related to Traumatic Stress. As in adults, traumatic stress in children results in hyper- or hypoarousal of the
hypothalamic–pituitary–adrenal (HPA) axis and the sympathetic nervous system (Charmandari, Tsigos, & Chrousos, 2005; Perry, 2001). Both of these responses occur along a continuum and entail specific neuropsychological and endocrine changes. With hyperarousal, the sympathetic nervous system is activated, and the fight or flight response is often triggered, resulting in increased heart rate, blood pressure, respiration, muscle tone, and release of glucose (Perry, 2001). The body also generates excessive amounts of cortisol, corticotrophin-releasing hormone (CRH), and catecholamines (e.g., norepinephrine and dopamine; Bremmer, 2003). From a prevention standpoint, knowledge of these potential responses is key, as school psychologists may see children referred for ADHD or other externalizing problems when, in fact, these problems are rooted in trauma. With hypoactivation of the HPA axis, the body is compensating for chronic or repeated exposure to stress (Charmandari et al., 2005). Hypoactivation is often associated with dissociative patterns including detachment from the environment, numbing, avoidance, and/or a freeze and surrender response, where the child is withdrawn, overly compliant, and/or passive (Perry, 2001). The direction of changes associated with excessive stress (e.g., hyper- vs. hypoarousal) is influenced by several factors including age, genetics, environmental variables, and nature of stressors (Perry, 2001; Pervanidou, 2008). Although the specific effects of these factors have not been completely delineated, some researchers suggest that younger children are more likely to engage in dissociation due to their difficulty in fighting or fleeing from threatening situations (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Also, preliminary research indicates that younger exposure to trauma is a risk factor for the development of full-blown PTSD, with higher risk conferred when young children experience multiple or chronic traumas (Pervanidou, 2008; van der Kolk et al., 2005). Such data underscore the importance of identifying at-risk children as early as possible.

Long-term changes in physical growth and neuropsychological functioning must also be considered in young trauma-exposed children since both of these domains are directly and/or indirectly influenced by the HPA axis (Pervanidou, 2008). Extensive and/or continuous interference with these systems during critical developmental periods may produce irreversible damage (Charmandari et al., 2005). Early trauma also has deep-seated effects on brain development including the creation of neural pathways and the movement and differentiation of neurons (Perry & Pollard, 1997). Given the tremendous brain growth that takes place during the first 2–3 years of life, preschoolers may be at higher risk for adverse neuropsychological effects related to trauma. More recently, genetic studies have also yielded valuable data regarding traumatic stress. For example, Drury, Theall, Keats, & Scheeringa (2009) found that diagnosis of PTSD and total number of symptoms was associated with the presence of a specific allele in a dopamine transporter gene in a sample of preschool children. While genetic testing is not part of standard assessment protocol for PTSD, such research emphasizes the importance of examining family histories related to traumatic stress.

Cognitive and Psychosocial Effects. Children who have experienced trauma may show a variety of cognitive effects, including problems related to attention, processing verbal information, and comprehension deficits (van der Kolk, 2003). Since trauma disrupts functioning of the hippocampus, memory difficulties are also common (Acosta, 2000). These problems, in turn, all have negative implications for preschoolers as they transition to more formal and structured classroom settings. Greater use of dissociative responses among trauma-exposed preschoolers may result in difficulty coordinating perceptual experiences, lack of participation in classroom routines, and poor receptive and expressive language skills (Kinneburgh, Blaustein, Spinazzola, & van der Kolk, 2005). Younger children who experience repeated trauma may have difficulties developing object constancy and establishing cognitive
representations of their environments. These difficulties, in turn, may make it harder to understand cause-and-effect relationships; build specific categories and concepts about people, places, and objects; and develop problem-solving skills (van der Kolk et al., 2005). Knowledge of these cognitive effects, in combination with a thorough intake history, will be helpful to school psychologists conducting psychoeducational assessments. While data are still preliminary, some research suggests that children exposed to trauma show specific cognitive profiles, including low performance on working memory and other executive functioning tasks (Samuelson, Burnett, & Wilson, 2010).

When toddlers and preschoolers experience trauma, families, and even some professionals, might assume that they are less vulnerable to long-term effects because they do not remember the stressful event. Consequently, a common parental reaction is to not discuss what happened in an attempt to shield the child and facilitate forgetting. However, even preverbal children who experience trauma can still encode and remember the event (Kaplow, Saxe, Putnam, Pynoos, & Lieberman, 2006). Due to less-developed verbal abilities and emotional vocabulary, young children often express trauma's effects through nonverbal means such as play, including aggressive themes when they have experienced abuse or witnessed interpersonal violence (Carrion, Weems, Ray, & Reiss, 2002). Behavioral reenactments of trauma with peers are often observed, with victims of physical or sexual abuse acting as perpetrators. With other forms of trauma, young children may demonstrate avoidance reactions in their play and peer relationships in general. Attachment-related anxiety and insecure attachments are commonly observed among children who have experienced trauma at home (Brown, 2005). Thus, these children develop early relationship templates of mistrust, which are subsequently manifested as fearful or aggressive interactions, even in the presence of healthy, nurturing adults and supportive peers.

**Prevention and Intervention.** Services and treatment for trauma are often conceptualized as interventions after the fact, rather than proactive measures. While reactive interventions are clearly valuable, there are multiple opportunities for school psychologists to implement prevention-based practices that will address the needs of young children who have experienced trauma.

One of the most fundamental practices is early identification of children who are at risk for trauma-related disorders due to adverse family environments, preexisting psychological problems, and/or direct trauma exposure through disasters, accidents, and more. For example, in reviews and meta-analyses of early childhood programs designed to prevent child abuse and neglect, Geeraert, Van den Noortgate, Grietens, and Onghena (2004) and Reynolds, Mathieson, and Topitzes (2009) found that several programs including either home visitations, hospital-based health services, parenting classes, or center-based preschools, combined with parent education and involvement, were effective in lowering rates of abuse and maltreatment. In these studies, risk reduction was demonstrated through positive changes in child, parent, and family functioning and parent-child interactions.

Another effective program, Incredible Years, which focuses on strengthening parent competencies and fostering involvement in children's schools, has yielded significant positive outcomes in several studies: (a) improvement of parent-child relationships in an urban, high-risk, multiethnic community (Scott et al., 2010); (b) reduction of ADHD symptoms in preschool children with conduct problems (Jones, Daley, Hutchings, Bywater, & Eames, 2008); and (c) reduction of externalizing problems and increases in maternal school involvement and supportive behaviors in socioeconomically disadvantaged, diverse families (Reid, Webster-Stratton, & Hammond, 2007). Pearl (2009) also described the effectiveness of Incredible Years as well as other parent management trainings (e.g., Helping the Noncompliant Child, Parent–Child
Interaction Therapy, Triple P-Positive Parenting, and Oregon Early Intervention Foster Care) in reducing preschoolers’ oppositional and aggressive behaviors.

While some of the aforementioned programs do not target trauma directly, their concentration on positive parenting and skill development provides a supportive foundation to address traumatic events if and when they occur. Prevention also involves helping at-risk families build upon strengths and resources which may buffer against extreme stressors and/or traumatic experiences. Family support and the larger family context, which includes extended family as well as other trusted individuals involved in the child’s life, can serve as protective factors. Some research has focused specifically on the use of family rituals as a protective factor in the face of stressors. Family rituals, defined as goal-directed and task-oriented events with a beginning and an end, include celebrations, goodbyes, leisure activities, and bedtime and dinnertime routines (Kiser, 2007). Such rituals constitute structure, outline roles within the family, set boundaries, and build and preserve family relationships. In a review and discussion of children’s exposure to complex traumatic stressors, including urban poverty, Kiser notes that there is a reliable link between family rituals and psychosocial adjustment, and she proposes that these rituals can be systematically applied as an intervention mechanism for at-risk families. Based upon this model, school psychologists should gain understanding of existing family rituals and collaborate with families to develop new ones that foster connectedness and healthy coping.

Beyond universal prevention, school psychologists can implement secondary and tertiary strategies for young children who have already experienced trauma. Accurate identification is crucial and must take into account the unique symptoms and responses manifested by this population. Scheeringa (2008) has developed an alternative algorithm for preschool PTSD, which includes wording modification for some symptoms to increase their developmental sensitivity. For example, young children may experience intrusive memories, but these are not necessarily distressing to them as the symptom is listed in the DSM-IV. Scheeringa’s algorithm also calls for decreasing the number of numbing and avoidance symptoms required for Criterion C of the DSM-IV from three to one, due to the fact that several of these are internalized and hard to detect in preschoolers or are unlikely to occur in this population (e.g., sense of foreshortened future). The validity of Scheeringa’s criteria in diagnosing younger children with PTSD has been supported through several studies (e.g., Meiser-Stedman, Smith, Glucksman, Yule, & Dalgleish, 2008; Scheeringa, Zeanah, Myers, & Putnam, 2003). In addition, the proposed diagnosis of PTSD in preschoolers for the DSM-V is closely aligned with Scheeringa’s schema.

As the direction of pediatric PTSD diagnosis continues to evolve, school psychologists are in an optimal position to educate and consult with families as well as school personnel to ensure early identification and intervention. This is especially pertinent for those serving on early childhood teams and/or RTI teams, as they can implement screening and other appropriate assessments for children at risk or those known to have trauma exposure. Trauma-exposed preschoolers are more likely to be overlooked than older students due to their limited verbal abilities. It is rare for them to provide direct narratives about traumatic events that are characteristic of older children. Additionally, school psychologists should watch for other behaviors that may signify traumatic stress: sleep disturbances, increased clinging behavior, developmental regression, and separation anxiety (Cook-Cottone, 2004; Terr et al., 1999). If families or educators are unaware of a trauma or lack knowledge of its developmental aspects, they may regard these problems as acting out and react to them harshly and/or inappropriately, which can exacerbate the child’s distress. For preschoolers, it is also crucial to incorporate reports from parents and teachers, as they have the most direct contact with the child and can provide more detailed accounts of changes in
functioning. One way to enhance the quality of these reports is to provide psychoeducation about traumatic stress and its effects. Assessment of preschoolers who have experienced trauma may also include use of standardized instruments, though relatively few have been developed for younger populations. One exception is the Trauma Symptom Checklist for Young Children, which is used to measure behavioral indicators of trauma in children, ages 3–12 (Briere, 2005).

Once initial assessment is complete, data can be used to formulate a developmentally appropriate intervention plan. If a child has experienced a single trauma, also known as simple trauma, it may be possible to prevent him/her from developing full-blown PTSD by providing counseling, family education, and close monitoring of functioning and psychosocial status. Early intervention is also crucial to prevent simple trauma from evolving into complex trauma, (e.g., exposure to more than one traumatic event or to multiple types of trauma).

Additionally, school psychologists should help direct education toward parents/caregivers so they can address the trauma early and prevent exacerbation of its effects. A number of studies have supported this approach, most notably with young children who have experienced sexual abuse (e.g., Deblinger Staffer & Steer, 2001). This research indicates that cognitive–behavioral interventions in particular can be beneficial in helping non-offending caregivers to (a) cope with their own reactions to their child’s abuse and be supportive in their parenting, (b) communicate openly about sexual abuse, and (c) use appropriate management skills to deal with behavioral problems. While studies with other types of trauma-exposed populations are needed to further validate the effectiveness of caregiver-based interventions, the aforementioned research highlights the importance of family context in addressing early childhood trauma.

Some researchers and clinicians have begun to adopt a more systems-oriented framework to trauma intervention. Ko et al. (2008), for example, advocate for an integrated approach across different service sectors, including healthcare, mental health, school systems, child welfare agencies, and criminal justice systems. As part of this approach, schools should extend beyond traditional crisis response plans, establish networks with early detection of students who experience serious trauma reactions, and then implement interventions focusing on the development of healthy coping and positive peer and family support (Jaycox, Kataoka, Stein, Wong, & Langley, 2005).

Several empirically supported cognitive–behavioral trauma intervention programs for children also engender involvement from multiple systems including: (a) Trauma System Therapy (TST; Saxe, Ellis, & Kaplow, 2007), a community-based, multiphase program targeting specific interventions to children based upon their emotional/behavioral regulation abilities and the support and stability of their environments; (b) Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which focuses on relaxation techniques, affective expression and modulation, cognitive coping, and creation of narratives to process traumatic experiences (Cohen & Mannarino, 2008); and (c) Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a skills-based, group intervention focusing on relaxation, modification of distressing thoughts, and social problem solving that also includes parent and teacher education (Jaycox, 2004). However, among these three, only TF-CBT has been applied and validated with younger children. School psychologists may provide direct or indirect services in multi-systems interventions. Indirect services include: (a) consultation and collaboration with teachers and other school professionals who provide individual, group, or classroom-based interventions for preschoolers; (b) development of workshops, referral contacts, and other resources for school staff and administrators; and (c) consultation and collaboration with families, outside therapists, and other community resources to monitor psychosocial functioning for children who receive trauma treatment outside of schools.

When it comes to direct services, school psychologists can provide counseling to young
trauma-exposed children, emphasizing the establishment of a safe, secure environment. Such an environment will help rebuild trust if trauma has been interpersonal in nature (Stein & Kendall, 2004). Individual play-based techniques are often an appropriate choice for preschoolers due to their limited verbal repertoires. Eventually, this type of therapy can translate into pathways for processing the trauma (Gil, 2006). Once the child’s symptoms have decreased, group play therapy may be an additional option for intervention. School psychologists with clinical training may want to consider use of child–parent psychotherapy or parent–child interaction therapy (Saltzman, Babayan, Lester, Beardslee, & Pynoos, 2009). These treatments focus on building secure and healthy attachment with caregivers, which is an established protective factor for children with trauma histories (Kim-Cohen, 2007).

Conclusions. Trauma exposure is now acknowledged as a significant mental health problem with detrimental effects for children of all ages, including preschoolers. Given the unique dynamics of trauma in younger children, schools and families must be equipped with appropriate knowledge and tools to effectively address the needs of this population. Due to their multiple roles as interdisciplinary team members, case managers, and mental health providers, school psychologists are in an optimal position to identify young, at-risk, children, assess cognitive and psychosocial effects of trauma, and to assist in the development and implementation of a solid prevention-based framework of services.

Adrienne Garro, PhD, is assistant clinical director for the school psychology professional diploma program at Kean University and an assistant professor in the Department of Advanced Studies in Psychology. David Brandwein, PsyD, is assistant director of clinical training for Kean University’s PsyD program in combined-integrated school and clinical psychology and an associate professor in the Department of Advanced Studies in Psychology. Tara Calafiore and Nicolette Rittenhouse are candidates in Kean University’s PsyD program in combined-integrated school and clinical psychology.

ACEs in Delaware: By The Numbers


| Percentage of Adverse Child Experiences Among Children 0-17 yrs |
|-----------------|-----------------|-----------------|-----------------|
|                  | 0               | 1 or 2          | 3+              |
| Delaware         | 52              | 35              | 13              |
| National         | 54              | 35              | 11              |

| Most Common ACEs (and percentage prevalence) Among Children 0-17 yrs |
|-----------------|-----------------|-----------------|-----------------|
|                  | Highest         | 2nd             | 3rd             | 4th             |
| Delaware         | Economic Hardship (25) | Divorce (21) | Violence (12) | Alcohol (7) |
| National         | Economic Hardship (26) | Divorce (20) | Alcohol (11) | Violence (9) and Mental Illness (9) |

ACEs Infographics

John Godfrey Saxe's (1816-1887) version of the famous Indian legend

It was six men of Indostan
To learning much inclined,
Who went to see the Elephant
(Though all of them were blind),
That each by observation
Might satisfy his mind.

The First approach'd the Elephant,
And happening to fall
Against his broad and sturdy side,
At once began to bawl:
"God bless me! but the Elephant
Is very like a wall!"

The Second, feeling of the tusk,
Cried, -"Ho! what have we here
So very round and smooth and sharp?
To me 'tis mighty clear
This wonder of an Elephant
Is very like a spear!"
The Third approached the animal,
   And happening to take
The squirming trunk within his hands,
   Thus boldly up and spake:
"I see," quoth he, "the Elephant
   Is very like a snake!"

And so these men of Indostan
   Disputed loud and long,
Each in his own opinion
   Exceeding stiff and strong,
Though each was partly in the right,
   And all were in the wrong!

MORAL.
   So oft in theologic wars,
The disputants, I ween,
   Rail on in utter ignorance
Of what each other mean,
_And prate about an Elephant
Not one of them has seen!

Trauma-Informed Connection for School Psychologists:
It’s easy for people to jump to conclusions about those around them. When working with students who may have traumatic backgrounds, it is important to view them with open eyes and let them explain who they are, rather than blindly jumping to conclusions.
## 2016-2017 DASP Board Members

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