Principal's Research Review

Supporting the Principal's Data-Informed Decisions

ISSN 1558-5948 VOL. 8, ISSUE 6 NOVEMBER 2013

The Role of Schools in Supporting Traumatized Students

By Eric Rossen and Katherine Cowan

Childhood trauma is among the most relevant and significant psychosocial factors affecting education today (Blaustein, 2013). The effects of those traumas are far reaching, with the potential to influence students, families, educators, and the overall school culture. Exposure to adverse experiences and childhood traumas poses a significant risk to student learning and mental health and is far more pervasive than previously thought. Whether the trauma is the result of chronic adverse experiences (e.g., neglect) or an acute crisis event (e.g., a tornado), schools play a crucial and unique role in mitigating the effects of adversity, stress, and trauma on students.

Given the large influence that schools have on the lives of youth, their responsibility for supporting the social and emotional development of students should not be overlooked. Schools are well-suited to offer an ongoing presence of trained, caring, stable adults; a learning environment that can naturally support and develop resilience and coping skills; and partnerships with families and community providers to help provide comprehensive supports.

Addressing trauma and its related issues is essential to the mission and purpose of schools: learning. Traumatized students are often focused on survival, which hampers their ability to learn, socialize, and develop the skills needed to thrive. Failure to provide adequate infrastructure to support students with trauma histories can undermine academic success. School staff members may also be affected by trauma, both in their roles as caregivers for students and by experiencing a crisis event themselves as part of the school community. As with students, teachers and

Traumatized students are often focused on survival, which hampers their ability to learn, socialize, and develop the skills needed to thrive.

Just the Facts

- Trauma generally results from actual or perceived harm to one's physical, psychological, or emotional well-being; the inability to cope; and some kind of impairment in daily life or functioning (Blaustein, 2013).
- A significant number of students experience adversity in their lives. For example, Copeland, Keeler, Angold, and Costello (2007) found that 68% of children and adolescents experienced at least one potentially traumatic event by age 16 years.
- In one study of traumatized youth, 78% of the children studied reportedly had multiple adversities, with an average initial exposure at age 5 years, suggesting that in many cases, trauma occurs early and repeatedly (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). Those data suggest that virtually every classroom has at least one student who has or is experiencing adversities that can lead to trauma.
- Students are primed to learn when they feel safe, connected and supported at school, and that is best achieved through a whole-school approach (Ristuccia, 2013).
- Communities that are more affected by poverty, homelessness, and other social vulnerabilities may find that the *majority* of students will experience significant stress (Blaustein, 2013).

nassp national association of secondary school principals

other staff members may need additional supports to deal with stressors.

Although individuals react differently to traumas and present with varying degrees of symptoms (or occasionally no outward symptoms), some common and essential elements can help support all students with trauma histories. Such foundational elements include effective principal leadership; consistent access to and availability of school-employed mental health professionals, such as school counselors, school psychologists, and school social workers; dedicated and job-embedded staff training that raises awareness of the consequences of trauma; and the development of effective family and community partnerships.

Defining Trauma

Trauma generally results from actual or perceived harm to one's physical, psychological, or emotional well-being; the inability to cope; and some kind of impairment in daily life or functioning (Blaustein, 2013). Put simply, trauma is an individual's response to stress. Whether an experience results in trauma is subjective and individually determined. In other words, two individuals may go through the same adverse experience and have different responses. It's important to remember that a traumatic reaction is not an attitude or a "choice," but rather a physiological and psychological reaction to stress. Certain factors can influence whether an experience or set of experiences leads to trauma. (See figure 1.)

Distinguishing crisis and trauma. The terms *crisis* and *trauma* are often used interchangeably, but although they overlap, the terms represent different concepts. A crisis is generally an event, experience, or condition that leads to danger or the potential for danger, whereas trauma is the result of an individual's reaction to adversity or stress. Crises or stressful experiences do not necessarily result in trauma for any given individual.

Often crises are referred to as unpredictable and unexpected experiences that result in a lack of time to adjust and adapt (DiRaddo & Brock, 2012). Importantly, crises alone do not cover the range of experiences that could lead to trauma, such as chronic maltreatment or exposure to community violence. This distinction is important when considering how schools can most effectively address the spectrum of trauma needs.

Crisis teams are quite commonly tasked with responding to specific and acute crisis events that affect individuals or the entire school and facilitating a return to "normalcy"; however, the team's role may not address ongoing intervention and longer-term recovery for traumatized students. A school safety team might be tasked to intervene when bullying or school violence occurs, but may not be trained to recognize the signs of trauma that may follow. Similarly the mental health team may be working with students who were referred by teachers and

Figure 1

Factors Impacting Response to Adverse Experiences

Individual Factors	Experience Factors
■ Previous experiences ■ Developmental level ■ Poverty level ■ Parental substance use or mental illness ■ Presence of a disability ■ Community characteristics	■ Physical proximity ■ Severity ■ Availability of social support ■ Availability and quality of intervention services ■ Presence of stigma (e.g., sexual abuse) ■ Chronic (ongoing) or acute (single-event) ■ Interpersonal (e.g., an assault) or noninterpersonal (e.g., a natural disaster)

Figure 2

Common Trauma Symptoms and Related Disabilities and Disorders

Behaviors and Symptoms of Trauma	Related Disability/Disorder
■ Difficulty processing instructions ■ Decreased attention, memory, and focus ■ Reduced executive functioning ■ Difficulty solving problems ■ Difficulty understanding consequences of actions	■ Learning disability/learning disorder ■ Attention Deficit/Hyperactivity Disorder (ADHD)
■ Heightened vigilance ■ Inaccurate perception of danger (i.e., viewing innocuous glances or gestures as threats) ■ Rapid response to perceived threats ■ Self-protective behaviors (e.g., aggression or withdrawal)	■ Anxiety disorder ■ Panic disorder ■ Emotional disability ■ ADHD (Impulsivity) ■ Oppositional Defiant Disorder/Conduct Disorder
■ Interpersonal difficulties (e.g., social withdrawal, difficulty making friends, untrusting)	■ Depression
■ Inconsistent mood ■ Easily overwhelmed or upset	■ Mood Disorder
■ Failure to thrive	■ Developmental Disorder
■ Rigidity and perfectionism	■ Obsessive Compulsive Disorder
■ Need-fulfilling behaviors (e.g., stealing or hoarding food, oversexualized behaviors, overeating, and demanding adult attention)	■ Eating Disorder ■ Sexualized behavior

parents, but may not consider the interplay between trauma and the symptoms associated with various educational disabilities. (See figure 2.) The challenge is to ensure that these services work in concert to prevent students from falling through the cracks and maximize prevention and early intervention for all students. An increasingly common and effective approach is to integrate the school crisis, safety, and mental health teams, all of whom have a student support role, within a multi-tiered support framework that seamlessly provides wellness promotion, prevention, preparedness, and interventions.

Potential sources of trauma. A range of experiences can potentially lead to trauma, including acute, single-event stressors and chronic and ongoing experiences. One well-known and comprehensive study on the impact of trauma, referred to as the Adverse Childhood Experiences study (Felitti et al., 1998), identified nine stressors across three areas: abuse, neglect, and household dysfunction. But numerous other experiences can lead to trauma, including but not limited to immigrant or refugee status; homelessness; exposure to community, school, or domestic violence; the death of a loved one; bullying or harassment; and natural disasters or terrorism. Importantly, what makes any of these experiences *traumatic* is the individual reaction rather than the experience itself.

Prevalence. A significant number of students experience adversity in their lives. For example, Copeland, Keeler, Angold, and Costello (2007) found that 68% of children and adolescents experienced at least one potentially traumatic event by age 16. More recently, the National Survey of Children's Health (Child and Adolescent, 2012) revealed that approximately 35 million children have had at least one adverse experience that could lead to childhood trauma. Other studies have found that more than 70% of children between the ages of 2 and 17 report being victimized within the past year (for example, by assault, theft, or maltreatment), with the majority reporting multiple incidents (Finkelhor, Ormrod, Turner, & Hamby, 2005). Notably, child victimization occurs at a rate more than two times higher than that of adults over the age of 35 (US Department of Justice, 2009). In 2010, child protective services estimated that nearly 700,000 students in the United States were victims of maltreatment (US Department of Health and Human Services, Affairs, 2012). Further, approximately 20% of children in the United States live in poverty, which represents another risk factor for exposure to stress.

To make matters worse, children regularly experience adversities more than once. In one study of traumatized youth, 78% of the children studied reportedly had multiple adversities, with an average initial exposure at age 5, suggesting that in many cases, trauma occurs early and repeatedly (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). Those data suggest that virtually every classroom has at least one student who has or is experiencing adversities that can lead to trauma. Taken further, communities that are more affected by poverty, homelessness, and other social vulnerabilities may find that the *majority* of students will experience significant stress (Blaustein, 2013).

Fortunately, children and youth are incredibly resilient, and the majority of students who experience some adversity will recover. In fact, some estimates suggest that among youth who have had an adverse experience, only 3–15% of girls and 1–6% of boys will develop posttraumatic stress disorder (US Department of Veterans, 2007). Nevertheless, even in the absence of posttraumatic stress disorder, exposure to stress and adversity can affect a student's learning, behavior, and mental health. Access to appropriate supports, including skill building and positive relationships with family, friends, and other caring adults, contributes to natural resilience just as it promotes recovery for more significantly affected individuals. Schools are ideally suited to provide such supports.

Effects of Trauma on Student Learning and Mental Health

The effects of trauma on students are complex and diverse. Generally, those who are exposed to adverse childhood experiences drop out of school at higher rates and have lower academic achievement, higher suspension and expulsion rates, and higher rates of referral for special education. As adults, these same individuals are at increased risk for various health problems (e.g., heart disease, diabetes, liver disease, and obesity) and mental health problems (e.g., substance abuse, depression, and suicide). The impact of trauma also demonstrates a cumulative dose-response relationship, wherein the more adverse experiences an individual has, the worse their outcomes are likely to be.

Trauma can lead to lasting changes in brain structure (e.g., reduced overall size and underdeveloped cortex) and function (e.g., irritability, excitability, and impulsivity). Trauma can also lead to overproduction of the hormones adrenaline and cortisol. Although both of those hormones are typically adaptive in times of stress or threat, overproduction can impede normal development, cognition, memory, and learning. Even more importantly, these hormones can suspend the higher-order skills needed for learning, getting along with others, and succeeding at school.

The symptoms of trauma seen at school can seem very similar to those of various psychiatric disorders and educational disabilities, making it often difficult to distinguish one from the other. Certain behaviors are common to trauma and the various disabilities

and disorders that share similar symptoms. (See figure 2.) Notably, many students experiencing stress and adversity do not display any symptoms at all. Those students are perhaps the most challenging to reach.

Using a Multitiered System of Supports to Help Traumatized Students

The difficulty in properly identifying traumatized students justifies a more universal and preventive trauma-informed approach to supporting students than relying only on intensive targeted interventions for selected students (Substance Abuse and Mental Health, 2012). This is best accomplished through a multitiered system of supports (MTSS).

An MTSS is a continuum of services and supports to students. At one end of the continuum, tier 1 supports are provided to *all* students in the school. These services integrate learning, social and emotional functioning, mental and physical health, and the overall well-being of students. Tier 1 services improve school climate and conditions for learning and all school staff members play a role. Examples of tier 1 initiatives include schoolwide bullying or violence prevention efforts, school lunch and physical activity programs, modifications to discipline practices, or positive behavior supports. Through MTSS, those efforts are evaluated and used to identify students who are not benefitting from tier 1 supports or who are at increased risk of difficulties. At the other end of the continuum (i.e., tiers 2 and 3), intensive and individualized interventions are provided on the basis of the needs of a particular student or students.

Students are primed to learn when they feel safe, connected, and supported at school, and that is best achieved through a whole-school approach (Ristuccia, 2013). Traumatized youth often feel that their safety is compromised and lack a sense of connectivity and trust at school. Tier 1 efforts can help provide the safe and supportive environment that students with trauma histories need in order to learn, and MTSS overall promotes resilience. More-intensive interventions and supports in tiers 2 and 3 can help those students with more significant needs. Such interventions could include individual or small group interventions at school and coordination with community-based service providers.

The MTSS model is not a program; instead, it is a framework for offering services in schools that meet the learning and mental health needs of all students. It allows for the integration of efforts on closely related issues (e.g. safety, mental health, and behavior) from the school staff members who provide relevant student and learning support services. This continuum also aligns well with best practices for school crisis management that encompass prevention, preparedness, immediate response, and long-term recovery, including the PREPaRE School Crisis Prevention and Intervention Training Curriculum developed by the National Association of School Psychologists (Brock, 2011; Reeves et al., 2011) and the US Department of Education's (2013) joint guidance for emergency planning.

Principal's Research Review is a publication of NASSP, 1904 Association Dr., Reston, VA 20191-1537. Telephone 703-860-0200. Fax 703-476-5432. Website www.nassp.org.

NASSP dues include the annual subscription rate of $50; individual subscriptions are not available. NASSP members can download this issue at www.nassp.org/prr.

Cultural and Developmental Considerations

Schools should regularly consider cultural differences when interpreting and assessing the effects of stress and trauma on students. Given the subjectivity of trauma, an individual reaction can depend largely on the lens through which the experiences are viewed. For example, domestic violence may be more tolerated in some cultures in which women are viewed as inferior or in which their role may be to avoid public shame and to keep the family together (Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; Robinson, 2003). In this example, differences in related cultural norms can affect the willingness to disclose experiences to others, the expression of traumatic stress, and whether the individual experiences trauma to begin with (Stamm & Friedman, 2000). Similarly, understanding the cultural context within which a student may have experienced a potentially traumatic event is necessary to effectively encouraging help-seeking behaviors, improving acceptance and collaboration with families, and adapting interventions to be most comfortable and acceptable for the student.

Schools also need to respond somewhat differently depending on the developmental level of the students. Younger students may not have the language skills or social networks that older students do and may instead rely a great deal on their parents and educators for protection and security. Conversely, older students can rely on their language skills and peers to help process experiences. Further, given that different developmental periods are associated with the development of different structures of the brain (e.g., the hippocampus during childhood and the frontal cortex during adolescence), trauma at any given time can have the greatest effect on that particular developing brain structure.

Crises That Affect the School Community

Although trauma is an individual reaction, educators must be prepared for the effect that crises can have on the entire school community. Such crises come unexpectedly and in many forms that can deeply touch or even engulf the community. The past school year (2012–2013) saw an extraordinary series of large scale events with Hurricane Sandy, the Newtown shootings, the Boston bombings, and the tornadoes in Oklahoma. More commonly, though, schools deal with such crises as the accidental or unexpected death or suicide of students or staff members, gang violence, or destructive weather events that do not rise to the level of an F5 tornado. For schools that are significantly affected, response and recovery requires the engagement of a system that is very likely under extreme stress. Depending on the nature and magnitude of the event, recovery can take months, even years, and the trajectory for individuals will vary tremendously. Therefore, a school's response to tragedy, much like an individual response, is subjective and dependent on multiple contextual and experiential factors, such as proximity, the number of individuals affected, and the level of disruption to the daily functioning of the school community. A school's capacity to meet the confluence of needs and mitigate trauma reactions in the event of a crisis will almost always reflect the functionality of the safety, crisis, and mental health resources that were in place before the crisis occurred.

Conclusion: Key Principles of Minimizing the Effects of Trauma

Schools have a critical role in supporting students with trauma histories. Despite the unique and subjective nature of trauma, some important underlying themes emerge:

- Many students experience serious stress or adversity at some point during their school careers, and in many cases, the risk occurs early and repeatedly; however, only a small portion of those individuals develop trauma or full-blown pathology.
- Many students have trauma histories that go unrecognized in school, which negatively affects their ability to learn, form relationships, and thrive.

- School-centered crises are rare and not the most common cause of trauma among students. Schools must be prepared for crises, however, and the quality of their responses will be dictated to some degree by the capacity of their ongoing safety, crisis, and mental health services.
- Schools have an opportunity to provide a range of supports to students who experience stress or trauma through an MTSS approach. More specifically, these approaches can help *all* students feel safe, supported, and connected, including those with undisclosed trauma histories. Schools employing MTSS also provide regular staff training, empower all educators to provide supportive environments, develop strong family-school-community relationships, and offer adequate access to school-employed mental health professionals. PRR

References

- Bauer, H., Rodriguez, M., Quiroga, S. S., & Flores-Ortiz, Y. (2000). Barriers to health care for abused Latina and Asian immigrant women. *Journal of Health Care for the Poor and Underserved*, *11*, 33–44.
- Blaustein, M. (2013). Childhood trauma and a framework for intervention. In E. Rossen and R. Hull (Eds.). *Supporting and educating traumatized students: A guide for school-based professionals* (pp. 3–21). New York, NY: Oxford University Press.
- Brock, S. (2011). *WS2: PREPaRE: crisis intervention & recovery: The roles of the school-based mental health professional*, (2nd ed.). Bethesda, MD: National Association of School Psychologists.
- Child and Adolescent Health Measurement Initiative. (2011/12). National survey of children's health. [Data Query]. Retrieved from www.childhealthdata.org/browse/survey?q=2257&r=1.
- Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (Eds.) (2003). Complex trauma in children and adolescents. Retrieved from the National Child Traumatic Stress Network website: www.nctsn.org/sites/default/files/assets/pdfs/ComplexTrauma_All.pdf
- Copeland, W. E., Keeler, G., Angold, A., Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, *64*(5), 577–584.
- DiRaddo, J. D., and Brock, S. E. (2012, May). Is it a crisis? *Principal Leadership*, *12*(9), 12–16.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V.,…Marks, J. S. (1998). The relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *14*, 245–258.
- Finkelhor, D., Ormrod, R. K., Turner, H. A., & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment*, *10*, 5–25.
- Reeves, M., Nickerson, A., Conolly-Wilson, C., Susan, M., Lazzaro, B., Jimerson, S., & Pesce, R. (2011). *WS1: PREPaRE: Crisis prevention and preparedness-comprehensive school safety planning*. (2nd ed.). Bethesda, MD: National Association of School Psychologists.

■ Ristuccia, J. (2013). Creating safe and supportive schools for students impacted by traumatic experience. In E. Rossen & R. Hull (Eds.). *Supporting and educating traumatized students: A guide for school-based professionals* (pp. 253–263). New York, NY: Oxford University Press.
■ Robinson, G. (2003). Current concepts in domestic violence. *Primary Psychiatry*, *10*, 48–52.
■ Stamm, B. H., & Friedman, M. J. (2000). Cultural diversity in the appraisal & expression of traumatic exposure. In A. Shalev, R. Yehuda, & A. C. McFarlane (Eds.) *International handbook of human response to trauma* (pp. 69–85). New York, NY: Plenum Press.
■ Substance Abuse and Mental Health Services Administration. (2012). *Trauma definition: Part two: A trauma-informed approach*. Retrieved from www.samhsa.gov/traumajustice/traumadefinition/approach.aspx
■ US Department of Education. (2013). *Guides for developing high-quality school emergency operations plans*. Retrieved from www2.ed.gov/about/offices/list/oese/oshs/emergency-operations-guides.html
■ US Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2012). *Child maltreatment 2011*. Retrieved from www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment.
■ US Department of Justice. (2009). *National crime victimization survey*. Retrieved from www.bjs.gov/index.cfm?ty=dcdetail&iid=245
■ US Department of Veterans Affairs. (2007). *PTSD in children and teens*. Retrieved from www.ptsd.va.gov/public/pages/ptsd-children-adolescents.asp

About the Authors

Eric Rossen is the director of professional development and standards for the National Association of School Psychologists , a nationally certified school psychologist, and coeditor of *Supporting and Educating Traumatized Students: A Guide for School-Based Professionals* (2012, Oxford University Press).

Katherine Cowan is the director of communications for the National Association of School Psychologists.