Chronic Childhood Trauma: Symptoms and Impact

A Meta-Synthesis


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Abstract

This meta-synthesis reviews literature on childhood trauma. While we're beginning to learn more about this vitally important subject, there are still steps that need to be taken. We know that trauma affects millions of kids in the United States. We know that if we address, the effects of many forms of trauma can be undone, or at least eased. We, as a nation, are not placing importance and value on the treatment of trauma in our children. Included in this meta-synthesis are examples of trauma symptoms, explained in terms of what we may see. Also, the importance of early identification of symptoms and treatment despite a possibility of not having a clinical diagnosis.

**1. Introduction**

*1.1 Background*

The word "trauma" can mean different things to different people. Does it mean a serious accidental injury, such as a traumatic brain injury as a result of a car accident? How about trauma from witnessing a loved one die? Can trauma be the right word to describe what a child experiences that is neglected by his caregivers?

Trauma encompasses many things. As defined by Merriam-Webster, trauma as a noun has three meanings. First: an injury to living tissue cased by an extrinsic agent. Second: a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury. Third, an emotional upset. While these definitions give a bit of the picture of trauma, they fail to encompass the many aspects of trauma, as experienced by children.

There are two realms of trauma: acute and chronic. Acute trauma is the result of a one-time event, such as a major injury, unexpected and violent death of a close friend or loved one or even an unexpected, serious illness that requires hospitalization. Chronic trauma occurs over an extended period of time; it is oftentimes at the hands of a caregiver or someone close to the victim. Chronic trauma is what will be referred to in this meta-synthesis.

While crime against male and female children ages 12-18 declined between 1995-2010 (White & Lauritsen, 2003) the number of children who are exposed to violence and traumatic events daily is too high. Direct neglect, physical abuse, mental abuse, emotional abuse and sexual abuse are the most readily thought of contributors to abuse. But there are more. What about observing abuse or violence? Does it make a difference if it seen through a TV screen?

It is bad enough that child trauma is often perpetrated by caregivers; add on that the coping strategies and attachment needed to overcome the trauma is not delivered by that same caregiver. So where can our children turn to? The most readily available place that comes to mind is school. However, I'm a teacher, I haven't seen any instruction on how to help students who have experienced, or are experiencing, trauma. There haven't been any district or school-wide trainings on trauma symptoms and what those children are experiencing on a daily basis. There isn't even a word of compassion for the students in staff meetings.

It is with high hopes that I look forward to the current spotlight that is starting to shine on trauma. Our children deserve better.

*1.2 Introduction: Author's beliefs and experiences*

I've wanted to be a teacher since I was in preschool. I took a somewhat unconventional route in achieving this goal. I completed my undergraduate degree in History/Political Science. Afterwards, I moved to Alaska for some adventure. I got a job at a busy restaurant, and worked there for a few years before returning to school. This waitressing job prepared me to work with students and parents in more ways that one would believe. Coming from a small Midwest town, Anchorage was a huge, and sometimes rude, awakening for me.

My first teaching certificate was a General Education Certificate that qualified me to teach kindergarten through 8th grade. When I was told that this would mean spending some time in a middle school, I had to do some serious reflection. I didn't like middle school when I was growing up; middle school didn't really like me either. However, I wanted to be a teacher, so I bit the bullet and set up my practicum at a middle school.

Within ten minutes of walking into that middle school, my previous elementary dreams flew out the window. The students' awkwardness, excitement, humor and wide range of desires and emotions are what got me. I enjoy 7th and 8th graders. They can tie their own shoes, but aren't complete set in their ways yet.

I ended up seeking a student teaching placement in a middle school and landed in an 8th grade gifted social studies classroom in a small middle school that encompassed an impressive range of students. This school was a lottery school, but also consisted of neighborhood kids and several buses from the nearby military base. Slightly over half of the student population was low income with free or reduced meals; the other half was dropped off and picked up by their parents everyday. I loved this school, the students, teachers and administration. I worked hard to make sure they all wanted me to be there in high hopes of obtaining a position once I completed by teacher preparation program.

I moved back to my home state of Minnesota for a short time, but upon my return to Alaska I substitute taught at Central as often as possible. After a few months, the Principal approached me and asked if I would be interested in teaching Special Education. I talked to

many teachers (special education and general education), did some soul searching, and ultimately decided to give it a go.

Similarly to my conversion to middle school, walking into my first Special Education classroom was a life-changing event. These were difficult students, I was their third teacher of the year, not counting the multitude of substitute teachers who'd come and gone. Winter break had just ended. Between the multitude of behaviors, learning IEP paperwork, attending (and running) meetings, taking Special Education classes and being a first time teacher, it was difficult. Despite all of this, there was not one day that I left school thinking "I don't like this, I don't want to go back."

As I've continued to teach, I've noticed that I naturally gravitate towards the students that other teachers don't seem to enjoy working with. The students who exhibit behaviors that make teachers want to pull their hair out. Students who seem to do everything they can to push teachers away, refuse to accept help or do their work and have very poor confidence in their abilities (not just academically abilities). These students intrigue me, I want to know more about them, I want to help them figure out whatever it is that is ailing them; that makes them push and poke at everyone and everything around them.

It is being drawn to these students and beginning to ask questions about who they are, what they've been through, what makes them tick and what they want in life that has drawn me to the purpose of my research for this meta-synthesis.

I originally began to get enticed to look deeper into these students when I read *The Boy Who Was Raised As a Dog* by Bruce D. Perry (2007). The way our brains work and respond to

trauma (such as neglect, rather than an acute trauma like a brain injury) is fascinating and has

such great implications on every aspect of our lives. Through reading this book, I learned the

basics of trauma. When I finished the book, I had many more questions than answers, some of

which have helped form the basis for this research.

With this meta-synthesis, I hope to begin to uncover answers to the following research

questions:

1. What is trauma?

2. What are the physiological factors or signs of trauma? (i.e. what does it *look* like?)

3. How can we help children who do not have a clinical diagnosis of Posttraumatic

   stress disorder (PTSD) or other related diagnosis?

*1.3 Purpose of this meta-synthesis*

As a Special Education teacher, I have the opportunity to see students in smaller groups

and interact in more one on one settings. During these times, I have seen that children exhibit

symptoms of stress and trauma quite frequently. When I first stated discovering this, I incorrectly

thought that Special Education teachers worked with the students who have experience trauma

considerably more than general education teachers. After the briefest research, it became quite

obvious that all teachers work with students who have experienced trauma. Although there are

higher incidences of trauma within certain demographics, the truth is, trauma knows no bounds.

The other hard and fast truth that regularly zips through my brain: trauma is completely

preventable.

When students are experiencing trauma, their brain is actually functioning differently. Perry (2007) discussed the effects of fear, which he states is "our most primal emotion" (p. 64) on the developing brain. The human brain is not done developing when a child is born; it continues to develop well into the late teen and early twenty years. It is this miraculous and continual development that also allows our brains to succumb to the negative impacts of trauma as well. As Perry explains throughout his book (and many other researchers do as well), there are real, lasting changes in the brain as a direct result of trauma. It is these cold, hard facts that make it so imperative for those who work with children to be able to spot the symptoms of trauma and be able to identify ways to help the child.

Maslow's hierarchy of needs offers an easy way to explain what happens when children have experienced trauma, but are still expected to perform at full academic capacity in school. In Maslow's hierarchy, physiological needs come first; we need food and water to survive. Second on the list, is safety. If a child does not feel safe, their body goes into what is often called "fight or flight" mode. When kids are in fight or flight mode, their brain is turned off to all things except keeping themselves safe. When you aren't sure if you have a safe place to go home to, the preamble of the constitution doesn't really matter. If we continue up through Maslow's hierarchy, belongingness and love needs are the third step, while esteem needs are the fourth. If you've met and worked with children who have experienced trauma, its quite visible when their self-esteem is low, and when they don't have someone providing them love and letting them know they are wanted. These "touchy feely" things matter, they are what provide the child with the safety and security that tells their brain that its okay to relax, and to allow new knowledge in.

The original design of this meta-synthesis was going to be in regards to what is current best practice for teachers and schools to help children who have experienced trauma. Unfortunately, my findings came up short. While there are a few studies that have looked into intervention programs, they were often run by clinicians or assistants, which is unrealistic for public education teachers and their students.

So I stepped back a bit. If it's hard to find intervention programs that have been tried in public education, where can we start? Recognizing what trauma looks like, is the first step. What does it look like? How does it manifest? Trauma is not like a fractured arm, you can't see the trauma sticking out like a bone. More importantly, what trauma looks like in one child, may be completely opposite for how it looks in the child sitting next to him.

## 2. Methods

### 2.1 Selection Criteria

The 38 journal articles included in this meta-synthesis met the following selection criteria:

1.     The articles explored the symptoms of trauma in children in the United States who were not currently in a residential program.

2.     The articles focused on various sources of chronic, complex trauma. Articles that examined trauma and traumatic stress that did not fit the Post Traumatic Stress criterion as set by the DSM-IV were included in the search. Articles that focused on one-time (acute trauma), international terrorism, natural disasters, military related trauma, refugees, grief, eating disorders, sexual orientation, diseases, chronic illness or aging were excluded from this meta-synthesis.

3.      The articles were published in peer reviewed journals related to the field of education and social sciences (e.g., psychology.)

4.      The articles were published between 2000 and 2015.

5.      The articles were written in English.

*2.2 Search Procedures*

Database searches and hand searches were conducted to locate articles for this meta-synthesis.

*2.2.1 Database Searches*

I conducted Boolean searches within the Educational Resources Information Center (ERIC, Ebscohost) using these specific search terms:

1. (Children) AND (symptoms of trauma) NOT (military) NOT (aging) NOT (refugees) NOT (natural disasters) NOT (sexual orientation) NOT (foreign countries) NOT (sexual abuse) NOT (accidents) NOT (residential) NOT (terrorism) NOT (diseases) NOT (chronic illness) NOT (grief) NOT (eating disorders).

These database searches yielded a total of 38 articles (Aideuis, 2007; Becker & Kerig, 2011; Bell et al., 2013; Berkowitz et al., 2011; Bogat et al., 2006; Briere et al., 2001; Brosky & Lally, 2004; Chapman et al., 2001; Cortes et al., 2005; Cruise et al., 2007; De Arellano et al., 2008; DePrince et al., 2009; English et al., 2005; Finkelhor et al., 2006; Fitzgerald & Cohen, 2012; Flannery et al., 2004; Ford et al., 2011; Goldstein et al., 2011; Goodkind et al., 2010; Graham-Bermann et al., 2009; Griffin et al., 2011; Jones, 2007; Jovanovic et al., 2011; Kataoka et al., 2009; Kerig et al., 2011; Lang et al., 2004; Lewis et al., 2012; Milot et al., 2010; Nuget et

al., 2006; Richards et al., 2004; Runyon et al., 2002; Runyon et al., 2009; Saltzman et al., 2006; Saul et al., 2008; Singer et al., 2004; Sullivan et al., 2004; Toth & Manly, 2011; Turner et al., 2011.)

*2.3 Coding procedures*

I used a coding form to categorize the information provided in each of the 38 articles included in this meta-synthesis. The coding form was based on: (a) publication type, (b) article focus, (c) research design, (d) participants, (e) data sources, (f) assessments used, and (g) findings.

*2.3.1 Publication type*

Each journal article was evaluated and categorized by its publication type. There were three publication types included in the results of my searches: literature reviews, theoretical articles and case studies. *Literature reviews* are critical evaluations of material that have already been published. Literature reviews include research syntheses and meta-analyses. *Theoretical articles* exist to expand, refine, construct, present, point out flaws or demonstrate an advantage of a theory over another. Theoretical articles draw on existing research (APA, 2010, p. 10). *Case Studies* illustrate a problem, provide a solution and/or point out that research still needs to be conducted. They are reports generated from working with an individual, group, community or organization (APA, 2010, p. 10). The publication type of these articles can be found in Table 1.

*2.3.2 Article Focus*

Anyone, regardless of age, race, sex, etc., can experience trauma. As such, there are a multitude of articles surrounding trauma that aren't directly linked to the research in this

meta-synthesis. The article focus looks at who the article looks at (children or adults) and what form of trauma they examine, if it is specified. The article focus can be found in Table 1.

*2.3.3. Research Design*

Each case study was classified by research design. *Qualitative* research uses language to explore and explain issues. *Quantitative* uses numbers to provide information. *Mixed methods* signifies that both qualitative and quantitative methods were used to present information.

*2.3.4. Participants, data sources, assessments and findings*

The information regarding participants within the studies is gathered from the studies themselves. The amount of information in the participant section was extensive or very basic depending on what was provided within the study. The data studies, for example observations, assessments, questionnaires, are also identified. As there are a multitude of assessments used to evaluate academics, stress, poverty, trauma, abuse, mental health, etc., I've included a section titled assessments in Table 2. This provides a quick glance at the assessments used within the study. Finally, the findings of each study are included in Table 2.

*2.4 Data analysis*

I used a modified version of the Stevick-Colaizzi-Keen method previously used by Duke (2011) to analyze the 38 articles used in this meta-synthesis. Recurring themes was first identified within each article. The recurring themes that were found throughout the 38 articles are: (a) the visible symptoms of trauma; (b) the types and causes of trauma; (c) trauma's impact on development and the brain; (d) importance of early intervention; (e) importance of addressing symptoms even in the absence of a clinical diagnosis. From these themes, I compiled a list of

statements that supported the meanings behind the recurring themes. All 38 articles have been

represented in these formulated meanings, found in Table 3.

**3. Results**

*3.1 Publication type*

I located 38 articles that met my selection criteria. The publication type of each article is

located in Table 1. Two of the 38 articles (5.3%) were literature reviews (Aideuis, 2007;

Fitzgerald & Cohen, 2012). Three of the 38 articles (7.9%) reviewed for this meta-synthesis were

theoretical articles (Bell et al., 2013; De Arellano et al., 2008; Toth & Manly, 2011). 33 of 38

articles (86.8%) used in this meta-synthesis were case studies (Becker & Kerig, 2011; Berkowitz

et al., 2006; Bogat et al., 2006; Briere et al., 2001; Brosky & Lally, 2004; Chapman et al., 2001;

Cortes et al., 2005; Cruise et al., 2007; DePrince et al., 2009; English et al., 2005; Finklhor et al.,

2006; Flannery et al., 2004; Ford et al., 2011; Goldstein et al., 2011; Goodkind et al., 2010;

Graham-Bermann et al., 2009; Griffin et al., 2011; Jones, 2007; Jovanovic et al., 2011; Kataoka

et al., 2009; Kerig et al., 2011; Lang et al., 2004; Lewis et al., 2012; Milot et al., 2010; Nuget et

al., 2006; Richards et al., 2004; Runyon et al., 2002; Runyon et al., 2009; Saltzman et al., 2006;

Saul et al., 2008; Singer et al., 2004; Turner et al., 2011).

**Table 1**

| Author(s) & Year of Publication | Publication Type | Article Focus |
|---|---|---|
| Aideuis, 2007 | Literature Reviews | Children with Complex Trauma Disorder; promoting attachment and emotional regulation |
| Becker & Kerig, 2011 | Case Study | Male adolescents; PTS symptoms relation to frequency and severity of delinquency |
| Bell et al., 2013 | Theoretical Article | Trauma in Classroom |

| Berkowitz et al., 2011 | Case Study | Youth at risk for PTSD; Secondary prevention |
|---|---|---|
| Bogat et al., 2006 | Case Study | Infants; trauma symptoms post IPV exposure |
| Briere et al., 2001 | Case Study | Young Children; trauma system checklist reliability |
| Brosky & Lally, 2004 | Case Study | Juvenile delinquents; prevalence of trauma, PTSD & dissociation |
| Chapman et al., 2001 | Case Study | Pediatric Acute Trauma patients; art therapy effectiveness on reducing PTSD |
| Cortes et al., 2005 | Case Study | Traumatized pediatrics; anxiety disorders |
| Cruise et al., 2007 | Case Study | Female juvenile offenders; mental health screening |
| De Arellano et al., 2008 | Theoretical Article | Ethnic Minorities with trauma related problems |
| DePrince et al., 2009 | Case Study | Children; Executive function performance and trauma |
| English et al., 2005 | Case Study | Children; maltreatment chronicity |
| Finkelhor et al., 2006 | Case Study | Children; peer & sibling violence |
| Fitzgerald & Cohen, 2012 | Literature Review | School age children; trauma-focused Cognitive Behavior Therapy |
| Flannery et al., 2004 | Case Study | Children; impact of exposure to violence in school on mental health & behavior |
| Ford et al., 2011 | Case Study | Outpatient Psych Patients; IPV, abuse, non-victimization trauma |
| Goldstein et al., 2011 | Case Study | Adolescents in child welfare; PTS symptoms and substance abuse |
| Goodkind et al., 2010 | Case Study | American Indian Youth in schools; Cognitive Behavioral Intervention for Trauma |
| Graham-Bermann et al., 2009 | Case Study | Children exposed to IPV; resilience and psychopathology |
| Griffin et al., 2011 | Case Study | Children in Child Welfare System |
| Jones, 2007 | Case Study | African American Children; exposure & resilience to chronic community violence |
| Jovanovic et al., 2011 | Case Study | Children of abused mothers; increased physiological markers |
| Kataoka et al., 2009 | Case Study | Latino Youth; violence exposure, PTSD & English language fluency |
| Kerig et al., 2011 | Case Study | Juvenile delinquents; sensitivity & specificity of detecting trauma with MAYSI-2 |
| Lang et al., 2004 | Case Study | Female adult survivors of childhood maltreatment; adult psychopathology & IPV |
| Lewis et al., 2012 | Case Study | Youth/parent dyads; youth witnessed violence |
| Milot et al., 2010 | Case Study | Maltreated Preschoolers |
| Nuget et al., 2006 | Case Study | Acute trauma pediatric patients; in-hospital vital signs as predictors of PTSD severity |

| Richards et al., 2004 | Case Study | Urban African American Adolescents; risky and protective contexts & exposure to violence |
|---|---|---|
| Runyon et al., 2002 | Case Study | Maltreated children with & without depression; differential symptom pattern of PTSD |
| Runyon et al., 2009 | Case Study | Parent-child dyads; Combined parent-child therapy |
| Saltzman et al., 2006 | Case Study | Children exposed to IPV; Relationship between IQ & PTS symptoms |
| Saul et al., 2008 | Case Study | Adolescents; DSM-IV PTSD criteria's fit to real life trauma experiences |
| Singer et al., 2004 | Case Study | Children; Effects of exposure to violence, parental monitoring and tv viewing on trauma |
| Sullivan et al., 2004 | Case Study | Abused children & their abused mothers; conjoint interventions program evaluation |
| Toth & Manly, 2011 | Theoretical Article | Maltreated Children; Bridging research & practice |
| Turner et al., 2011 | Case Study | Children; type & location of peer victimization |

*3.2 Research design, participants, data sources, assessments and findings of the studies*

34 of 38 articles (86.8%) used in this meta-synthesis were case studies (Becker & Kerig, 2011; Berkowitz et al., 2006; Bogat et al., 2006; Briere et al., 2001; Brosky & Lally, 2004; Chapman et al., 2001; Cortes et al., 2005; Cruise et al., 2007; DeArellano et al., 2008; DePrince et al., 2009; English et al., 2005; Finklhor et al., 2006; Flannery et al., 2004; Ford et al., 2011; Goldstein et al., 2011; Goodkind et al., 2010; Graham-Bermann et al., 2009; Griffin et al., 2011; Jones, 2007; Jovanovic et al., 2011; Kataoka et al., 2009; Kerig et al., 2011; Lang et al., 2004; Lewis et al., 2012; Milot et al., 2010; Nuget et al., 2006; Richards et al., 2004; Runyon et al., 2002; Runyon et al., 2009; Saltzman et al., 2006; Saul et al., 2008; Singer et al., 2004; Sullivan et al., 2004; Turner et al., 2011). The research design, participants, data sources, assessments and findings of the studies can be found in Table 2.

*3.2.1 Research Design*

31 of 34 articles were quantitative (Becker & Kerig, 2011; Bogat et al., 2006; Briere et al., 2001; Brosky & Lally, 2004; Chapman et al., 2001; Cortes et al., 2005; Cruise et al., 2007; DePrince et al., 2009; English et al., 2005; Finklhor et al., 2006; Flannery et al., 2004; Ford et al., 2011; Goldstein et al., 2011; Goodkind et al., 2010; Graham-Bermann et al., 2009; Griffin et al., 2011; Jones, 2007; Jovanovic et al., 2011; Kataoka et al., 2009; Kerig et al., 2011; Lang et al., 2004; Lewis et al., 2012; Nuget et al., 2006; Richards et al., 2004; Runyon et al., 2002; Runyon et al., 2009; Saltzman et al., 2006; Saul et al., 2008; Singer et al., 2004; Sullivan et al., 2004; Turner et al., 2011). One of the 34 articles that consisted of case studies was mixed methods (Berkowitz et al., 2006). Two of the 34 articles that were case studies were qualitative in nature (DeArellano et al., 2008; Milot et al., 2010;).

### 3.2.2 Participants

A majority of the 34 case studies included in this meta-synthesis analyzed data gathered from/about children. 26 of 34 (76.5%) (Becker & Kerig, 2011; Berkowitz et al., 2011; Briere et al., 2001; Brosky & Lally, 2004; Chapman et al., 2001; Cortes et al., 2005; Cruise et al., 2007; DeArellano et al., 2008; DePrince et al., 2009; English et al., 2005; Flannery et al., 2004; Ford et al., 2011; Goldenstein et al., 2011; Goodkind et al., 2010; Griffin et al., 2011; Jones, 2007; Kataoka et al., 2009; Kerig et al., 2011; Lewis et al., 2012; Milot et al., 2010; Nuget et al., 2006; Richards et al., 2004; Saltzman et al, 2006; Saul et al., 2008; Singer et al., 2004; Turner et al., 2011). Seven of the 34 case studies (20.6%) examined data from parents and their children (Bogat et al., 2006; Finkelhor, et al., 2006; Graham-Bermann et al., 2009; Jovanic et al., 2011;

Runyon et al., 2002; Runyon et al., 2009; Sullivan et al., 2004). One of 34 (2.9%) case studies examined data from adults (mothers) only (Lang et al., 2004).

*3.2.3. Findings of the studies*

The findings of the 34 case studies included in this meta-synthesis are summarized as follows:

1.  Children from all ages, races, sexes and socioeconomic statuses experience trauma. The diagnostic tools, as they are set now, may not qualify a student who has experienced trauma and is exhibiting symptoms to be treated. The time frame in which trauma is acknowledged and appropriately dealt with is vital to the child's recover.

2.  Children who experience trauma may undergo physiological changes. When trauma occurs at a young age, the likelihood of it affecting the child's development (of their brain and body) is greater. Trauma affects every aspect of a child's life, from ability to access basic needs, to academic and social aspects as well.

3.  Schools are a logical place for children who have experienced trauma to get help. The chance for continual attendance in therapy or meetings is higher if the students are in school already anyway; transportation to clinics can be hard, financially and time-wise for parents. As teachers see students for a good portion of their day, progress can be monitored and therapy adjusted based on need, symptoms and social/peer interactions. There are significant challenges to providing services in

schools as well. At the top of the list is a lack of financial resources in public

education to fund counselors and therapists in every school.

Table 2

| Authors | Research Design | Participants | Data Sources | Assessments | |
|---|---|---|---|---|---|
| Becker & Kerig, 2011 | Quantitative | 83 adolescent boys in juvenile detention center. Ages: 12-17 years. | Interviews; assessments; review of records | Posttraumatic Stress Disorder Reaction Index (PTSD-RI) | ● There is a correlation between posttraumatic stress symptoms and delinquency.<br>● There appears to be no correlation between delinquency and trauma exposure.<br>● The more early detection put in place, the better for kids and society. |
| Berkowitz et al., 2011 | Mixed Methods | 106 youth; 7-17 years old; exposed to potentially traumatic event who endorsed at least one new and distressing symptom of PTSD. | Questionnaire; Assessments; Interviews. | Trauma History Questionnaire (THQ); Parent Behavior Inventory (PBI); Perceived Social Support – Family (PSS-Fa); UCLA Posttraumatic Stress Disorder Index (PTSD-RI); Behavior Assessment System for Children, Second Edition – Self Report (BASC-2); Child Behavior Checklist (CBCL); PTSD | ● The Child & Family Traumatic Stress Intervention shows promise to be a relevant tool to reduce posttraumatic stress symptoms amongst children within 30 days of a potentially traumatic event.<br>● Compared to a different intervention with the same number of sessions, (but a psychoeducation approach and supportive counseling approach instead) kids were 65% less likely to exhibit posttraumatic stress symptoms. |

| | | | | Checklist – Civilian Version (PCL-C); Trauma Symptom Checklist for Children (TSCC). | |
|---|---|---|---|---|---|
| Bogat et al., 2006 | Quantitative | 48 mothers reported about their 1 year old infants who'd witnessed episodes of Intimate Partner Violence (IPV) during their first year of life. | Assessments; interviews | Toddler Temperament Scale (TTS); Severity of Violence Against Women Scales (SVAWS); Beck Depression Inventory (BDI); PTSD Scale for Battered Women; Infant Traumatic Stress Questionnaire (ITSQ) | ● Mother reported severe IPV was shown to predict trauma symptoms in infants. <br> ● Depression showed no link to trauma symptoms in infants. <br> ● Aside from witnessing violence, infants get a secondary effect by emotional compromised caregiver. |
| Briere et al., 2001 | Quantitative | Caretaker reports of 219 children, mean age: 7.1 | Analysis of Assessment | Trauma Symptom Checklist for Young Children (TSCYC). | ● The clinical scales report good reliability. <br> ● There are 8 clinical scales with the TSCYC, all are about abuse. <br> ● Based on caretaker response, there are validity measures for over and under reporting built in. <br> ● The mood related scales showed no association with child maltreatment. |
| Brosky & Lally, 2004 | Quantitative | 152 adolescents; 76 females; 76 males; 12-18 years old. Referred for | Retrospective survey | Review of records from the Child Guidance Clinic of the Superior Court | ● Females have a higher prevalence of trauma than males. |

| | | Psychological Evaluation from the Superior Court of the District of Columbia | | of the District of Columbia. Incidences of trauma assessed from a compiled checklist; PTSD assessed using the DSM-IV. | ● There is a higher prevalence of PTSD in females. However, only four females and four males met full PTSD criteria. |
|---|---|---|---|---|---|
| Chapman et al., 2001 | Quantitative | 85 adolescents; 7-17 years old; 31 received art therapy, 27 received standard hospital care, 27 presented no baseline PTSD; all in a level 1 trauma center for traumatic injuries; | Assessments, review of records, interviews. | University of California at Los Angeles Post Traumatic Stress Disorder Index – Child or Adolescent version (PTSD-1); University of California at Los Angeles Post Traumatic Stress Disorder Index – Parent version (PTSD-1); Post Traumatic Stress Disorder Diagnostic Scale; Family Environment Scale. | ● This form of art therapy is based on the child telling and re-telling their traumatic experience as a story as an important part of their overall narrative.<br>● There was no considerably change in the kids who partook in art therapy vs the kids who received standard hospital care.<br>● Kids that were involved in this study experience acute trauma only. No children with complex or chronic trauma nor child abuse were allowed in the study. |
| Cortes et al., 2005 | Quantitative | 59 kids; ages 6-14; history of at least 1 traumatic event; 50% receiving | Assessments. | Clinician-Administered PTSD Scale for Children and Adolescents | ● PTSY symptoms may predict future anxiety disorders.<br>● Specifically avoidance/numbing and hyperarousal symptoms. |

| | | | | (CAPS-CA); Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version (K-SADS-PL). | ● Specific PTSD symptoms, even without a PTSD diagnosis, can help predict future diagnosis and issues. |
|---|---|---|---|---|---|
| | | trauma interventions; all currently in safe & stable homes. | | | |
| Cruise et al., 2007 | Quantitative | 145 female detained youth; 12-17 years old; 64.1% African American, 34.5% Caucasian, 1.4% biracial. | Retrospective record review/analysis that utilized assessments, interviews and checklists. | Massachusetts Youth Screen Instrument – Second Version (MAYSI-2); Trauma Symptom Checklist for Children (TSCC); | ● 3 subgroups based on the MAYSI-2 scales<br>→ co-occurring group: 19.3%<br>→ high mental health symptoms: 33.8%<br>→ no symptoms groups: 46.9%<br>● There was no ethnic differences found between groups.<br>● First disposition: older girls mostly fell into the no symptom group , while the younger girls fell in to the high mental health groups.<br>● Groups one and two were significantly higher in anger and trauma related problems. They were also more likely to report past suicide and physical abuse.<br>● Group three may not require additional help follow up. Groups one and two definitely do. |
| De Arellano et al., 2008 | Qualitative | Ethnic minority children | Review of literature | | ● All children experiencing trauma need to be approached with a culturally relevant understanding<br>● INFORMED Approach: |

| | | | | | **I**nvestigate the target population; **N**avigate new ways of delivering assessment services based on study of target population; **F**urther assess extended family and other collaterals; **O**rganize background assessment to better accommodate target populations; **R**ecognize and broaden the range of traumatic events to be assessed; **M**odify types of trauma-related sequelae assessed; **E**valuate the effectiveness of the modified assessment; **D**evelop the assessment based on its evaluation. |
|---|---|---|---|---|---|
| DePrince et al., 2009 | Quantitative | 110 children; mean age of 10.39. Parentlly identified as being exposed to potentially traumatic events | Battery of assessments and checklists | Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV); Gordon Diagnostic System (GDS); Brief Test of Attention (BTA); UCLA PTSD Index; Child Dissociative Checklist; DSM-Anxiety Problems Scale of the Child | ● Did NOT address potentially important links between trauma and other executive functions that are critical to goal-directed behaviors like working memory, inhibitions and processing speed (354.) <br> ● While resources are more likely to be dedicated when a child is diagnosed with PTSD, studies (like this one) show that children who are exposed to family violence have greater school difficulties – academically and behaviorally. |

| | | | | Behavior Checklist (CBCL). | |
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| English et al., 2005 | Quantitative | 519 children (part of a 2005 LONGSCAN study); all have been reported as maltreated. | Interviews, assessments, checklists. | LONGSCAN; Child Behavior Checklist and Vineland Screener; Trauma Symptom Checklist for children; Child Behavior Checklist (CBCL); Vineland Scales of Adaptive Behavior Scales, screener; Trauma Symptom Checklist – alternate version (TSCC-A). | ● The age of the first report of maltreatment affects child's functioning. The younger the child at the first report, the higher chance she will have problems.<br>● Behavior problems have more to do with the total number of maltreatment incidents and their development timing.<br>● Impairments of socialization functioning do not depend on how any incidents of maltreatment there are, more on the distribution of it over time.<br>● The more developmental periods with maltreatment reports, the more externalizing behavior problems there are likely to be. |
| Finkelhor et al., | Quantitative | 2030 children; 2-17 years old; 1000 children, 1030 caregivers of 2-9 year olds; 51% male; 10% household income under $20,000; 76% white, 11% black, 9% Hispanic, 3.5% other. | Telephone sampling, questionnaires, checklists. | Juvenile Victimization Questionnaire (JVQ); Trauma Symptoms Checklist for Children (TSCC); Trauma Symptom Checklist for Young Children (TSCYC); | ● Despite popular perception of child on child crime being "character building" or less serious because they're not as strong as adults or because the consequences aren't as sever, even low-frequency violence against peers resulted in trauma symptoms.<br>● While less serious, sibling violence actually produces more symptoms (especially in younger kids.) This is most likely due to the chronic nature of sibling violence. |

| Flannery et al., 2004 | Quantitative | Used data from two studies: 5969. First group: grades 3-8; second group grades 9-12. | Interviews, questionnaires, assessments. | Trauma Symptom Checklist for Children (TSC-C). | ● Students who were exposed to more violence at school reported higher levels of psychological trauma symptoms (p. 54). <br> ● More older kids (middle school and up) report witnessing more violence. Younger kids report being victimized more. <br> ● Males are victimized 10-15% more than females. <br> ● Middle School students have the highest rates of being threatened. <br> ● Trauma is higher in girls, younger children, and non-Caucasian youth. <br> ● Higher levels of exposure (as a witness and as a victim) produce higher reporting of symptoms. <br> ● Students in high-violence exposure schools had higher rates of clinically significant trauma symptoms. |
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| Ford et al., 2011 | Quantitative | 114 consecutive children admissions to a child & adolescent outpatient psychiatry clinic | Chart review & data analyses | | ● Exposure to interpersonal violence (not just abuse) should be considered in assessment and treatment for children receiving outpatient care <br> ● Larger samples need to be studied to examine the relationship between interpersonal violence and severity of internalizing disorders |
| Goldstein et al., 2011 | Quantitative | 253 youth/emerging adults; ages 15-20 who were involved | Battery of Assessments, checklists, questionnaires | Child Trauma Questionnaire – Short Form (CTQ-SF); Trauma | ● There was a correlation between alcohol use and PTSD/PTSS lower than the community statistics (this could be due to |

| | | with child welfare. 61.4% female. | | Symptoms Checklist for Children (TSCC); Ontario Student Drug Use Survey (OSDUS); Alcohol Use Disorders Identification Test (AUDIT); CRAFFT | these children knowing a caseworker has a close eye on them.)<br>● There was more illicit drug use than in the community, statistically.<br>● There was an increase in drug and alcohol use in the year after leaving the Child Welfare system.<br>● Dissociation and anger are two of the biggest predictors of alcohol and drug use. |
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| Goodkind et al., 2010 | Quantitative | 23 American Indian children ages 12-15, all of whom have experienced clinically significant levels of both violence exposure and PTSD symptoms | Assessments | Cognitive Behavioral Intervention for Trauma in Schools (CBITS) | ● The CBITS was adapted to fit American Indian culture; it has positive effects on American Indian youth in grades 6-8<br>● After six months, many symptoms had returned to baseline; a possible reason could be that there is continual new trauma<br>● CBITS is for acute trauma, not chronic<br>● Made to be school based because of higher chances of attendance in program and it is easier to work with kids. Possible negatives of working in schools: stigmatizing, it can be expensive in time, people and money. |
| Graham-Bermann et al., 2009 | Quantitative | 219 children and their mothers; children: 6-12 years old; children were exposed to IPV within the last year. 109 boys, 110 girls. Most lived within the | Interviews, checklists, assessments. | Child Behavior Checklist (CBCL); Child Depression Inventory (CDI); Harter Perceived Self-Competence Scales for Children; Conflict Tactic Scales (CTS); | ● Maternal health is a significant factor in children's resilience.<br>● Patterns that have been drawn from past shelter studies apply to community settings as well.<br>● One-size fits all therapy is not sufficient for children with trauma.<br>● Parental therapy and teaching parenting strategies and coping and safety skills for |

| | | community, very few were currently living in shelters. | | Family Fears and Worries Scales (FWS); Beck Depression Inventory; Posttraumatic Stress Scale for Family Violence; Anxiety and Parental Childrearing Styles Scale (APCSS); McMaster Family Assessment Device (FAD) | children is key for children's success in IPV households.<br>● Children fall in to four clusters:<br>  → Severe Problems: 24%<br>  → Struggling: 45%<br>  → Depressed: 11%<br>  → Resilient: 20% |
| --- | --- | --- | --- | --- | --- |
| Griffin et al., 2011 | Quantitative | 14,103 Children in Child Welfare. Ages 0-17 | Assessment and Analysis of assessments | Child and Adolescent Needs and Strengths (CANS) | ● Mental Health screenings must include trauma<br>● Evidence-based, trauma-focused treatment must be administered<br>● Clinicians should not diagnose a youth in child welfare with a mental illness without first addressing the impact of trauma |
| Jones, 2007 | Quantitative | 71 African American Students; 9-11 years old; 56% girls. | Interviews, questionnaires, assessments. | Children's Report of Exposure to Violence-Revised (CREV-R); Angie/Andy Cartoon Trauma Scales (A/A CTS); Kinship Social Support Measure; | ● Formal kinship (in include non-relatives) and spirituality help provide true coping measures to children.<br>● Africentric combines formal kinship, informal and spirituality.<br>● When the Africentric score is high, PTSD symptoms are shown to be decreased and coping skills are shown to be increased. |

| | | | | spirituality questionnaire; Africentric support score. | |
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| Jovanovic et al., 2011 | Quantitative | 36 children and their mothers; mothers ages: 18-65, primary caretaker of a 6-13 year old. Mother exclusions: active psychosis, bipolar disorder, suicide ideation or significant medical illness. Child exclusions: autism, bipolar disorder, psychotic disorder or cognitive disability. | Questionnaire, checklists, assessment, interviews. | Structured Clinical Interview for DSM-IV; Childhood Trauma Questionnaire (CTQ); PTSD Symptom Scale (PSS); Beck Depression Inventory (BDI); Traumatic Events Screening Inventory Parent Report (TESI). | ● Maternal childhood physical abuse is associated with heightened dark-enhanced startle in their children during the initial phase of the experiment. <br>● Maternal childhood emotional abuse is associated with heightened sympathetic nervous system activity in their children. |
| Kataoka et al., 2009 | Quantitative | 1601 latino students; 6-8 years old; from socio-economically disadvantaged areas in Los Angeles; 47% female. | Self-reports, interviews, assessments. | Life Events Scale (LES); Child Posttraumatic Symptom Scale (CPSS); | ● Students who report higher English fluency also reported higher PTSD symptoms, great exposure to trauma and more avoidance and re-experiencing. Important to note, that students self-stated their fluency level with a likert response to "How well do you speak English?" Measures were available in English and |

| | | | | | Spanish and were administered by bilingual bicultural clinicians.<br>● In school services would fit this population the best. |
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| Kerig et al., 2011 | Quantitative | 498 Youth in a juvenile detention center in the Midwest; 337 boys, 161 girls; 12-17 years old. | Assessment | Massachusetts Youth Screen Instrument – Second Version (MAYSI-2); UCLA Posttraumatic Stress Disorder Reaction Index for DSM-IV, Adolescent Version (PTSD-RI); Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA). | ● MAYSI-2 is a good net to cast to see if a child has trauma symptoms. The MAYSI-2 will not self diagnose.<br>● There needs to be a cut off score established to determine when kids need further testing, more help or more specific help.<br>● Girls do report experiencing more trauma than boys. Much of the trauma they report is sexual or physical and is perpetrated by their caretakers, boyfriends or family. |
| Lang et al., 2004 | Quantitative | 42 female victims of IPV; 30 women with no history of serious trauma. 18-57 years old. | Questionnaires, interviews, checklists, assessments. . | Hollingshead Index of Social Status; Childhood Trauma Questionnaire (CTQ); Los Angeles Symptom Checklist (LASC); Dissociative Experiences Scale (DES-T); Center for Epidemiologic | ● Women with a history of IPV had higher levels of psychopathology, reported more current relational aggression and functioned more poorly.<br>● Childhood sexual abuse in past associated with increased anxiety and sensitivity.<br>● Emotional neglect in childhood is associated with more dissociative and depressive symptoms.<br>● More types of childhood maltreatment equal more difficulties for the child. |

| | | | | Studies-Depression Scale (CES-D); Beck Anxiety Inventory (BAI); Anxiety Sensitivity Index (ASI); Conflict Tactics Scale Revised (CTS-2); Short Form 36 (SF-36); Structured Clinical Interview for the DSM-IV (SCID); Clinician Administered PTSD Scale for DSM-IV (CAPS). | |
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| Lewis et al., 2012 | Quantitative | 766 Dyads – children were 12 years old | Analysis of assessment | Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) | ● Youth reported violence equates a higher frequency and number of symptoms – regardless of parents reporting<br>● There is a large discrepancy between the 42% of children reporting witnessed violence and the 15% of their parents reporting it as well. |
| Milot et al., 2010 | Qualitative | 23 maltreated children<br>62 non-maltreated children<br>All children: 46-72 months; from | Assessments; checklists | Parent-Child Conflict Tactic Scale (CTSPC); Trauma Symptoms Checklist for Young Children (TSCYC); | ● Trauma-related symptoms from early maltreatment may trigger the development of psychosocial problems in preschoolers.<br>● Maltreated children are often affected by maltreatment by a caregiver in a 2 fold manner: first, is the abuse/neglect by the |

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| | | economically disadvantaged families; lived with mother (not in foster/other care). | | Child Behavior Checklist 1 ½-5 years Teacher Report Form (CBCL-TRF); | caregiver; second is the lack of attachment to a caregiver and lack of coping skills being taught.<br>● A single traumatic event can be overcome by appropriate response, conditioning or support from their caregiver. |
| Nuget et al., 2006 | Quantitative | 82 children; 56 boys, 26 girls; ages 8-18; all had been admitted to a trauma center. | Review of hospital/EMT records; Assessments; self-reporting. | Injury Severity Scale (ISS); Heart Rate; Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA); Reynold's Child Depression Scale (RCDS); Reynold's Adolescent Depression Scale (RADS). | ● Elevated heart rates – particularly during Emergency Medical Service (EMS) transport – could be used to identify children who are at risk for development of PTSS.<br>● No correlation was found between depression, heart rate and PTSS.<br>● All trauma's in this study were acute. |
| Richards et al., 2004 | Quantitative | 167 children; grades 6-8; 54% girls; African American; from 8 Chicago neighborhoods ranging from dense poverty to middle class; 45% live with their mothers, 33% with | Self-report, assessment, questionnaires, checklists. | Experience Sampling Method (ESM); Things I Have Seen and Heard; Self-Report Delinquency; Achenbach's Child Behavior Checklist; Checklist of Child Distress Symptoms. | ● Unmonitored time, unstructured time and time with peers are related to greater exposure to violence, which is related to an increase in stress and more emotional and behavioral difficulties.<br>● Being with family and in structured environments reduces the exposure to violence.<br>● Notable: children in the study (and elsewhere who live in inner-cities) asked for schools, churches and safe buildings to |

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| | | 2 parents, 5% with father, 17% with grandparents or other. | | | be open later and have relevant activities for them to do. |
| Runyon et al., 2002 | Quantitative | 96 children; 5-17 years old and their parents; 54 females, 42 males; 70% white, 9.2% African American, 10.2% Hispanic, 10.6% unknown. | Assessments. | Children's Schedule of Affective Disorders and Schizophrenia (K-SADS); Children's Depression Inventory (CDI); | ● Nine items reflecting depressive symptomology are what differentiated between the major depressive disorder (MDD) group, the PTSD group and the combined group.<br>● Notable, the PTSD and MDD group experience more flashbacks. |
| Runyon et al., 2009 | Quantitative | 21 Children; ages 4-14 years old; 12 caregivers, ages 25-54 years old; all but one family was referred by state child protective services. Of the kids: 13 females, 8 males; 9 biological mothers, 1 biological father (and stepfather to another child), 1 male partner to a mother, 1 grandmother. | Interviews, assessments, questionnaires. | Parental: Beck Depression Inventory – II (BDI-II); Parental Anger Inventory (PAI); Achenbach Child Behavior Checklist (CBCL). Child self-report: Children's Depression Inventory (CDI); Kiddie Schedule for Affective Disorders and Schizophrenia for School-Aged Children Present and Lifetime | ● Consists of three parts: Parental-Intervention, Child Intervention, Parent-Child Intervention.<br>● A small sample was used and there were many limitations. There was also no follow up to know if the results were lasting.<br>● Presenting group therapy to parents as "classes" reduced the stigmatization. Group therapy provided peer groups to parents where they could learn from each other's attempts/practicing of new parenting techniques.<br>● Exhibited in Pre to post treatment:<br>→ Child PTSD: Improved.<br>→ Parents perceptions of internalizing and externalizing: improved.<br>→ Parent reported and child reported corporal punishment: huge decrease. |

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| | | | | Version – PTSD (KSADS-P/L PTSD). Parent & child report: Parent-Child Conflict Tactics Scale (CTSPC); Alabama Parenting Questionnaire-Self Report (APQ). | → Parent inconsistencies: decreased.<br>→ Parental emotional adjustment: improved (for example managing anger.) |
| Saltzman et al., 2006 | Quantitative | 59 children and adolescents; 46% in foster placement; 71% had prior protective service involvement; 34 boys, 25 girls; 7-15 years old. | Assessments, questionnaires, interviews. | Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA); Wechsler Abbreviated Scales of Intelligence (WASI). | ● This study showed a relationship between low IQ and increased PTSD symptomatology, particularly with re-experiencing symptoms.<br>● Kids who experience trauma and have lower IQ are least well equipped to deal with it. |
| Saul et al., 2008 | Quantitative | Sub-sample from the national Survey of Adolescents. Sub-sample: 1,581 adolescents; 757 females, 824 males; "yes" response to at least 1 trauma and "yes" response to | Interviews, review of data, assessment. | Victimization history assessed using procedures adapted from the National Women's Study & the PTSD Field Trial Survey. Witnessed violence assessed using questions from the Los Angeles | ● The four factor model used showed to be a significantly better fit than the DSM-IV or Anthony et al.<br>● The four factors are:<br>→ Re-experiencing<br>→ Avoidance<br>→ Emotional numbing<br>→ Arousal<br>● The emphasis is placed on the difference between numbing and avoidance – they should NOT be combined. |

| | | if they had fear of serious injury or death during the event. | | Disturbance Study. Diagnostic Interview Schedule updated to DSM-IV criteria | ● DSM-IV and Anthony et al, are good. The four factor model is better. |
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| Singer et al., 2004 | Quantitative | 2245 Students in grades 3-8 from 11 public schools. Ages 7-15; 49% female; 57% white, 33% black, 5% Hispanic. | Self-reporting, questionnaire | Recent Exposure to Violence Scale; Past Violence Exposure Scale; Trauma Symptoms Checklist for Children (TSC-C). | ● Several hours a day of television (TV) watching is associated with higher trauma symptoms scores.<br>● Exposure to violence within the last year is a powerful contributor to children's psychological distress.<br>● Early detection of recent violence exposure is key!<br>● This study did not support the association between parental monitoring and symptoms of psychological trauma. |
| Sullivan et al., 2004 | Quantitative | 79 kids, 46 mom. | Checklists, assessment, interviews. | Child Behavior Checklist: Parent Report Version (CBCL); Parenting Stress Index (PSI); Trauma Symptom Checklist for Children (TSCC); Children's Perception of Interpersonal Conflict (CPIC). | ● Children who scored above clinical at the pretest were still above clinical at the posttest. However, they had significantly reduced their scores.<br>● Overall, three measures were significantly reduced: anxious/depression; internalizing; and externalizing.<br>● Parents had significant improvement in their scores for isolation, life stress and health. |

| Turner et al., 2011 | Quantitative | 2,999 youth; 6-17 years old; 50% female; 55% non-hispanic white, 20% non-hispanic black, 5% other, 19% Hispanic; Households: 59% 2 parent, 11% 1 parent plus stepparent, 24% single parent, 6% some other caregiver. | Telephonic interviews, checklists, questionnaires. | Juvenile Victimization Questionnaire (JVQ); Trauma Symptoms Checklist for Children (TSCC); Trauma Symptom Checklist for Young Children (TSCYC) | ● Victimization occurs in and out of school. Whether it occurs in or outside of school, symptomology levels are nearly the same. <br>● Victimization, when broken into 6 categories, provides better information and analysis than "bullying" does. <br>● Emotional victimization has the strongest independent effect on symptom levels. <br>● Out of school victimization left the victims feeling "very afraid" much often. Perhaps because no one was around to stop the incident. <br>● The perception of non-physical victimization is harmful to children. <br>● Current "bullying" measure require peer victimization incidents to be repeated and that the perpetrator be in power. This doesn't work to protect all victims (ex. Sexual or emotional victimization). |

*3.3. Emergent themes*

Several themes emerged from my analysis of the 38 articles that matched my criteria for this meta-synthesis. These five emerging themes include: (a) symptoms of trauma; (b) potential causes of trauma; (c) trauma's impact on development and the brain; (d) importance of early intervention; (e) importance of addressing symptoms even in the absence of a clinical diagnosis. All five emerging themes and their meanings can be found in Table 3.

**4. Discussion**

This discussion will combine a summary of the aforementioned emerging themes with observations and implications for my own practice as a special education teacher.

*4.1. Symptoms of trauma*

As trauma presents itself in different ways, the symptoms can be hard to nail down. In examining Table 3, it quickly becomes obvious that symptoms that stem from trauma overlap with many other disorders, conditions and life issues. Twins may experience the exact same trauma at the exact same time and come away with different symptoms – possibly even no symptoms! Difficulty in determining whether symptoms are related to trauma or not should not stop professionals (teachers, mental health, etc.) from seeking answers.

As a Special Education teacher, I can report that the symptoms listed in Table 3 can be seen in several of my students. So what can we, as educators do? Approach all children with understanding. When we assume that students are behaving poorly because they merely feel like breaking rules, we are doing them a huge disservice.

Picture this, a seventh grade student is in his bedroom sleeping when he hears gunshots and glass break; his sister has been shot in the room next to him. The next day in school he attempts to get in a fight with every student he comes across. Is he trying to ruin his peers' and teachers' day? Or is he going through a traumatic period and it is showing through aggression? Of course, I would assume the latter until I can prove otherwise. Unfortunately, many educators (and even more adults, in general) don't take the time to think about what else is going on in these kids lives. Or they assume that because they grew up in a difficult house with bad conditions that this kid can make it out fine just like them. What is imperative to remember is that we cannot compare ourselves to others. We haven't been in their shoes; we don't know what experiences have molded them into who they are. We can, however, provide support, consistency and a safe place within our schools.

## 4.2. Potential Causes & Perpetrators of Trauma

Children can experience trauma through neglect, physical abuse, assault and victimization, sexual abuse and victimization, emotional abuse and victimization, property victimization, and internet harassment, observation or witnessing of violence and perceived threat of harm or death. All of the aforementioned ways that children can experience trauma all several extensions and caveats as well.

Trauma can be perpetrated by various people in children's lives as well. Caregivers, siblings, peers, television and strangers are the most common perpetrators.

Peer violence, victimization and abuse are often called bullying in today's world. Unfortunately, bullying does not cover the multitude of ways that peers can harass and

victimize each other. To qualify as bullying, peer victimization incidents must be repeated over time and the perpetrators must have, or be in, greater power than the victim (Turner et al., 2011, p. 1062).

While emotional victimization is often thought of as a lesser evil than physical or sexual victimization, studies have shown that it actually has the strongest independent effect on a child; followed by physical assault (Turner et al., 2011).

Consideration for where children are being victimized needs to be addressed as well. Victimization of our children occurs at home, at school and everywhere else they may go. In a study of Urban African American Young Adolescents, it was observed that unmonitored time, unstructured time and time with peers are related to greater exposure to violence (Richards et al., 2004). Also notable in this study: kids asked for schools, churches and community centers to stay open later with activities for them to do. Children *want* to feel secure and safe. In the peer violence study (Turner et al., 2011), children reported that they felt more fear in out of school peer victimization than in school. This could be because they trust that an adult will come to stop the victimization in school; while out of school, there may be no one to stop it. In my own work as a teacher, I have students in an after school homework helper club that have no desire to work on their homework or get their grades up. They would prefer to stay at school for an extra hour and a half than go home to an empty house.

*4.3. Trauma's Impact on early development and the brain*

Perry (2006) interweaves the inner workings of human brain development in his written work. Within *The Boy Who Was Raised As A Dog*, Perry briefly discusses how the brain develops. The brainstem continues developing after birth and into early infancy. The midbrain and limbic systems are next. The frontal lobes, which are in charge of learning how to regulate planning, self control and abstract thought continue to develop from adolescence into the early twenties. Throughout this whole time, the brain is growing, developing, adapting and rewiring itself.

When children are forced to focus all of their brain power and bodily strength on survival, it changes how they grow and develop. Malnutrition can stunt growth; of the body and brain. If children are left in the fight or flight mode for a long time, they may have a hard time relaxing and coming out of that mode when they are full, rested and in a safe place.

If we apply this to our education system, we get into a tangle. Children are to come to school to learn. However, if those children didn't have a place to sleep the night before, or didn't eat since the lunch the day before, are academics going to register as an important part of their day? Would you worry about the outcome of the French Revolution if you didn't know where you and your little brother are going to sleep that night or if you'll get any food?

Compassion, understanding and providing benefit of the doubt can go a long way with our students who have experienced, or are experiencing trauma.

*4.4. The importance of early intervention*

After reading the section before this regarding the impact of trauma on developing brains and bodies, the importance of identification and intervention should be a bit more clear.

Fortunately, there are programs that have had success in helping students who have experienced trauma overcome their issues associated with it. The intervention that deems itself as most beneficial in my eyes is the group therapy for parents and children. Within this model, parents meet for group therapy, children meet for group therapy, and as time goes on and both and parents and children make strides, their therapy combines. This group therapy proved beneficial in the pilot program for several reasons. First, the parents that partook saw the group therapy as a type of class, which reduced the stigmatization that is often associated with "therapy." Also, the parents could learn from their peers, rather than strictly from a therapist. Another very important aspect of the parent-child therapy group is the role that child plays in helping the parent understand what their actions do to the child. Towards the end of the program, the child and parent develop a safety strategy and the child writes about their trauma as part of their overall personal narrative. Within the therapy, parents receive education on parenting and discipline skills, anger management and techniques to calm down when they get upset. Children learn safety techniques and that they are not responsible for the adult's behavior (Runyon et al., 2009).

Any intervention or counseling program for children who have experienced trauma would be beneficial. Early intervention is best, as it increases the chances of the child recovering and being able to live without the fear and symptoms they developed through the trauma.

*4.5 The importance of addressing symptoms*

What about the lack of training and knowledge regarding trauma in our students? This shouldn't keep us from helping them in ways that we do know. Most educators have at least received an introduction to working with students who have ADD, ADHD, autism, oppositional defiant disorder etc. If we know how to help students who have the same, or similar symptoms, why can we not go ahead and offer the child who has been traumatized the same support? A major difficulty of identifying trauma is that the perpetrators is not willing to admit to wrongdoing. Maybe they don't know that what they are doing to the child is wrong (especially in the case of emotional abuse, neglect or witnessing violence). Perhaps the child is not willing to discuss what is happening at home with teachers, counselors of even office of children services agents. It is all of these roadblocks in gathering accurate, helpful information that support the reasoning to provide assistance in whatever ways we have available to us.

Table 3

| Recurring Themes | Formulated Meanings |
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| Symptoms of Trauma | ● Recurring physical complaints: stomachache, headache<br>● Hyper-vigilance/heightened startle reaction (an above normal state of reaction): constantly checking the room, may be jumpy<br>● Sleep disorders/recurring nightmares (can be sleeping too much, or too little): may come to class late; falls asleep at desk; consistently puts head on desk; appears lethargic<br>● Weight change (sudden gain or loss): clothes appear extremely tight or loose<br>● Regression – returning to previously met developmental behaviors: actual actions depend on the child's current developmental level. Younger children may return to thumb sucking. Older children may throw temper tantrums.<br>● Repeated play behaviors; role playing the traumatic event: child that used to play independently with all toys may now stick to just one<br>● Social isolation: child chooses to sit alone; avoids social interaction; quits extracurricular activities |

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| | ● Increase in risk-taking behaviors: drugs, alcohol, sex<br>● Attention seeking; negative or positive: suddenly becoming an overachiever or underachiever; student acts out to get to get attention<br>● Increased aggression: yelling, inability to stop aggression once it starts<br>● Difficulty regulating emotions; can be easily angered or upset: mood swings<br>● Phobias – may be connected to the trauma, but don't have to be<br>● Stress: not turning assignments in, or turning them in late; easily overwhelmed by homework, new projects, additional work<br>● Distrust: sits away from classmates, unwilling to work together with anyone; may tell teachers/peers they know they don't care about them<br>● Lack of self-confidence: uncertainty in presenting/talking/writing in class; "perfectionist" thoughts (it won't be right, so why try?)<br>● Inability to focus: constantly tapping, drumming, fidgeting, looking around room<br>● Learning disabilities/poor skill development: pattern of learning problems in conjunction with other trauma symptoms<br>● Trauma flashbacks: low energy, motivation, lack of sleep, anxiety<br>● Dissociation: appears to "blank out", highly inconsistent in work and participation<br>● Changed attitudes about people in general, life and the future: lack of planning for the future; expecting future trauma<br>Based largely from Table 1 in Bell et al. (2013, p. 141) |
| Potential Causes & Perpetrators of Trauma | Potential Causes:<br>● Neglect<br>● Physical abuse/assault/victimization<br>● Sexual abuse/victimization<br>● Emotional abuse/victimization<br>● Property victimization<br>● Internet harassment<br>Potential Perpetrators:<br>● Caregivers (mother, father, grandparent, foster parent, etc.)<br>Unfortunately children often experience trauma at the hands of their caregiver(s). This trauma can be through physical/sexual abuse or witnessing physical/sexual abuse; neglect of basic needs (food, water, love, attachment); emotional scarring or abuse; perceived threat of injury or death; witness to pain or suffering by parent (drug overdose, abuse, assault, fear).<br>● Siblings<br>Most siblings argue. All too often siblings rough house, hit, kick, punch or throw things. While an act alone may not constitute trauma (although it should never be ignored or left out), repeated acts over a period of time |

| | can have a huge affect on children. Emotional and physical abuse by siblings occurs frequently. Intimidation and neglect can also occur at the hands of siblings.<br>●Peers<br>When childhood peers are considered to have caused trauma, they are often called bullies. Unfortunately, calling all peer on peer occurrences bullying seems to minimize the effect it truly has the children. To truly constitute bullying, an even must happen more than once and the perpetrator must be stronger than the victim. This is not always the case when a child is victimized by a peer. Sexual assault, for example, may only happen once, the peer may be the same strength as the victim, and it could definitely be a traumatic experience for a child with lasting implications.<br>●Television<br>Children can experience trauma through watching violent programs on TV. Children of all ages, but especially young children, can have a hard time differentiating between what is real and what is made up. When they watch people being killed, injured, stalked, abused, raped and beat up on TV, it can have a very traumatic effect on them.<br>●Strangers<br>When strangers are the perpetuators of violence or abuse, the world can become a very scary place to the child. Not knowing who lurks around corners, or being afraid to be on their own, can stunt a child's creativity, growth and willingness to try new things. |
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| Trauma's Impact on early development and the brain | ●Children's brains are not complete when they come out of the womb. They continue to grow and develop well into their early twenties. Throughout that whole time, the brain is growing and adapting. The effects that being nurtured or starved have on the brain are significant for the rest of that human's life.<br>●When infants, children learn emotions, reactions and interactions through watching and listening to their caregivers facial expressions and sounds. If a child is neglected in their early years, they do not form an attachment to anyone. They don't learn facial expressions or the meanings behind them.<br>●The brain grows and develops in stages. The brainstem is mostly completed while still in utero and in very early infancy. Next, the midbrain and limbic systems develop. During the teenage years, the frontal lobes of the cortex begin to form; they aren't fully developed until *late* adolescence. This is the time of learning how to regulate planning, self control and abstract thought. These processes continue to re-organize and develop into the early twenties. |

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| | ● If children are physically or sexually abused when they are young, the brain moves into fight or flight mode. While in fight or flight mode, its only goal is survival; staying out of danger and getting enough food and water to survive. If the brain has to focus all of its time and energy on the very basics of survival, it doesn't have the time, strength or nurturing to develop. |
| Importance of Early Intervention | ● As learned above, children's brains are developing and growing rapidly. It is for this reason that trauma can so greatly affect a child's brain. Fortunately, the brain's amazing ability to grow, develop, change and learn also helps them unpack, identify and overcome trauma that has occurred.<br>● Children who have experienced trauma need to be in a safe, nurturing environment. Because the primary caregiver is often-times also the perpetrator of the trauma, taking the child away from them seems the right thing to do. However, children who have experienced trauma, even at the hands of their primary caregiver, don't want to be taken away; they didn't do anything wrong.<br>● Early intervention and education, of the parent and the child, can reverse traumatic experiences and situations. Group therapy that involves both the parent (who has caused trauma) and the child has shown to be beneficial for both parties. Parents learn new parenting skills, anger management, appropriate discipline, and most importantly, what the trauma they are exposing their child to does to their child's brain and body. Children learn how to protect themselves and how to differentiate between their emotions of abuse and the actual act of it. Together, a safety plan can be devised. |
| Importance of addressing symptoms | ● The DSM-V has 7 disorders listed in the Trauma- and Stressor-Related Disorders chapter (APA, 2013, p. 265-290): Reactive Attachment Disorder; Disinhibited Social Engagement Disorder; Postttraumatic Stress Disorder (PTSD); Acute Stress Disorder; Adjustment Disorders; Other Specified Trauma- and Stressor-Related disorder; Unspecific Trauma- and Stressor Related Disorder.<br>● Each of the above mentioned disorders require specific diagnostic criteria in order to diagnose a human with said disorder. Unfortunately, some in the education and mental/behavioral health fields believe a clinical diagnosis is required before symptoms can be addressed.<br>● Research shows that treatment of trauma symptoms, even without clinical diagnosis, is beneficial for children (and adults). The sooner that a child can begin the path to intervention, recovery and normalcy, the better.<br>● More and more children are being referred for Special Education Services. More and more children are being diagnosed with ADHD, ADD and other attention and behavioral disorders. With the high prevalence of trauma in |

| | our current world, it is imperative that children be examined thoroughly before diagnosing them with a mental illness. Trauma symptoms can often look like symptoms that occur in various mental illnesses. Once trauma is discovered and treated, if a child still fits the criteria for a mental illness, then, and only then, should they go down the path to diagnosis.<br>● Many mental illnesses have overlapping symptoms with trauma. Hyperarousal is also seen in bipolar disorder. Anxiety is also seen in panic disorders. Social withdrawal and sleep difficulties are also seen in major depressive disorder, a number of anxiety disorders and psychotic disorder. |
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## 5. Conclusion

The findings of this meta-synthesis highlight the relevance and importance of recognizing, treating and supporting trauma in our children. The evidence shows that while trauma does occur more often in certain environments, no group of people, adults or children, are completely safe from experiencing trauma. While there aren't many current studies that examine how trauma can be effectively addressed in public education, there is a definite need to begin designing and testing such programs. The difficulty lies in testing the programs for effectiveness in the most real-world situations as possible. Co-morbidity statistics have shown us that most often, children experience a host of issues and experiences that add to their trauma. Research

studies that are in residential treatment centers and/or are highly exclusive do not provide reliable real-life outcomes.

Although teachers, mental health agencies and providers, school personnel, parents and the community at large are beginning to see and hear more about trauma, the groundwork really has not been laid to make schools a successful place to treat children who have experienced trauma. As poverty, violence and oppression continue to run rampant in our country, providing services in schools for traumatized children just may be the key to giving them a fair shake in life.

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