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Trauma and children: A call to action in school psychology.

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Abstract

Unfortunately, it is not uncommon for children or adolescents to be exposed to traumatic events. Experiences such as sexual or physical abuse, severe accidents, cancer or other life threatening illness, natural or man-made disasters, or the sudden death of a relative or peer can all result in maladaptive responses. As all children are in attendance at schools, this location seems the most logical place to meet the needs of children who have experienced these types of events. Therefore, it is imperative that psychologists working in schools have training in meeting the needs of this segment of the population. This manuscript summarizes the incidence of trauma in children, discusses the schools as a prime location for the provision of mental health services, and argues for the need to include training in trauma and trauma interventions in school psychology training programs.

KEYWORDS: Trauma, School Psychology, Training, Trauma Interventions

Trauma in Children: A Call to Action in School Psychology

Unfortunately, it is not uncommon for children or adolescents to be exposed to traumatic events. Felitti and colleagues (1998) conducted a retrospective study of over 17,000 adults and found that more than one half of their sample reported experiencing at least one adverse event in childhood with approximately one quarter reporting having experienced two or more. It is important to note that their definition of adverse event included only psychological, physical, or sexual abuse; violence against their mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. It did not include events such as experiencing a severe accident, having cancer or other life threatening illness, living through a natural or man-made disaster, or the sudden death of a relative or peer. If these experiences are included the incidence of trauma exposure would only be higher.

Effects of Trauma on Children

While not every child exposed to a traumatic event experiences negative outcomes, trauma symptoms are not uncommon and have been categorized into four domains: affective, behavioral, cognitive, and physical (Cohen, Mannarino, & Deblinger, 2006). Common affective symptoms include fear, depression, anger, and frequent mood changes; behavioral symptoms usually center on avoiding reminders of the trauma; cognitive symptoms usually involve distorted cognitions about themselves, others, the event, or the world (e.g., “the event is my fault”); and physical symptoms include stress related responses such as elevated heart rates and blood pressure, increased muscle tension, and hypervigilance. It has also been found that prolonged exposure to trauma and maltreatment can decrease brain size and functioning (DeBellis et al., 1999).

Scheeringa and Zeanah (2008) found rates of PTSD in children post Hurricane Katrina of 62.5% for those who stayed in the city and 43.5% in those who evacuated.

Scheeringa, Zeanah, Myers, and Putnam (2003) found that the rate of PTSD from a variety of traumatic events (mainly auto accidents and witnessing domestic violence) in a nonreferred sample was 26%. Ghosh-Ippen, Briscoe-Smith, and Lieberman (2004) found the rates of PTSD in clinic-referred children who had witnessed domestic violence were more than 40% and rates of PTSD from a variety of traumas were found to be 69% (Scheeringa, Zeanah, Drell, & Larrieu, 1995) and 60% (Scheeringa, Peebles, Cook, & Zeanah, 2001).

Not all children experience negative symptomatology, however. Many children exposed to trauma are resilient (i.e., quickly return to prior functioning) (Malchiodi, Steele, & Kuban, 2008) and others may actually improve in functioning via a process called Post Traumatic Growth (PTG) (Leckman & Mayes, 2007). Calhoun and Tedeschi (2006) identify five domains of PTG. These are personal strength, new possibilities, relating to others, appreciation of life, and spiritual change. Personal strength refers to the realization that the individual may be stronger than they imagined. New possibilities consist of developing new interests, sometimes related to the trauma they experienced. Relating to others involves the development of a greater connection to other people and increased compassion for others who may be suffering (Calhoun & Tedeschi). Especially when death or injury is part of the traumatic experience, individuals may develop a new appreciation of life and a reexamination of priorities. Finally, some individuals report deeper spiritual and existential meaning in their lives (Calhoun & Tedeschi).

Incidence of Trauma in Children

Children and adolescents may experience a number of different types of trauma. These can include abuse (e.g., sexual, physical), grief, exposure to domestic and community violence, natural disasters, or a combination of the above (Little, Akin-Little, & Gutierrez, 2009). Increasing numbers of children and adolescents have also been victims of natural disasters. More than one million people were displaced, at least temporarily, by Hurricane

Katrina in 2005 and many never returned to their homes in South Louisiana and Mississippi (Akin-Little & Little, 2008). In addition, major floods throughout the United States happen frequently. In fact, during the 20th century, floods were the number-one natural disaster in the United States in terms of the number of lives lost and property damage (United States Geological Survey, 2000). In addition, the United States is the most active area on earth for tornadoes. Over a recent 3-year period (2007-2009) an average of 1315 tornadoes struck the United States per year causing a total of 228 deaths (NOAA, 2010) and in the first 9 months of 2011 alone 537 people were killed by tornadoes. Finally, while earthquake deaths are not common in the United States, the potential for a major earthquake (especially on the west coast) is present and as recently as 1994 sixty people were killed by a magnitude 6.7 earthquake in Northridge, California (USGS, 2010). While there are similarities across natural disasters each is unique in some way which in turn may influence the type of reaction of victims (Evans & Ohlner-Stinnett, 2006).

Child abuse is another frequent source of trauma in children. According to United States Government statistics 758,289 children were maltreated in the United States in 2008 with rates among states ranging from 1.5 to 29.1 per 1,000 children (U.S. Department of Health and Human Services, 2010). Of this number 71.1% were neglected, 16.1% were physically abused, 9.1% were sexually abused, 7.3% were psychologically maltreated, 2.2% were medically neglected, and 9.0% fell into an “other” category which included abandonment and threat of harm (USDHHS). It should be noted that these add up to more than 100% because some children fell in multiple categories. With regard to sexual abuse, a 1998 meta-analysis found that in the United States the incidence of sexual abuse ranged from 3% to 37% for boys and 8% to 71% for girls with an average of 17% for boys and 28% for girls (Rind, Tromovitch, & Bauserman, 1998). In addition, the US Department of Education estimates 9.6% of students are targets of educator sexual misconduct sometime during their

school career (Shakeshaft, 2004). Many researchers also believe these numbers are underestimates (Freyd et al., 2005).

Exposure to domestic or community violence is another area in which children experience trauma. In 2009 in the United States, an estimated 1,318,398 violent crimes occurred nationwide, a rate of 429.4 violent crimes per 100,000 inhabitants (Federal Bureau of Investigation, 2010). Homicide rates varied by region but were highest in the South. A total of 15,241 persons were murdered in the United States in 2009 including 1,348 individuals under the age of 18 (FBI). School violence is also not uncommon in the United States. According to the U.S. Department of Education, Institute of Education Statistics (2009) during the 2007-2008 school year 85% of public schools reported at least one violent crime. In addition, there were 1.5 million victims of violent crimes at school, 10% of male students and 5% of female students in grades 9-12 reported being threatened or injured with a weapon at school, and 25% of public schools report that bullying occurred on a daily or weekly basis.

An even more common form of trauma for children is grief. Studies have found that approximately four percent of American children experience the death of a parent before the age of 18 (Social Security Administration, 2000). The death of a loved one can be one of the most severe forms of trauma a child may encounter (Ayyahh-Abdo, 2001). Each year 7,000 to 12,000 American children and adolescents are affected by the suicide of a parent (Wilcox et al., 2010). In addition, with the death rate of children age birth to 17 being 62.4 per 100,000 (CDC, 2007), having a close friend or sibling die is not uncommon. Notably, these data do not include the number of children who experience the death of a grandparent or someone else close to them. Unfortunately, the data are clear that experiencing the death of someone close is not uncommon in childhood.

Children are exposed to traumatic events. The data are unequivocal that exposure to traumatic events is not uncommon in childhood and adolescence. Psychologists working in schools have contact with these children and, sometimes, schools are one of the few places of stability. It is the contention of the authors of this article, that it is very important for psychologists working in the schools to have some training in meeting the needs of these children and adolescents via the most efficacious interventions.

Schools and Mental Health

Many people have argued that schools are a logical location for the provision of mental health services. The argument is made that schools are, for to all intents and purposes, the most logical place to gain access to all children, as it is the one place where children's educational, emotional, and behavioral needs can be addressed (Adelman & Taylor, 2010; Burns et al., 1995; Paternite, 2005). Schools are located in every community in the United States and, as school attendance is mandatory, they are the one location where access to almost all children is guaranteed. In addition, schools are convenient for families and provide an environment ideally suited for the implementation of a variety of different treatment modalities. Willie Sutton, a bank robber in the 1930s through 1950s, allegedly replied to a reporter's inquiry as to why he robbed banks by saying "because that's where the money is." This idea has led medical schools to teach their students "Sutton's Law" which suggests that when diagnosing illness, physicians should first consider the obvious. We propose that "Sutton's Law" also applies to meeting the mental health needs of children and adolescents. It is just obvious that we should provide mental health service in schools because "that's where the children are."

In an extensive review of the literature on school-based mental health services for children, Hoagwood and Erwin (1997) found empirical support for three types of interventions: cognitive-behavioral therapy, social skills training, and teacher consultation.

Similarly, Durlak and Wells (1997) conducted a meta-analysis of 177 programs designed to prevent behavioral and social problems in children and adolescents. Results indicated that programs involving modifications in the school environment, individual mental health promotion efforts, and providing children help in negotiating stressful transitions produced significant effect sizes ranging from 0.24 to 0.93. They noted that most programs had positive effects in both reducing problem behavior and increasing student social competency.

Anglin, Naylor, and Kaplan (1996) concluded that adolescents with mental health symptoms who were referred to school-based clinics were more likely to receive treatment than students who were referred for services in other settings. Bruns and colleagues (1999), found that personnel in schools with expanded school mental health programs (ESMH) were more likely to refer students with suspected emotional and behavioral problems for services than were individuals in non-ESMH schools (52% versus 28%). Not only do children who receive metal health services in schools show improvements in behavior (e.g., Hall, 2000) and emotional functioning (e.g., Nabors & Reynolds, 2000) they also have shown improvements in academic outcomes (e.g., Jennings, Pearson, & Harris, 2000; Kalafat, Illback, & Sanders, 1997). It is clear then, that school-based provision of mental health services are beneficial and not only make the provision of mental health services more efficient, it makes it more likely that students in these schools will receive the services they need. This can be especially true in the provision of services to children who have been exposed to trauma (Little, Akin-Little, & Somerville, 2011).

Interventions for Trauma

Many children who are exposed to trauma manifest psychological problems such as those described earlier in this paper. The development of Posttraumatic Stress Disorder (PTSD), while differing in frequency across different trauma populations (Roberts, Kitchiner, Kenardy, & Bisson, 2009), is not unusual in children and may become chronic if not

addressed. Research has clearly established that exposure to trauma may severely affect children's psychological, physical, and social development, increasing rates of major depression, PTSD, school failure, and other emotional and behavioral problems (Saigh et al., 2008). Over the past two decades various interventions have been developed in an attempt to mitigate the effects of trauma and prevent the onset of chronic PTSD (Roberts et al.).

Trauma-Focused Cognitive Behavior Therapy (TF-CBT). One intervention which has been empirically supported for use with children who have experienced trauma is Trauma-Focused Cognitive Behavior Therapy (TF-CBT). While most of the research (i.e., controlled, randomized trials) has supported the efficacy of TF-CBT with sexually abused children (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Knudsen, 2005), this intervention has also proved efficacious for other types of trauma (Cohen, 2005; Cohen, Mannarino, & Deblinger, 2006; Cohen, Mannarino, & Staron, 2006). TF-CBT was one of only three interventions identified as meeting the criteria for evidence-based practice by the Kauffman Best Practices Project (Chadwick Center for Children and Families, 2004) and the only one placed in the most rigorous category, “well supported, efficacious treatment.” It is the only trauma treatment for children with a scientific rating of 1, meaning it is well supported effective practice, by the California Evidence-Based Clearinghouse for Child Welfare (2010). Roberts and colleagues (2009) conducted a meta-analysis of interventions focused on treating symptoms of PTSD and concluded the only significantly effective intervention was TF-CBT. In addition, TF-CBT has been demonstrated to be equally effective with both White and African American children and youth (Weiner, Schneider, & Lyons, 2009).

Cognitive Behavioral Intervention for Trauma in Schools (CBITS). Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a skills-based group intervention for children aged 10 to 15 exposed to traumatic events (Jaycox, 2004). The focus of the

intervention is on PTSD symptomatology, depression, and anxiety (National Child Traumatic Stress Network, 2008). The intervention has been evaluated by the National Registry of Evidence-based Programs and Practices (SAMSHA, 2010) and received outcome ratings of 3.1 out of 4.0 for PTSD symptoms, 3.0 out of 4.0 for depression symptoms, and 3.4 out of 4.0 for psychosocial dysfunction. CBITS has been used with children who have witnessed, or been the victims of violent acts (Stein et al., 2003), been exposed to a natural disaster (Cohen et al., 2009, Jaycox et al., 2010, Walker, 2008), a house fire, or been physically injured/abused (National Child Traumatic Stress Network, 2008). It has been implemented in multiple locations across the United States and has been used with different cultural groups including Latinos (Kataoka et al., 2003), Native Americans (Morsette et al., 2009), and African Americans (Jaycox et al.).

Abuse Focused-Cognitive Behavioral Therapy (AF-CBT). Abuse Focused-Cognitive Behavioral Therapy (AF-CBT) was designed for work with abused children and their offending caregivers and is based on behavioral principles. Designed for children who have experienced physically abusive behavior, it is designed to promote the expression of prosocial behavior while minimizing coercive, aggressive, or violent behavior. It is applied both individually and in the family context. It was also one of the three interventions identified as meeting the criteria for evidence-based practice by the Kauffman Best Practices Project (Chadwick Center for Children and Families, 2004). AF-CBT has been found to improve functioning in school-aged children, their parents (caregivers), and their families (Kolko, 1996a; 1996b). It has a rating of 3, meaning it has promising research evidence and the overall weight of evidence supports the benefit of the practice, by the California Evidence-Based Clearinghouse for Child Welfare (2010).

Training in Trauma in School Psychology

It is clear from the previous section that evidence-based treatments exist for children who have experienced traumatic events. In addition, schools are the most logical location for the provision of these services to best meet the mental health needs of children. School psychologists are therefore in the best position to deliver these services. One of the key recommendations of the Kauffman Best Practices Project to Help Children Heal from Child Abuse (Chadwick Center for Children and Families, 2004) was that "Graduate schools of psychology, social work, psychiatry, and marriage and family counseling all need to incorporate the emerging evidence base into their curriculum so students learn what works and what does not while still in school, at least as is practical in a constantly evolving field" (p. 30). The question then is, do training programs in school psychology adequately prepare their students to work with children who have been abused or have had other traumatic experiences?

To gauge the level of training in trauma, the program web page for all APA accredited programs in School Psychology and Combined Professional-Scientific Psychology with a School Psychology component (n = 67) were accessed (APA, 2011). Eighteen programs were located in Departments of Psychology, 47 in Schools of Education, and two in other administrative units. Eight offered the Psy.D. and 59 the Ph.D. In the description of the program on their main web page, no program identified trauma intervention as a focus of training and only one university (Tulane) offered a sub-specialization in Trauma-Focused School Psychology. When the curriculum of each program was reviewed, few programs required specific courses in trauma (e.g., Columbia) intervention or crisis intervention (e.g., UCSB, Lehigh). The number of courses in counseling/therapy and the total number of intervention courses (excluding practicum) were also recorded. Specific courses identified as counseling or therapy ranged from zero to four (M = 1.51, SD = .90) and the total number of intervention courses (inclusive of counseling/therapy) ranged from two to six (M = 4.32, SD

= .89). It is entirely possible that some of these intervention courses include a component on trauma or crisis but that is not clear from the information provided on program web pages. Most programs have room in their curriculum to include training in trauma interventions (the mode number of intervention courses was 4) as part of an existing course and hopefully this area is given at least some attention. We propose, however, that school psychologists in training need more than just a cursory overview of interventions for children who have experienced traumatic events. Columbia University, for example, has a course entitled "Child-Adolescent PTSD and Related Internalizing Disorders." Tulane University offers an entire sub-specialization in Trauma-Focused School Psychology. With the need for services for children exposed to trauma continuing to grow, and the schools being the ideal location to provide these services, shouldn't we reconsider our training priorities and make trauma interventions a central component of school psychology training? We believe the answer is yes.

Summary

It is clear that the incidence of children exposed to trauma is not isolated. It happens to children of all ages, races, ethnicities, and socio-economic status. While not all children exposed to trauma develop negative symptoms, a high percentage do and these children need the opportunity to receive high quality evidence-based interventions delivered by trained personnel. The vast majority of children attend school, schools provide an excellent environment in which to deliver these types of services to children in need, and school psychologists are in the best position to provide these services. Isn't it time that the training we provide to doctoral level school psychologists catches up with the need and the opportunity? It is our belief that every doctoral level school psychology training program should include a dedicated course to training school psychologists to deliver these services. This would be a first step in meeting the ever growing need of children and adolescents.

While one way to ameliorate the training deficit is via providing such training in school psychology graduate programs, there is also training available for school psychologists who are currently practicing. Specifically, basic TF-CBT training is available on-line (see http://tfcbt.musc.edu/ for free on-line continuing education training) and additional training can be obtained after completing this free 10-hour course. There are other continuing education courses available on-line and face to face that can also be used to increase the competency of psychologists in trauma intervention.

Regardless of where you are there are children who have been exposed to trauma and these children are most likely attending schools. Teachers and other school personnel are, for the most part, not trained in dealing with grieving and traumatized children and youth (Reid & Dixon, 2001). However, school psychologists can make a difference in the lives of these children through direct service provision and consultation with teachers and school staff. It is imperative that we make sure school psychologists are trained and available when needed.

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