

Creating Trauma-Sensitive Schools: Supportive Policies and Practices for Learning

Children and adolescents in the U.S. experience high rates of stress and adversity from a wide variety of sources. These include physical, emotional, and sexual abuse; neglect; exposure to community violence; bullying; natural disasters; poverty; homelessness; immigration; and parental issues such as domestic violence, incarceration, death, mental illness, involvement in substance abuse, and military deployments. Such experiences undermine students' ability to learn, form relationships, and manage their feelings and behavior and place them at increased risk for trauma and a range of negative academic, social, emotional, and occupational outcomes (Rossen & Hull, 2013). Thus, there is increasing awareness of the need to create *trauma-sensitive schools*.

Trauma-sensitive schools have the potential to increase positive outcomes among *all* students, regardless of trauma history. This is important given that not all students who experience adverse childhood experiences will go on to suffer symptoms of trauma. Designed to be safe and attuned to the needs of students, families, the community, and school staff, trauma-sensitive schools support the academic competence of students, provide tools to support students and staff in managing emotional and behavioral challenges, and support teachers and other staff in negotiating difficult situations (Blaustein, 2013).

Adverse childhood experiences and trauma negatively impact a significant proportion of the school-aged population. Yet many educators and other professionals are still unaware of these children's complex needs and how to meet them during the school day (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008; Rossen & Hull, 2013). Although some argue that such efforts are secondary to the goal of educating children, the increasing recognition of the impact of stress, adversity, and trauma on learning has brought a sense of urgency to the creation of trauma-sensitive schools (Cole, Eisner, Gregory, & Ristuccia, 2013).

SCOPE OF THE PROBLEM

The list of potentially trauma-inducing issues that impact children and adolescents is very long, precluding a full presentation of prevalence rates in this document.

- *Child abuse and neglect*: There are more than 3 million referrals involving 6 million children each year for child abuse and neglect in the U.S. (Institute of Medicine and the National Research Council, 2014). An estimated 679,000 children were victims of abuse and neglect in fiscal year 2013 (U.S. Department of Health and Human Services, 2015).
- *Exposure to violence*: Nearly 61% of youth younger than age 17 report having been exposed to violence in the past year (Finkelhor, Turner, Ormrod, & Hamby, 2009; Sickmund, & Puzanchera, 2014). Students ages 12–18 were victims of 749,200 serious violent crimes and simple assaults in 2012, and

7% of students in grades 9–12 reported being threatened or injured with a weapon, such as a gun, knife, or club, on school property in 2011 (Robers, Kemp, Rathbun, & Morgan, 2014).

- *Bullying*: During the 2009–10 school year, 23% of public schools reported that bullying occurred among students on a daily or weekly basis (Robers et al., 2014).
- *Natural disasters*: Nearly 14% of U.S. children aged 2–17 report having been exposed to a disaster in their lifetime, and more than 4% report having experienced a disaster in the past year (Becker-Blease, Turner, & Finkelhor, 2010).
- *Homelessness, poverty, and food insecurity*: More than 1.6 million American children, one in 45, are homeless during the course of each year (National Center on Family Homelessness, 2011). During the 2008-09 academic year, schools across the U.S. identified 956,914 students who were homeless, a 41% increase over two years (National Center for Homeless Education, 2010). In 2013, 21% of school-age children were living in poverty (Kena et al., 2015). More than one in five U.S. children is food insecure (ETS Center for Research on Human Capital and Education, 2013).
- *Immigration*: In 2013, there were 7,255,000 U.S. children under age 18 who are foreign-born or who have at least one foreign-born parent, in which neither resident parent is a U.S. citizen (Kids Count Data Center, 2015). The number of unaccompanied children entering the U.S. grew dramatically from 6,000 in 2011 to an estimated 60,000 in 2014 (U.S. Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement, n.d.).
- *Parental issues*: Approximately 8.3 million children in the U.S. have parents under correctional supervision (prison, jail, parole, or probation), and nearly half of those children are in or approaching adolescence (Correctional Association of New York, 2009). There were 700,000 children with at least one military parent deployed to a war zone in 2007 (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families, and Service Members, 2007).

CONSEQUENCES

An abundance of empirical evidence reveals that childhood traumatic experiences can chronically and extensively alter social, psychological, cognitive, and biological development (Cook et al., 2005). Here are a few of the many empirical findings:

- Childhood traumatic experiences can produce negative changes in the structure and function of the brain that are pervasive and lasting (Anda et al., 2006; Lupien, McEwen, Gunnar, & Heim, 2009; Teicher et al., 2003).
- Childhood traumatic experiences have the power to undermine child and adolescent development in myriad areas that threaten academic success: communication skills, coherent sense of self, coping skills, peer and adult relationships, the ability to attend to classroom tasks and instructions, organizing and remembering information, and grasping cause-and-effect relationships (Briggs-Gowan, Carter, & Ford, 2011; Cole et al., 2005; De Bellis, Woolley, & Hooper, 2013; Goodman, Miller, & West-Olatunji, 2012; Madrid, Grant, Reilly, & Redlener, 2006; Williams, 2007).
- Adverse childhood experiences increase a child’s risk for a range of health problems as an adolescent and adult, including alcohol and substance abuse, depression, intimate partner violence, multiple sexual partners, suicidality, unintended pregnancy, and adolescent pregnancy (Centers for Disease Control and Prevention, 2014).

- Negative health outcomes for children and adolescents are a function of the amount and degree of exposure to stress and adversity, with the risk for negative outcomes increasing with each cumulative adverse experience (Felitti et al., 1998).

ASSESSMENT

Although adversity and trauma are pervasive among students, service providers regularly attempt to address the symptoms rather than the source of distress (Cooper et al., 2007). Several screening measures have become available to examine exposure to adverse childhood experiences, and the National Child Traumatic Stress Network (n.d.) has compiled a compendium of standardized measures for use in assessing complex trauma. However, it is important to note that not all individuals experiencing adversity or stress develop trauma, and assessing the development of trauma symptoms poses several challenges.

- A single psychiatric diagnosis does not exist that can account for the cluster of symptoms that research has shown occurs frequently in children exposed to trauma (D'Andrea, Ford, Stobach, Spinazolla, & van der Kolk, 2012).
- There are few psychometrically sound diagnostic instruments for directly assessing trauma in children, and those that are available do not appropriately consider children's developmental levels (Hawkins & Radcliffe, 2006; Strand, Pasquale, & Sarmiento, 2011).
- Assessment is often accomplished using parent questionnaires, and research indicates that parents may be less aware of their child's symptoms of internalizing disorders, such as anxiety and depression (Teagle, 2002), and those of their older children, since their symptoms may become less overt and occur in settings outside of the home (Achenbach, Dumenci, & Rescoria, 2002).
- Only 16% of adolescents develop PTSD after exposure to adverse experiences. Rates also ranged from 8% among boys experiencing non-interpersonal adversity to 33% of girls experiencing interpersonal adversity (Alisic et al., 2014).

INTERVENTIONS

Trauma-informed care is based on these core principles: creating a sense of safety; practicing trustworthiness and transparency; employing collaboration and mutuality; practicing empowerment; fostering voice and choice; and recognizing cultural, historical, and gender issues (Substance Abuse and Mental Health Services Administration, 2014). School-based programs and approaches have been developed to address the impact of childhood traumatic experiences by reducing emotional and behavioral problems and fostering resilience. For programs that involve screening for trauma, students are selected for participation via four major avenues: referrals from school-employed mental health professionals or teachers, nomination by parents, targeted screening at school, and general screening at school (Jaycox, Morse, Tanielian, & Stein, 2006). Given the complex and varied presentation of trauma symptoms, however, no single intervention is appropriate for all children and adolescents. Although many have not yet been evaluated, some have demonstrated positive results and many are based on evidence-based techniques (Jaycox et al., 2006).

- Empirical studies have demonstrated the positive impact of trauma-focused cognitive behavioral therapy (TF-CBT) to help children, adolescents, and their caregivers overcome trauma-related difficulties. Findings consistently demonstrate its effectiveness in reducing symptoms of posttraumatic

stress disorder, symptoms of depression, and behavioral difficulties (Child Welfare Information Gateway, 2012).

- An evaluation of trauma-sensitive practices in high school yielded evidence that it significantly increases student resilience overall and on each of its component dimensions: supportive relations, problem solving, and optimism. Grades were uniformly higher among 70% of students whose resilience scores had increased, irrespective of initial trauma levels (Longhi, 2015).
- The Attachment, Self-Regulation, and Competency (ARC) model for addressing the impact of trauma experiences is grounded in child development theory and empirical knowledge about the effects of trauma. It emphasizes intervening with the child-in-context and the creation of effective and sustainable outcomes through systemic change (Blaustein & Kinniburgh, 2010; Kinniburgh, Blaustein, & Spinazzola, 2005).
- The Head Start Trauma Smart program is used in Head Start classrooms to decrease the stress of chronic trauma, foster social and cognitive development, and create a trauma-informed culture for young children, parents, and staff. An evaluation revealed statistically significant improvements in the ability to pay attention, externalizing behaviors, internalizing behavior, and oppositional defiance (Holmes et al., 2014).

SCHOOL-BASED MENTAL HEALTH SUPPORTS

Research has shown that social support, resilience, and hope are important in helping children successfully cope with the mental and behavioral challenges that often accompany exposure to trauma (Hines, 2015). To ensure the academic success of these students, it is necessary for schools to address their health and emotional well-being. Specific school-based interventions are most effective when they are implemented within the context of integrated and coordinated mental and behavioral health services for all students (Adelman & Taylor, 2013; Huang et al., 2005). Involvement of specialized instructional support personnel, such as school psychologists, school counselors, and school social workers, is critical given that few pre-service teacher preparation programs include components to help educators develop the skills and coping strategies needed to detect and teach traumatized students (Wong, 2008). School-based mental health supports take a variety of forms:

- Interventions using positive behavior supports have been shown to improve academic performance and decrease behavior problems (Caldarella, Shatzer, Gray, Young, & Young, 2011; Luiselli, Putnam, Handler, & Feinberg, 2005; Waasdorp, Bradshaw, & Leaf, 2012).
- Students who participate in school-based social and emotional learning programs show significant improvement in grades and standardized test scores, social and emotional skills, caring attitudes, and positive social behaviors, and a decline in disruptive behavior and emotional distress (Bierman et al., 2010; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011).
- Interventions that foster students' engagement in school have been shown to reduce high school dropout (Reschly & Christenson, 2006) and improve academic performance (Battistich, Schaps, & Wilson, 2004; Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004).
- Interventions that foster strong and supportive relationships with teachers help students to feel more safe and secure in school, feel more competent, make more positive connections with peers, and achieve greater academic success (Hamre & Pianta, 2006).

SCHOOL POLICIES

Policies to support trauma-informed care are relatively new, but emerging rapidly within some organizations. Several areas are ripe for policy development, including the need to develop practice standards and collect evidence of the impact of interventions (Yatchmenoff, 2015). Yet, schools that have already implemented comprehensive school safety policies and practices are already naturally trauma sensitive to some degree. Multitiered systems of supports, positive school climates, and well-trained staff contribute to positive outcomes for students while fostering trauma-sensitive environments. For some schools, even small steps can produce significant progress toward the creation of trauma-sensitive learning environments. Broad consensus is emerging regarding which policies support the creation of trauma-sensitive schools, such as the following:

- The ecologies of trauma-sensitive schools have these interrelated characteristics: 1) Staff understand trauma's impact on learning and the need for a school-wide approach; 2) the school helps students feel safe (physically, socially, emotionally, and academically); 3) the school addresses students' needs in holistic ways that take into account their relationships, self-regulation, academic competence, and physical and emotional well-being; 4) the school connects students to the school community and provides them with multiple opportunities to practice newly developing skills; 5) staff work as a team and share responsibility for all students; and 6) staff anticipate and adapt to students' ever-changing needs (Cole et al., 2013).
- Effective discipline policies can be especially important in counteracting the effects of trauma (Ristuccia, 2013). Zero tolerance policies, in particular, have been shown to be ineffective and even counter-productive in terms of supporting appropriate behavior and increasing student engagement in school (American Psychological Association Zero Tolerance Task Force, 2008). Supportive approaches to discipline involving fair and consistent enforcement efforts and the availability of caring adults are more effective, while avoiding the negative consequences of punitive approaches (Gregory et al., 2010).
- Interventions based on positive behavior supports have been shown to decrease behavior problems and improve academic performance (Caldarella et al., 2011; Waasdorp, Bradshaw, & Leaf, 2012).
- School codes of conduct should promote positive student behaviors and include graduated systems of developmentally appropriate responses to student misconduct that hold students responsible for their actions. Examples include making sure interventions are culturally appropriate, engaging students in efforts to improve the code of conduct, making use of restitution, employing cooling off periods, and ensuring that students continue to receive quality instruction when they are removed from the classroom for disciplinary reasons (Morgan, Salomon, Plotkin, & Cohen, 2014).

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