5-1-2015

Effects of Childhood Trauma on Students: The Role of School Counselors

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A Capstone Project submitted in partial fulfillment of the

Requirements for the Master of Science Degree in

Counselor Education at

Winona State University

Spring 2015

Winona State University

College of Education

Counselor Education Department

CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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Effects of Childhood Trauma on Students: The Role of School Counselors

This is to certify that the Capstone Project of

Student Name

Has been approved by the faculty advisor and the CE 695 – Capstone Project

Course Instructor in partial fulfillment of the requirements for the

Master of Science Degree in

Counselor Education

Capstone Project Supervisor: _____
Name

Approval Date: _____

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Abstract

The literature review discusses effects of childhood trauma, short term and long-term effects as well as three evidence based interventions that are currently being used to help treat symptoms of childhood trauma. The research indicates that childhood trauma is complex, and effects children in differing ways depending on many different factors. Research also indicates that with the correct treatment and support, children who have experienced trauma can reduce signs of depression, anxiety and post-traumatic stress disorder (PTSD). School counselors play a large role in treatment, as there are often barriers for children to receive mental health support outside of the school system. This paper looks at three evidence-based interventions, their methods and effectiveness, and how school counselors who serve students who have experienced trauma can utilize them.

Introduction

"More than half of all children in the United States are exposed to trauma, either as witnesses or victims" **(**RAND Health). Children, who have experienced trauma, are at a heightened risk to develop post-traumatic stress disorder (PTSD) as well as depression **(**RAND Health). Offering support and treatment within the school, reduces barriers to mental health services for children who have experienced trauma **(**RAND Health). As the mental health professional in a school, school counselors are faced with the task to support all students in order for them to strive in the three domains of their life; personal/social, career and academic. Because students who have experienced trauma are at a higher risk to develop PTSD and depression, it is essential that there are interventions in place that benefits the child's mental well being **(**RAND Health). There are many evidence-based interventions that have shown success when working with children who have experienced trauma (Fontes, 2000). Being able to have a safe and stable school environment is key to the healing process for these children (Brunzell, Waters, & Stokes, 2015). It is important for a network of school professionals to work together, but specifically for the mental health professional in the building: the school counselor, it is essential they have the expertise to work with children who have experienced trauma (Brunzell, Waters, & Stokes, 2015). After a review of literature surrounding effects on children who have experienced trauma, three trauma based interventions are discussed within this paper; Cognitive Behavioral Intervention for Trauma in Schools, Trauma-Focused Cognitive Behavioral Therapy, and Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling. A discussion follows about how these interventions can be utilized by the school counselor to help students who have experienced trauma be successful while at school.

Review of Literature

According to The National Child Traumatic Stress Network "the United States reports that up to 40% of students have experienced, or been witness to, traumatic stressors in their short lifetimes" (Brunzell, Waters, & Stokes, 2015). The effects of childhood trauma are broad, ranging from external problems such as oppositional defiant to internal problems such as anxiety (Alvarez, Masramon, Pena, Pont, Gourdier, Roura-Poch, & Arrufat, 2015). When someone experiences trauma at an early age, they are prone to exhibit impairments in emotional development, behavior regulation, attention, posttraumatic distress and dissociation (Price, Higa-McMillan, Kim, & Frueh, 2013). Children who are traumatized may exhibit polar opposite behaviors from one another (Monahon, 1993). Some children may exhibit rigid behaviors such as controlled eating habits or inflexible rituals, while others may exhibit a lack of control of behaviors such as aggression and emotional regulation (Monahon, 1993).

The type of traumas a child experiences, is related to the way the trauma manifests in a child (Alvarez, Masramon, Pena, Pont, Gourdier, Roura-Poch, & Arrufat, 2015). Through the research the CDC conducts, they define Adverse Childhood Experiences to include verbal, physical and sexual abuse as well as family dysfunction (substance abuse, parental divorce, parent incarceration, domestic violence or mental illness) ("Adverse Childhood Experience," 2010). When looking at prevalence of Adverse Childhood Experiences, 59.4% of 26,229 adult respondents indicated having one ACEs in their childhood and 8.7% indicated 5 or more ("Adverse Childhood Experience," 2010). The prevalence of the types of Adverse Childhood Experiences varies. Verbal abuse (25.9%), household substance abuse (29.1%) and divorced parents (26.6%) were the highest reported experiences ("Adverse Childhood Experience," 2010). When looking at the other ACEs 14.8% of respondents reported physical abuse, 12.2% reported

sexual abuse, and 16.3% reported witnessing domestic violence ("Adverse Childhood Experience," 2010).

When children are exposed to interpersonal trauma by a caregiver over a long period of time, they are at greater risk for clinical problems, than other children who are exposed to multiple non-caregiver traumatic events **(**Kisiel et.al, 2014). When child sexual abuse is a part of a child's trauma history, these children had a significantly greater risk for a range of symptoms than those groups without experience with child sexual abuse **(**Kisiel et.al, 2014). These symptoms include suicidailty, depression and sexualized behaviors **(**Kisiel et.al, 2014). An individual's risk for attempting suicide increased from 2 to 5 fold when one of the 8 categories (verbal, physical and sexual abuse, substance abuse, parental divorce, parent incarceration, domestic violence and mental illness) that the CDC uses to define adverse childhood experiences, was reported (Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001). When the number of adverse childhood experiences increased, the risk of ever attempting suicide also increased (Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001).

The Complexities of Trauma

When trauma is experienced at an early age, is prolonged, and at the hands of a caregiver this can disrupt psychological, neurobiological, relational and cognitive development (Price, Higa-McMillan, Kim, & Frueh, 2013). Poly-traumatization, which is defined as, experiencing more than one type of trauma, is one factor in the complexity of trauma (Alvarez, Masramon, Pena, Pont, Gourdier, Roura-Poch, & Arrufat, 2015). Because of the many layers of different traumatic events, when multiple types of trauma are experienced, the effects are also layered and can become even more complex (Alvarez, Masramon, Pena, Pont, Gourdier, Roura-Poch, & Arrufat, 2015). Children, who witness domestic violence on top of experiencing abuse first hand,

show to be less attached to parents in adolescence, than children who only witness the violence **(**Sousa, Herrenkohl, Moylan, Tajima, Klika, Herrenkohl, & Russo, 2011). When compared to those who have never experienced abuse and to those who have experienced one type of abuse, the presence of schizophrenia and clinical dissociation are more closely related to child patients who have experienced more than one type of abuse (Alvarez, Masramon, Pena, Pont, Gourdier, Roura-Poch, & Arrufat, 2015). Children, who are victims of sexual abuse and also have witnessed domestic violence, are the most common candidates to be diagnosed with PTSD **(**Sousa, Herrenkohl, Moylan, Tajima, Klika, Herrenkohl, & Russo, 2011). Children who experienced more than 4 adverse childhood experiences were 2.4 times more likely to suffer from anxiety, 2.5 times more likely to have panic reactions and 3.6 times more likely to have a depressed affect when compared to those who have not experienced an adverse childhood experience (Anda et al., 2005). When the types of trauma that are experienced, are layered and compounded with one another, it increases the risk for adverse effects (Turner, Finkelhor, & Ormrod, 2006).

The source of the trauma also plays a large role in the effects of the trauma. When the source of the trauma is from a caregiver, the attachment relationship is compromised, leading to issues later with relationships and bond forming (Turner, Finkelhor, & Ormrod, 2006). This is significant to childhood development, as 80% of maltreated children, will develop insecure attachment patterns (Delima & Vimpani, 2011).

When compared with children who have non-abusive parents, children who have abusive or neglectful parents demonstrate higher frequency of impaired cognitive functioning by late infancy (Cook et. al, 2005). One explanation of the added effects of trauma from a caregiver may be that when compared to other trauma, caregiver related trauma had a significantly earlier onset

and longer duration than other traumas experienced by children **(**Kisiel et.al, 2014). When this idea is looked at in more depth, we can see the comparative outcomes for those youth who didn't suffer a caregiver related trauma, but did experience a traumatic event **(**Kisiel et.al, 2014). Caregiver related trauma increased the severity of symptoms in certain areas (difficulties regulating impulses, memory and attention, attachment and interpersonal relationships) and a greater range of functional difficulties when compared to non-caregiver related trauma survivors **(**Kisiel et.al, 2014). Caregiver related trauma also is a risk factor for higher rates of mental health needs including higher rates of PTSD **(**Kisiel et.al, 2014). It is also noted that multiple types of caregiver trauma, put children at an even higher risk for a broader range of difficulties **(**Kisiel et.al, 2014). Non-caregiver related trauma also has certain patterns of symptoms; it is more likely that a child who experienced non-caregiver trauma will have problems with alcohol and other drugs **(**Kisiel et.al, 2014).

There are also some perceived gender differences when researchers look at the effects of childhood trauma (Godinet, Li, & Berg, 2014). Gender has been shown to have difference in behavior problems among trauma victims (Godinet, Li, & Berg, 2014). For children who have experienced maltreatment, females tend to display more internalizing symptoms; depression, anxiety and eating disorders, while males display more externalizing symptoms; aggression and harm directed at self and others (Delima & Vimpani, 2011).

Effects of Attachment

Childhood traumatic experiences are often at the hands of a caregiver. In one particular study, there were 1,823 children that all had experienced trauma, over 1,600 of those children, had experienced a caregiver related trauma **(**Kisiel et.al, 2014). As stated earlier, caregiver trauma affects the way in which children form attachments and bonds **(**Kisiel et.al, 2014). When

children have not learned to successfully and positively interact with adult caregivers, they have greater difficulty later developing adequate peer relationships as well as relationships with other adults in their life (Blaustein & Kinniburgh, 2010). When there are interruptions and negative interactions in attachment bonds, children grow up to have difficulty forming solid, functioning relationships **(**Kisiel et.al, 2014).

Neurological Effects

When the human body goes through trauma, stress levels are elevated which activates our biological stress response (Delima & Vimpani, 2011). When the stress response is stimulated for a prolonged amount of time, it is really the stimulation of the hypothalamic-pituitary-adrenal axis (Delima & Vimpani, 2011). When this system is stimulated over a prolonged amount of time, when it is meant for acute stress response, it results in adverse physical and mental health effects (Delima & Vimpani, 2011). Reduced immune functioning, cardiovascular disease, persistent mild depression, major depression, oppositional defiant disorder and attention deficit hyperactivity disorder have been shown to have ties back to neurological factors related to stress response (Delima & Vimpani, 2011). There is also much research that has been done that looks at specific areas of the brain and the associated effects that has on the well being of an individual that has experienced trauma (Anda et al., 2005). MRI's have shown reduced functioning of the amygdala and hippocampus among women who were sexually abused as children (Anda et al., 2005). The hippocampus plays a large role in the brains memory storage and retrieval process(Anda et al., 2005). When looking specifically at children who reported having adverse childhood experiences, when the number of ACEs increased, it was found that impaired memory of childhood also increase (Anda et al., 2005). Trauma experiences have been shown to not just effect the behavior of children in the moment, but research has shown that significant

neurological changes take place for some individuals who experience trauma as a child, leading to many other health implications in the future (Anda et al., 2005).

Long-Term Effects

The effects of childhood trauma do not just effect victims in childhood, they continue well into adulthood (Delima & Vimpani, 2011). As Delima & Vimpani explain the responses of the brain at the time of trauma as a child, research also indicates that this is something that follows into adulthood, and continues to be a delay (Delima & Vimpani, 2011, Suzuki, Poon, Papadopoulus, Kumari, & Cleare, 2014). Adults, who experienced trauma as a child, have shown reduced stress responses and depressed cortisol responses (Suzuki, Poon, Papadopoulus, Kumari, & Cleare, 2014).

Although, there are many possible explanations of the development of depression and other mental health diagnoses in adulthood, many studies have indicated that early childhood traumatic events are a high indicator of mental health concerns in adulthood (Alvarez, Masramon, Pena, Pont, Gourdier, Roura-Poch, & Arrufat, 2015). One study indicates that experiencing trauma as a child doubled the risk of developing psychosis as an adult (Alvarez, Masramon, Pena, Pont, Gourdier, Roura-Poch, & Arrufat, 2015). Childhood trauma has also been indicated by research to significantly increase the odds of becoming depressed in adulthood (Coleman et al., 2013). Females, who witnessed parental violence as a child, were twice as likely to report moderate depression and 3 times as likely to report moderately severe depression, compared to their study cohort who did not witness parental violence as a child (Nicodimos, Gelaye, Williams, & Berhane, 2009). Male participants from the same study, were twice as likely to report having suicidal thoughts when they witnessed violence, compared to those who did not (Nicodimos, Gelaye, Williams, & Berhane, 2009). Female participants who witnessed

parental violence also reported higher rates of poor self-image and lower self-esteem then participants who did not witness violence as a child (Nicodimos, Gelaye, Williams, & Berhane, 2009).

Academic Concerns

Although not as much research as been conducted on the specific academic concerns of children who have experienced trauma, there is some research that indicates adverse educational outcomes ("Adverse Childhood Experience," 2010). In study done by the Center for Disease Control, respondents with the lowest educational attainment are the most likely to have indicated they have experienced 5 or more adverse childhood experiences ("Adverse Childhood Experience," 2010). While those with lower rates, or 0 adverse childhood experiences, had higher rates of earning not only a high school diploma but also post secondary education ("Adverse Childhood Experience," 2010).

Research indicates that experiencing traumatic events can set a negative path for children in their educational development ("Adverse Childhood Experience," 2010). Because of changes to the hippocampus activation, there may be deficits in memory tasks as well as deficits in verbal declarative memory (O'Neill, Guenette, & Kitchenham, 2010, Delima & Vimpani, 2011). Traumatic events can interfere with a child's ability to self-soothe and regulate their emotions; concerns at school can stem from this, as students who have experienced trauma as a child have demonstrated less creativity and less flexibility in problem solving (O'Neill, Guenette, & Kitchenham, 2010). Children who have secondary trauma, such as witnessing violence in their home, also show deficits in abstract reasoning and executive functioning (O'Neill, Guenette, & Kitchenham, 2010). Creativity, flexibility in problem solving, abstract reasoning and executive functioning are all things that young children exhibit in their learning process, but children who

have experienced or witness a traumatic event, have shown delays and deficits in theses main developmental areas, causing gaps and concerns within the school building (O'Neill, Guenette, & Kitchenham, 2010). When looking specifically at children who are survivors of sexual abuse, in one study looking at social and academic effects of child sexual abuse, 39% of child sexual abuse survivors had clinical academic concerns, 34% exhibited externalized and withdrawn behaviors, and 28% reported social problems (Daignault & Hébert, 2009). Based on this particular research, it is noted that 10% of the general population are expected to fall into these categories (Daignault & Hébert, 2009).

The negative sense of self that is developed by children who have experienced or witnessed trauma also plays a role in their performance academically (Brown, Brack, & Mullis, 2008). Students who have experienced trauma, may have a hard time concentrating in school, may not complete work on time or have difficulty understanding the material (Brown, Brack, & Mullis, 2008). If educators are unaware of the reasoning behind this, they may assume the child is lazy, slow or just refusing to do the work (Brown, Brack, & Mullis, 2008). This then plays into the self esteem and self worth of these students, if they are hearing from school professionals that they aren't trying or they aren't understanding, when in fact this is one way that their trauma experience is manifesting it may have a negative effect on the students' self-esteem (Brown, Brack, & Mullis, 2008).

Children, who are survivors of sexual abuse, have learned different coping skills, then children who have not been sexually abused (CSA and School Counselors). These coping skills can create problems for them in school; lying, making up excuses, blaming others for not having work completed, refusing to do homework, or getting angry with a teacher (CSA and School Counselors). These are all things that these children have learned, to survive in cope in their

everyday life, but when they come to school they are seen as negatives, which then can create problems in the classroom, as well as during unstructured time (Brown, Brack, & Mullis, 2008). When looking at child physical abuse as well as child sexual abuse, the increased exposure to either of these experiences, was significantly related with failing to achieve secondary school qualifications, gaining a high school diploma, and attending a University (Boden, Horwood, & Fergusson, 2007).

The research that has been done on academic concerns relating to trauma is not extensive, but the research that has been completed does show that there is a link between physical abuse and neglect with academic and social difficulties (O'Neill, Guenette, & Kitchenham, 2010). The link may not be caused directly by the exposure to the trauma, but rather the social and familial context surrounding the trauma (Boden, Horwood, & Fergusson, 2007). More research needs to be done on this area, in order to fully understand the relationship between academic performance and trauma experiences.

Current Trauma Interventions

When a child has experienced trauma, one or many parts of their lives have high levels of stress, so while the child is at school, it is important that stress levels are low (Fontes, 2000). School is sometimes the only place children have a safe and regulated environment, so within this environment, children who have experienced trauma can and should receive treatment and support (Fontes, 2000). School counselors act as the mental health professional within the school setting to help support children who have experienced a traumatic event. The intervention type chosen by the school counselor will depend on the severity and type of trauma experienced by the child. In all instances, the stability and safe network of school professionals proves to be important in the process of healing for children who have experienced trauma (Fontes, 2000,

Brunzell, Waters, & Stokes, 2015). There are many different evidence based interventions that have been developed; below three are discussed.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Cognitive Behavioral Intervention for Trauma in Schools or CBITS was developed by a research organization, RAND in collaboration with UCLA and Los Angeles Unified School District (LAUSD) **(**RAND Health). CBITS has been used for many different types of trauma including; witnessing or being a victim of violence, being in a natural or man-made disaster, being in an accident or house fire, or being physically abused/injured ("CBITS fact sheet"). Cognitive Behavioral Intervention for Trauma in Schools is skills-based, group intervention ("CBITS fact sheet"). The aim is to reduce Post-Traumatic Stress Disorder, depression and general anxiety in children who have experienced trauma ("CBITS fact sheet").

Main Components

CBITS includes group sessions, individual sessions, and homework assignments to reinforce the skills learned throughout the sessions ("CBITS fact sheet"). Through the group and individual sessions participants learn about the effects of trauma and are guided through cognitive therapy and social problem-solving techniques **(**RAND Health). Participants also will develop a narrative of their traumatic experience **(**RAND Health). Through Cognitive Behavioral Intervention for Trauma in Schools, children will learn skills in relaxation, how to challenge upsetting thoughts and social problem solving ("CBITS fact sheet"). Children will also process through their traumatic memories and grief ("CBITS fact sheet").

There are 10-group sessions, 1 hour in length as well as one to three individual sessions held throughout ("CBITS fact sheet"). Participants are also given assignments to complete outside of sessions, in order to solidify their knowledge of the skills learned **(**RAND Health).

Another competent to CBITS is parent and teacher education; parents will participate in two education sessions and teachers will participate in one education session ("CBITS fact sheet"). CBITS has 6 essential components; education about reactions to trauma, relaxation training, cognitive therapy, real life exposure, stress or trauma exposure and social problem solving ("CBITS fact sheet").

Effectiveness

Cognitive Behavioral Intervention for Trauma in Schools utilizes the Child PTSD Symptom Scale and the Children's Depression Inventory and the Pediatric Symptom Checklist to assess symptoms of trauma in the child ("CBITS fact sheet"). The assessments are given before CBITS is implemented, immediately following the program completion and three months after the end of the program ("CBITS fact sheet").

In one study, a group of students who were on a wait list was compared to students who received CBITS immediately following the baseline assessment performed better in math and reading **(**RAND Health). Cognitive Behavioral Intervention for Trauma in Schools have been shown to reduce symptoms of PTSD as well as depressive symptoms in students who have completed the intervention treatment ("CBITS fact sheet"). CBITS is being widely implemented and recognized by national organizations such as the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Administration and Centers for Disease Control and Prevention, and the U.S. Department of Justice **(**RAND Health).

Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR/NST)

Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling or STAIR/NST aims to reduce trauma related symptoms specifically looking at PTSD as well as

enhance specific social and emotional competencies that might be stunted by a traumatic experience ("STAIR/NST fact sheet"). STAIR/NST is an appropriate intervention for girls aged 12 to 21, who have experienced trauma ("STAIR/NST fact sheet"). Although particularly geared from sexual and physical abuse survivors, other trauma experiences including community violence, domestic violence, and sexual assault have been included in the target population ("STAIR/NST fact sheet").

Main Components

The Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling program is looked at in two phases ("STAIR/NST fact sheet"). The first phase focuses on skill training and targets social and emotional competency building ("STAIR/NST fact sheet"). Interventions that are used throughout treatment include emotional regulation skills, social skill development, positive self-definition exercises, and goal setting and achievement ("STAIR/NST fact sheet"). The second phase, which incorporates the narrative story telling component of this intervention, focuses on emotional processing of the trauma experience and developing a positive future life narrative (STAIR/NST fact sheet).

Effectiveness

Although Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling doesn't show a change in academic performance in participants, there are positive outcomes after participating in STAIR-NST ("STAIR/NST fact sheet"). Participants show a decrease in PTSD symptoms, depression and dissociation ("STAIR/NST fact sheet"). After STAIR-NST participants also show an improvement in emotion regulation and social skills ("STAIR/NST fact sheet").

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) combines trauma sensitive interventions with cognitive behavioral therapy ("TF-CBT fact sheet"). TF-CBT is an appropriate intervention for children ages 3 to 18, who have experienced a non-caregiver trauma (Child Welfare, 2012). Trauma-Focused Cognitive Behavioral Therapy is based on learning and cognitive theories (Child Welfare, 2012). Through these approaches, distorted believes and attributions that are related to the trauma are addressed while providing a supportive environment (Child Welfare, 2012).

Main Components

Establishing and maintaining a positive therapeutic relationship with the child is one of the main components of Trauma-Focused Cognitive Behavioral Therapy. Trauma-Focused Cognitive Behavioral Therapy aims to reduce the child's negative emotional and behavioral responses to trauma, shift maladaptive beliefs and also provide support and skills to non-offending parents (Child Welfare, 2012). TF-CBT utilizes 12 to 18 sessions that are 50 to 90 minutes in length (Child Welfare, 2012). TF-CBT uses an individualized counseling approach, and incorporates parent/caregiver sessions as well (Child Welfare, 2012). The main components of Trauma-Focused Cognitive Behavioral Therapy can be summarized by the abbreviation "PRACTICE" (Child Welfare, 2012). PRACTICE stands for: P-psychoeducation and parenting skills, R-relaxation techniques, A-affective expression and regulation, C-cognitive coping and processing, T-trauma narrative and processing, I-in vivo exposure, C-conjoint parent/child sessions and E-enhancing personal safety and future growth (Child Welfare, 2012).

Effectiveness

To date, there have been 11 studies conducted to show the effectiveness of Trauma-Focused Cognitive Behavioral Therapy (Child Welfare, 2012). When looking at the results as a whole, TF-CBT consistently reduces symptoms of PTSD, depression and behavioral difficulties (Child Welfare, 2012). When compared to other intervention models such as supportive therapy, nondirective play therapy, child-centered therapy, TF-CBT participants show significantly greater gains in many areas including; ability to cope with reminders of trauma, reductions in depression, anxiety, behavior problems and trauma-related shame, development of improved personal safety skills and are more prepared to cope with future trauma reminders (Child Welfare, 2012).

Discussion

Although there are many evidence-based interventions for children who have experienced trauma, three were discussed in this paper; Cognitive Behavioral Intervention for Trauma in Schools, Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling, and Trauma Focused Cognitive Behavioral Therapy. All three of the interventions discussed in this paper show improvements in trauma symptoms, but they require many sessions to fully implement, that most school counselors do not have the time for. As a future school counselor, it is important to have brief, yet effective interventions to help support students who have experienced trauma while they are at school.

There are key components of the more extensive interventions discussed above that can be utilized by school counselors to help support students who have experienced trauma in a more brief way, while still being effective. One of these key components would be relaxation techniques, which is discussed in both Trauma-Focused Cognitive Behavioral Therapy and Cognitive Behavioral Intervention for Trauma in Schools (“TF-CBT fact sheet”, “CBITS fact

sheet"). Knowledge of ways to relax for students, who have experienced trauma, is essential in the school setting. Research addresses that exposure to traumatic events deregulates children and they may not have the correct coping skills to deal with their emotions (CSA and School Counselors). Working on relaxation techniques with students' gives them the tools to calm down that they may not have had before, or that may have been interfered with because of the trauma experience. Along the same lines as relaxation techniques is another component from one of the above interventions, and that is emotional regulation ("STAIR/NT fact sheet"). When children are exposed to trauma, their emotional developed is often impaired (Price, Higa-McMillan, Kim, & Frueh, 2013). School counselors can use their time with students who have experienced trauma to rebuild their emotion identification and regulation skills. Social problem solving is component within CBITS that would be important for school counselors to implement with students who have experienced trauma. Research indicates students who have experienced trauma as a child have demonstrated less creativity and less flexibility in problem solving (O'Neill, Guenette, & Kitchenham, 2010). With the research in mind, that shows less flexibility in problem solving, school counselors will need to access the students' ability to problem solve, and incorporate this component into their intervention with students.

Although each of the three interventions discussed in this paper have a component that looks at the trauma experience, so the child can process through it, other research advises that exposure and direct exploration of the trauma is not appropriate for the school environment (Nickerson, Reeves, Brock & Jimerson, 2009). It is important as the school counselor, to identify areas of concern within the school environment and use techniques to help the student be the most successful they can be while at school. If more intensive trauma work needs to be done, a referral should be made to an outside source.

While many school counselors will not have the time and resources to fully implement the interventions discussed within this paper, there are many key components that they can pull from the interventions to use. The school environment is sometimes the only stable environment for children who have experienced a traumatic event, which heightens the importance of interventions in this setting (Fontes, 2000). Outside of school, many students whom need mental health support, will not receive it which also places an important responsibility on the school system to identify and treat students who have experienced trauma (Fontes, 2000). Research indicates many effects of trauma on children, not only in the present moment but also long term effects into their adult lives. Without the support and intervention early on, children are at an increased risk to continue to have symptoms of their trauma throughout their life (Delima & Vimpani, 2011). These reasons are why it is essential work for the school counselor to be able to effectively work with children who have experienced trauma in their lives.

An area that needs more research done is looking at the link between trauma experiences and academic performance. At this time there is a lack of research on the effect of trauma on academic performance. The research that has been done shows decreased academic performance in those that experienced trauma, but a direct link cannot be determined (Boden, Horwood, & Fergusson, 2007). There are many other factors, such as home environment and poverty that the research has not fully taken into account (Boden, Horwood, & Fergusson, 2007). The research that has been done suggests that there are other factors involved; so more research needs to be done in this area in order to completely understand how trauma affects students' academic performance.

There has been more extensive research that shows the effectiveness of trauma-based interventions in reducing symptoms of PTSD, depression, and anxiety. Although these findings

cannot be directly related to school performance; more research looking at students' academic performance before and after their involvement with these evidence based interventions may give us a wider picture of how these interventions can help children who have experienced trauma, in many different aspects of their lives.

The three interventions discussed within this paper are only three of many that are currently being used in the field. They contain important techniques to help children who have experienced trauma, cope and move past their traumatic experienced. Although school counselors most often will not have the time or resources to fully implement these interventions, important things can be taken from them to be utilized by the school counselor; relaxation techniques, emotion regulation and social problem solving skills. While at school, children who have experienced trauma will not leave their trauma behind, which is why it is essential for the school counselor to work with these students to ensure success in and out of school.

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