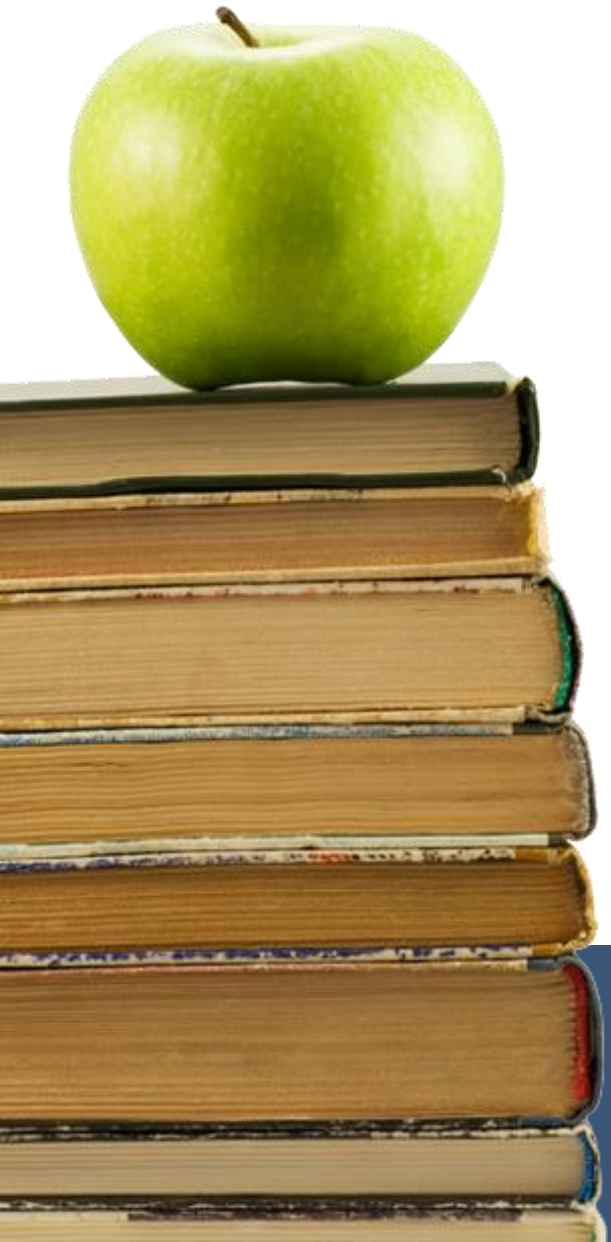

PBIS and Trauma Informed Schools

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2nd Annual Northern California PBIS/School Climate Symposium
April 17, 2015

The research reported here was supported by the Institute of Education Sciences, U.S. Department of Education, through Grant R324A110027 to SRI International. The opinions expressed are those of the authors and do not represent views of the Institute or the U.S. Department of Education.

Outline of presentation

- Brief overview of:
  - The effects of trauma on children
  - PBIS and trauma informed schools
- The *Cognitive Behavioral Intervention for Trauma in Schools* (CBITS) program
- Description of study design
- Summary of preliminary results:
  - Trauma screening
  - Baseline measures

Defining Trauma

What is trauma?

- Highly stressful event, such as:
  - Abuse
  - Abandonment
  - Accident
  - Exposure to violence or abuse
  - Bullying
  - Community violence
  - Homelessness
  - Injury/hospital stay
  - Loss of loved one
  - Natural disaster
- Characterized by unpredictability
- Threatens physical or mental well-being
- Evokes feelings of extreme fear or helplessness
- Overwhelms an individual's capacity to cope

Prevalence of trauma and violence

- 2009 survey of U.S. children under age of 17
  - More than 60% were victims or witnesses of violence
    - 25% witnessed a violent act
    - 10% saw one family member assault another
  - Nearly one-half (46%) were assaulted at least once in past year
    - 10% were injured in the assault
  - One-fourth (25%) were victims of robbery or vandalism
  - 10% were victims of child maltreatment (physical or emotional abuse, neglect, or family abduction)
  - 1 in 16 (6%) were victimized sexually

Post Traumatic Stress Disorder

- Most children experience stressful events which can affect them emotionally and physically.
  - Reactions to stress are *usually* brief, and they recover without further problems.
- **Posttraumatic Stress Disorder** is the development of *ongoing* and pervasive difficulties following exposure to one or more extreme traumatic events that were life-threatening or perceived to be likely to cause serious injury.
  - Symptoms may last several months to years.
  - About 5% of children are diagnosed with PTSD.
  - Risk of developing PTSD is related to severity of the trauma and the child's relationship to the victim(s).

Effects of Trauma on Children

Adverse Childhood Experiences Study

- The ACE study is a large-scale population study that examines the association of traumatic childhood experiences and serious household dysfunction to multiple health behaviors that impact later life physical and mental health.
- The study has examined more than 17,000 patients who participate in routine health screenings.
- The study was run through a collaboration between the Centers for Disease Control and Prevention in Atlanta and Kaiser Permanente in San Diego.

Adverse Childhood Experiences Study

- Categories of childhood exposure to trauma that were asked about in ACE study:
  - Psychological abuse
  - Physical abuse
  - Sexual abuse
  - Mother treated violently
  - Living in a household with someone who as a substance abuser
  - Living in a household with someone with mental illness
  - Living in a household with someone who was imprisoned
- More than half of those participating in the ACE study reported at least one exposure, and 27% reported more than 2 categories of childhood exposures.

Adverse Childhood Experiences Study

- Compared to people who had no history of ACEs, those with histories of exposure to **four** or more were:
  - Twice as likely to smoke
  - Seven times more likely to be alcoholics
  - Six times more likely to have had sex before the age of 15
  - Twice as likely to have been diagnosed with cancer
  - Twice as likely to have heart disease
  - Four times as likely to suffer from emphysema or chronic bronchitis
  - Twelve times as likely to have attempted suicide
  - Ten times more likely to have injected street drugs

Effects of trauma on children

- Symptoms of trauma may include:
  - Isolation
  - Hyperactivity
  - Aggression
  - Anger
  - Sadness
  - Distraction
  - Fearfulness
  - Moodiness
- Children exposed to violence are more likely to have:
  - Behavior problems
  - Poor school performance
  - Problems with authority
  - Difficulty following directions
  - More school absences
  - Somatic complaints
  - Poor sleep and nightmares
  - Symptoms of depression
  - Fewer friends

Exposure to trauma over time

- **Single** exposure to an event may cause

  - Jumpiness
  - Intrusive thoughts
  - Interrupted sleep
  - Nightmares
  - Anger
  - Moodiness
  - Social Withdrawal
  - Disorganized or agitated behavior

  Any of which can interfere with concentration and memory

- **Chronic** exposure can:
  - Adversely affect attention, memory, and cognition
  - Reduce ability to focus organize and process information
  - Interfere with effective problem solving and/or planning
  - Result in overwhelming feelings of frustration and anxiety

Developmental reactions: Adolescents

- Adolescents may:
  - Feel self-conscious about their emotional responses
  - Engage in self destructive behavior
  - Experience feelings of shame/guilt
  - Express fantasies about revenge and retribution
  - Experience feelings of fear, vulnerability, and concern over being labeled “abnormal” or different from peers, causing withdrawal from friends/family.
- A traumatic event in adolescence may foster a radical shift in the way these children think about the world.

Common reactions to traumatic events

- Thinking about the traumatic event all the time
- Wanting NOT to think or talk about it
- Feeling “crazy” or out of control
- Being on guard to protect self
- Feeling shame, feeling bad about self
- Feeling anger
- Feeling sadness, grief, loss
- Having health problems

Trauma effects in the classroom

How might a traumatized student act in class?

- Fails to understand directions
- Over-reacts to:
  - Comments or criticism from teachers and peers
  - Noises (startles at bells, slamming doors)
  - Physical contact
  - Environmental cues (low lighting, sudden movements)
- Has difficulty with authority and redirection
- Misreads context; fails to connect cause with effect
- Clingy and worried about safety
- Distracted and unable to complete work/homework
- Irritable or angry
- Uncomfortable, in pain, or sick

Trauma effects on academic outcomes

- Trauma symptoms interfere with concentration, memory, and cognition, leading to:
  - Decreased IQ and reading ability (Delaney-Black et al., 2003)
  - Lower grade-point average (Hurt et al., 2001)
  - Decreased rates of high school graduation (Grogger, 1997)
  - Increased expulsions and suspensions (LAUSD Survey)

Video

PBIS and Trauma Informed Schools

Positive Behavioral Interventions & Support

- A systems approach for establishing the **social culture** and individualized behavioral supports needed for schools to be effective learning environments for **all** students.
- Evidence-based features of SWPBS
  - Prevention
  - Define and teach positive social expectations
  - Acknowledge positive behavior
  - Arrange consistent consequences for problem behavior
  - On-going collection and use of data for decision-making
  - Continuum of intensive, individual interventions.
  - Administrative leadership – Team-based implementation (Systems that support effective practices)

Why should schools be trauma informed?

- Children are more likely to access mental health services through primary care and schools than through specialty mental health clinics. (Costello et. al., 1998).
- Schools are de facto mental health system often providing the only mental health services available to children (Burns et. al., 1995).
- Strategies for creating trauma informed schools fit well into existing initiatives such as PBIS.

PBIS and trauma informed schools

- Trauma informed schools:
  - Acknowledge the prevalence of traumatic occurrence in students' lives.
  - Create a flexible framework that provides universal supports.
  - Are sensitive to unique needs of students.
  - Are mindful of avoiding re-traumatization.
- A trauma informed school is most effectively created and maintained when positive universal supports and strategies are part of daily school programming.

Trauma informed schools

Practices in trauma informed schools often involve a shift in thinking. Embracing a trauma informed school culture requires:

- Understanding of how trauma impacts the individual.
- Understanding symptoms/behaviors as attempts to cope.
- Avoidance of retraumatization.

Trauma informed schools

Schools that implement trauma informed practices increase trauma awareness by ensuring school staff, educators, and administrators:

- Recognize the potential effects of trauma on education (e.g., attendance, grades, test scores, classroom behavior, etc.).
- Identify students who are in need of help due to exposure to trauma.
- Consider students' trauma histories and needs in every aspect of service delivery.

Trauma informed schools

How can support staff help?

- Help the school community understand trauma and its impact on individuals.
- Focus on prevention of future trauma exposure.
- See learning-interfering behaviors as possibly symptoms of students coping with trauma.
- Promote skill building and resiliency.
- Support student empowerment.
- Build on student strengths.

Trauma Informed Practices for Educators

Goal of Interventions:
Restore developmental progress

- **Affect Regulation**: Teaching emotional self-regulation and adapting student environment to meet needs
- **Trust in Human Relationships**: Modeling appropriate boundaries
- **Joy in Exploration and Learning**: Creating safe environments to learn and explore

The power of school relationships

- School is where traumatized children can:
  - Forge strong relationships with caring adults
  - Learn in a supportive, predictable, and safe environment
- Mastering academic and social skills are key to healing, so:
  - Increase teaching and learning time
  - Reduce time spent on discipline
- Partner with parents and guardians:
  - Support parents who may be struggling with symptoms of trauma themselves
  - Teach students how to regulate and calm their emotions and behavior

Using a “trauma lens”

A shift in perspective from:

“What is wrong with this student?”

to

“What has this student been through?”

What can I do to support my student?

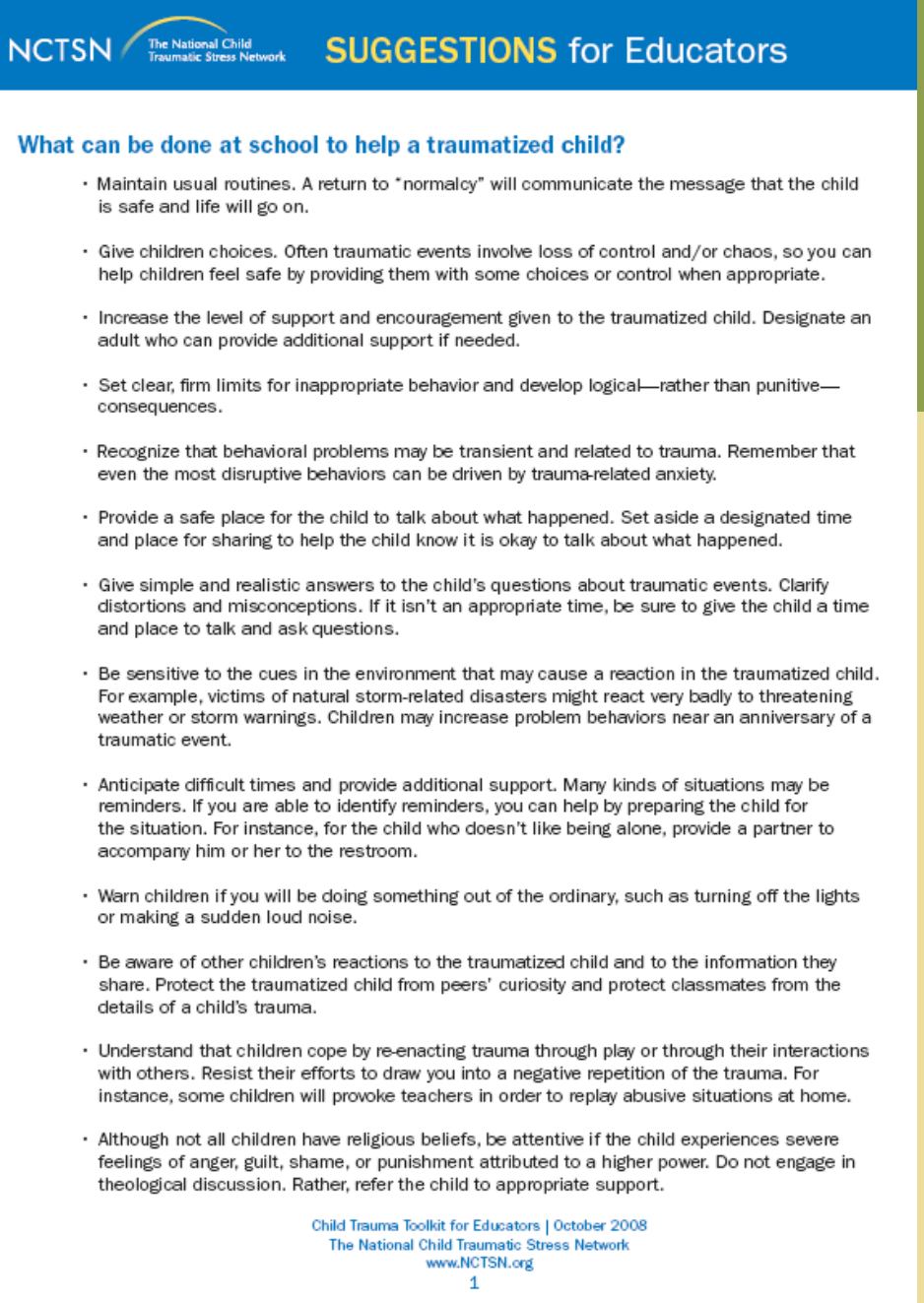
- Maintain consistency, “normalcy”
  - Predictable routines, clear expectations, firm behavior limits, consistent rules
- Help youth cope with day to day problems
  - Be sensitive to environmental cues and reminders of trauma
- Maximize the student’s sense of safety
  - Accept no bullying or teasing
  - Provide a safe place for student to talk/calm self
  - Use a calm, soft voice to forewarn a student of a fire drill, change in lunch period, or circumstances that may remind the student of past trauma
- Give clear choices when possible, giving a sense of control
- Use restorative practices to build relationships and skills

How can I show my understanding?

- Use positive or progressive discipline
- Understand that youth process their experiences through their interactions with others
  - Students may try to re-enact or provoke situations
  - Know this is one way to cope with trauma
  - Resist efforts of provocation and power struggles
- Express positive thoughts for the future: Be strengths-based
- Be prepared to provide extra support, encouragement, and referral for counseling as needed. Ask:
  - How are you today?
  - What is your goal for today?
  - Who can you ask for help today?

Self care is important

- Seek support/consultation if:
  - You are dreaming about students' traumas, or can't stop thinking about them
  - You are having trouble concentrating, sleeping, or are feeling more irritable
  - You feel numb or detached



NCTSN The National Child Traumatic Stress Network **SUGGESTIONS for Educators**

What can be done at school to help a traumatized child?

- Maintain usual routines. A return to "normalcy" will communicate the message that the child is safe and life will go on.
- Give children choices. Often traumatic events involve loss of control and/or chaos, so you can help children feel safe by providing them with some choices or control when appropriate.
- Increase the level of support and encouragement given to the traumatized child. Designate an adult who can provide additional support if needed.
- Set clear, firm limits for inappropriate behavior and develop logical—rather than punitive—consequences.
- Recognize that behavioral problems may be transient and related to trauma. Remember that even the most disruptive behaviors can be driven by trauma-related anxiety.
- Provide a safe place for the child to talk about what happened. Set aside a designated time and place for sharing to help the child know it is okay to talk about what happened.
- Give simple and realistic answers to the child's questions about traumatic events. Clarify distortions and misconceptions. If it isn't an appropriate time, be sure to give the child a time and place to talk and ask questions.
- Be sensitive to the cues in the environment that may cause a reaction in the traumatized child. For example, victims of natural storm-related disasters might react very badly to threatening weather or storm warnings. Children may increase problem behaviors near an anniversary of a traumatic event.
- Anticipate difficult times and provide additional support. Many kinds of situations may be reminders. If you are able to identify reminders, you can help by preparing the child for the situation. For instance, for the child who doesn't like being alone, provide a partner to accompany him or her to the restroom.
- Warn children if you will be doing something out of the ordinary, such as turning off the lights or making a sudden loud noise.
- Be aware of other children's reactions to the traumatized child and to the information they share. Protect the traumatized child from peers' curiosity and protect classmates from the details of a child's trauma.
- Understand that children cope by re-enacting trauma through play or through their interactions with others. Resist their efforts to draw you into a negative repetition of the trauma. For instance, some children will provoke teachers in order to replay abusive situations at home.
- Although not all children have religious beliefs, be attentive if the child experiences severe feelings of anger, guilt, shame, or punishment attributed to a higher power. Do not engage in theological discussion. Rather, refer the child to appropriate support.

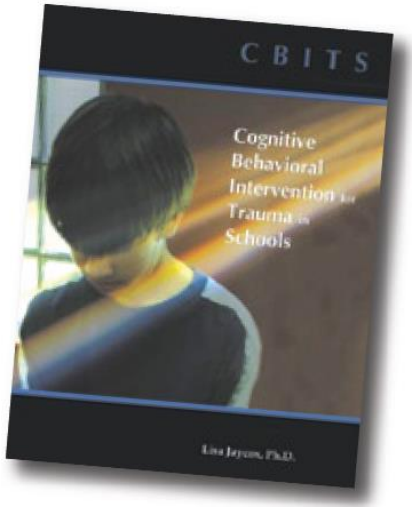
National Child Traumatic Stress Network

- Educators' toolkit in English and Spanish
  - Trauma facts
  - Resources for parents
- www.NCTSN.org

Cognitive Behavioral Intervention for Trauma in Schools: An Evidence-based Program for Students Exposed to Trauma

CBITS program overview

- School-based intervention developed by UCLA, RAND, & LAUSD
  - Delivered to students experiencing significant distress due to trauma
    - Implementers = MSWs, licensed psychologists, or interns
  - Tailored for the school setting and diverse populations
  - 10 weekly student group sessions, 1 individual (1-on-1) session
    - Two parent education meetings
- Cognitive behavioral techniques
  - Education about common reactions to trauma
  - Relaxation training: imaginal exposure
  - Cognitive therapy: fear thermometer
  - Real life exposure: fear hierarchy and coping strategies
  - Stress or trauma memory: drawing/writing exercises
  - Social problem-solving: HOT seat



Goals of CBITS

- Reduce symptoms of:
  - Post traumatic stress
  - General anxiety
  - Depression
  - Low self-esteem
  - Aggression and impulsivity
  - Other behavior problems
- Build resilience
  - Coping and decision making skills
  - Communication and social skills
  - Self care and self regulation
- Increase peer and parent support

CBITS evidence

- Cited as recommended practice by:
  - U.S. Dept of Justice (OJJDP) (Exemplary Program)
  - Promising Practices Network (Proven Program)
  - White House's Helping America's Youth (Highest Quality Evidence)
  - CDC Prevention Research Center (Effective Program)
  - SAMHSA's National Registry (3.8/4.0 Dissemination Rating)
  - National Child Traumatic Stress Network
- Previous research findings include:
  - Increased coping skills
  - Reduced trauma (PTSD) symptoms
  - Reduced depression symptoms
  - Reduced psychosocial dysfunction

Relevant research studies

- Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., et al. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. *Journal of the American Medical Association, 290*(5), 603-611.
- Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., et al. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(3), 311-318.
- Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., et al. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress, 23*(2), 223-231.
- Jaycox, L. H., Stein, B., Kataoka, S., Wong, M., Fink, A., Escudera, P., et al. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. Journal of the American Academy of Child and Adolescent Psychiatry, 41(9), 1104-1110.

CBITS website

- www.cbitsprogram.org
- Registration is **free** for:
  - On-line training
  - Sample materials and forms
  - Implementation assistance
  - Video clips
  - On-line community of experts and colleagues
    - Advice, networking, sharing materials

CBITS Study in San Francisco Unified School District

Funders and partners

- Funders
  - Department of Education, IES, NCSER (Goal 3 RCT)
- Partners:
  - Local School District: School Social Workers (SSWs)
  - UCLA: training, technical assistance, and fidelity rating
  - Stanford University: weekly clinical supervision

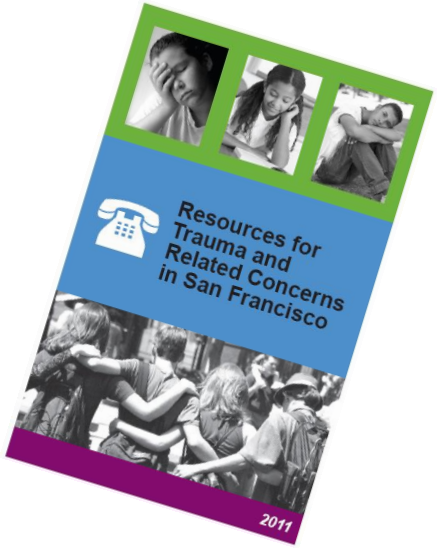
Sheryl Kataoka

Audra Langley

Shashank Joshi

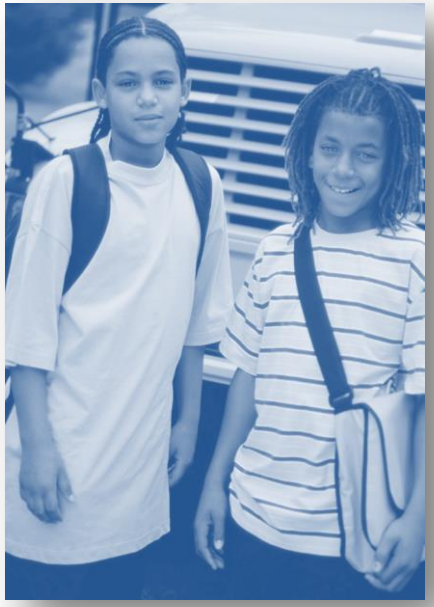
School participation

- Selected **12 middle schools** in neighborhoods with elevated violence, crime, and poverty rates
- Each school has at least 1 SSW, a certified clinician
- Each participating school receives:
  - **Resources** and **support** to implement CBITS
  - Yearly **stipends** ($1,000 per school)
  - Ongoing **staff education** and consultation
    - Training for *all* SSWs (including non-participating)
    - Weekly clinical supervision
  - Local **Resource Guide** for trauma services
  - **Data** to support applications for potential funding

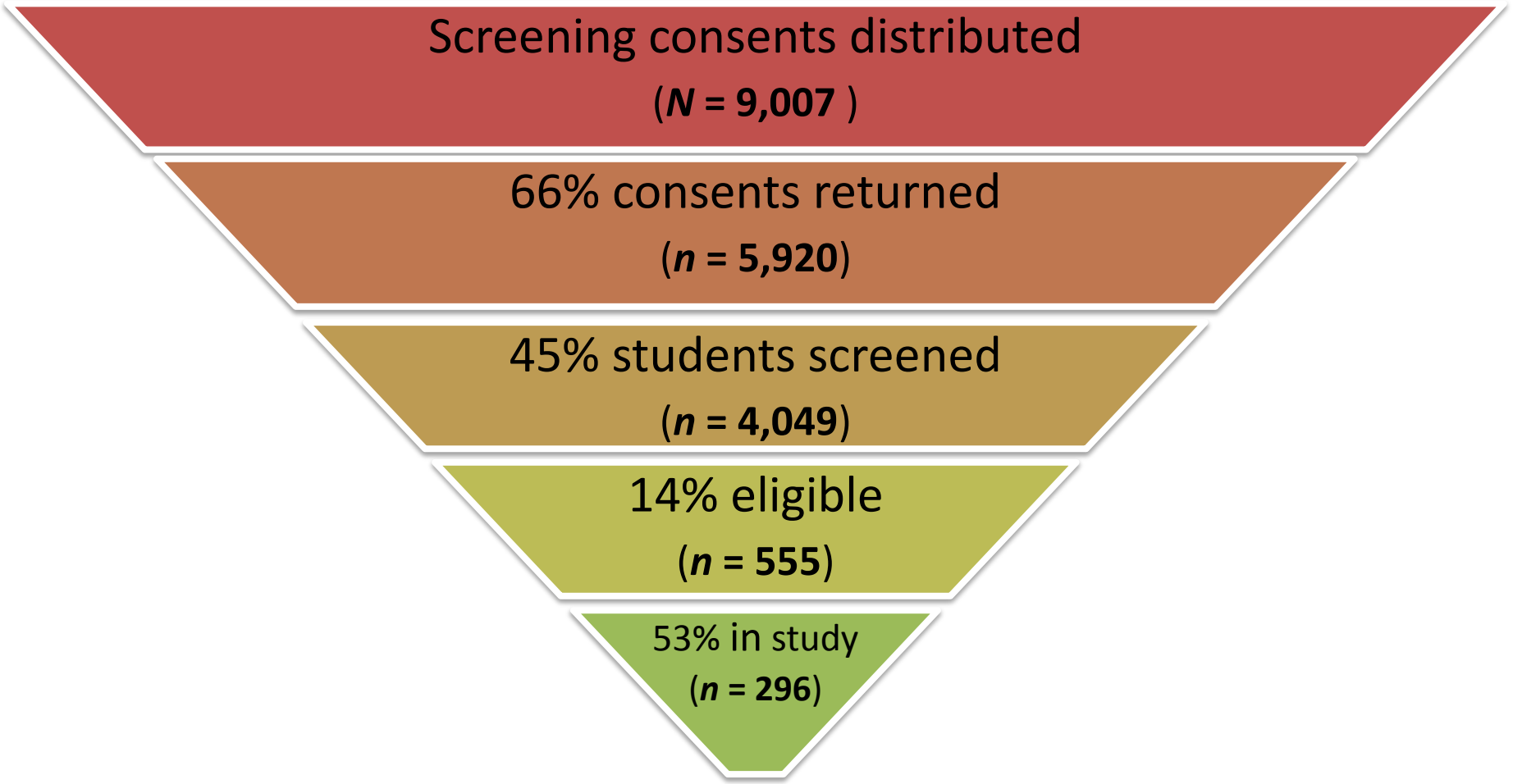


Screening and recruitment process

- **Active consent** for all incoming 6th grade students
  - Trauma Symptom Checklist for Children, PTS subscale (Briere, 1996)
  - Traumatic Events Screening Inventory (Ford & Rogers, 1997)
- **Eligibility** criteria:
  - 80th percentile on TSCC-PTS (*T* score 58+)
  - Endorsement of 1+ trauma event on TESI
  - Parent consent, student assent
- **Randomization** (after consent) to:
  - CBITS group or
  - *Business-as-usual* comparison group
    - Both received *Trauma Resource Guide*



Participants

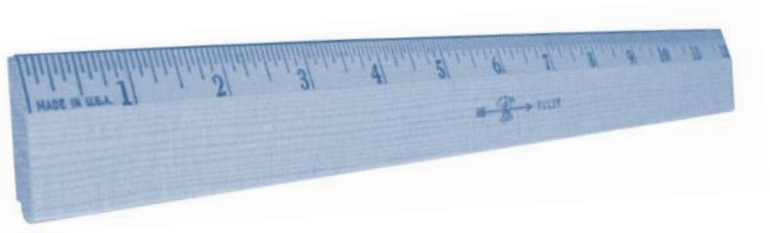


Data collection

Instrument	Purpose	Respondent
TSCC (Briere, 1996)	Trauma symptoms	Student (self report)
CRI-Y (Moos, 1993)	Coping responses	Student (self report)
SACA (Stiffman et al., 2001)	Services outside CBITS	Student (self report)
PSQI (Buysse et al., 1989)	Sleep duration/quality	Student (self report)
YSR (Achenbach & Rescorla, 2001)	Behavior	Student (self report)
WJ3 Brief Battery (Woodcock et al., 2006)	Reading and math achievement	Student (direct assessment)
AET (Walker & Severson, 1990)	Academic engagement	Classroom observation
TRF	Classroom behavior	Teacher

Other measures

- Student Record data
  - Attendance, grades, and services (e.g., special education)
- Social Validity surveys (students and SSWs)
  - Assess satisfaction with program content, materials, and impact
- Alliance surveys (students and SSWs)
  - Assess satisfaction with relationship
- Fidelity measures
  - Ratings of audiotaped sessions by external (UCLA) staff
  - Random sample: 20% of all sessions



Data collection timeline

Year 1	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
	Cohort 1 (C1) Screening and Consent		C1 Baseline	C1 Treatment			C1 Posttest			
Year 2	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
	Cohort 2 (C2) Screening and Consent		C2 Baseline	C2 Treatment			C2 Posttest C1 Follow-up			
Year 3	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
	Cohort 3 (C3) Screening and Consent		C3 Baseline	C3 Treatment			C3 Posttest C2 Follow-up			
Year 4	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
							C3 Follow-up			

Preliminary Results:

Participant Descriptives

Student screening: Total sample (*N* = 4,049)

- Overall prevalence of elevated trauma = 14%
  - Prevalence ranged from 7% to 21% by school
- Prevalence by gender:
  - 13.4% of females
  - 14.3% of males

Traumatic Events: Participants with elevated scores, lifetime events (n=550)

Traumatic Event	% Students
Been in serious accident	37%
Witnessed serious accident	48%
Natural disaster	30%
Relative sick/injured	73%
Been seriously ill/injured	55%
Relative died	58%
Separated from family	34%
Attacked by animal	31%
Threatened with harm	54%
Slapped, punched, or hit	67%
Witnessed someone slapped or hit	71%
Witnessed attack with weapon	15%

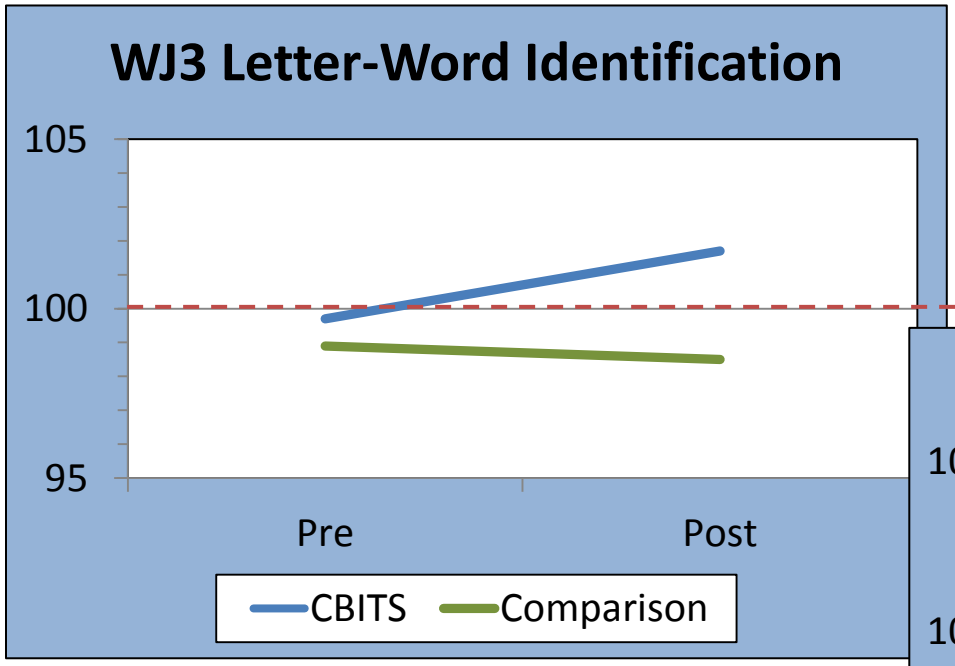
Mean Events endorsed
6.3

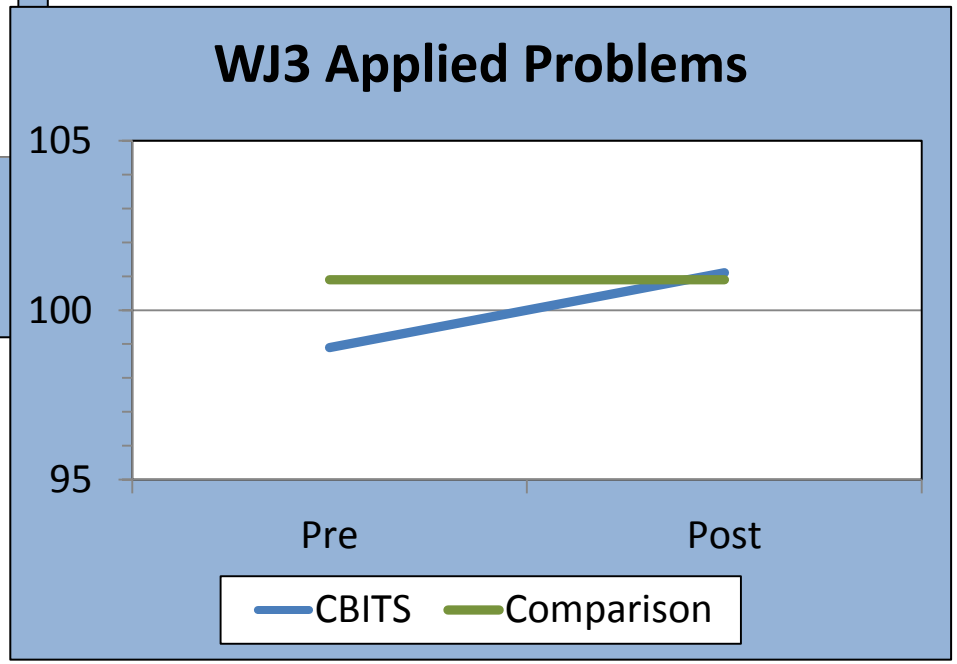
# Events	% Students
1–2	3%
3–4	14%
5–6	29%
7–8	30%
9–11	23%

Preliminary Results:

Pre-Post Repeated Measures

Preliminary academic outcomes

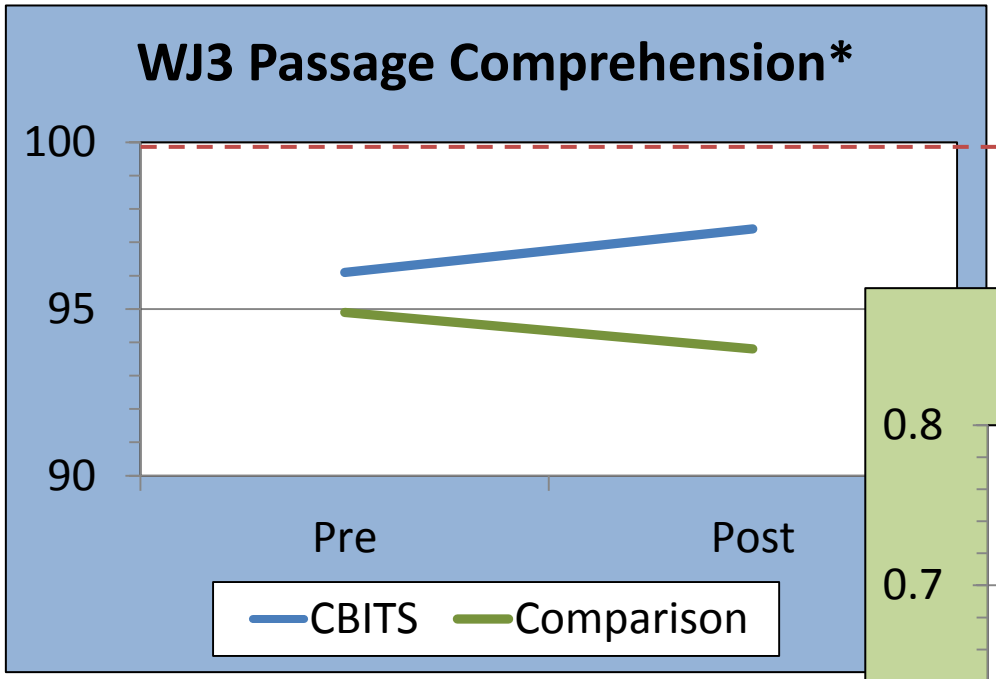


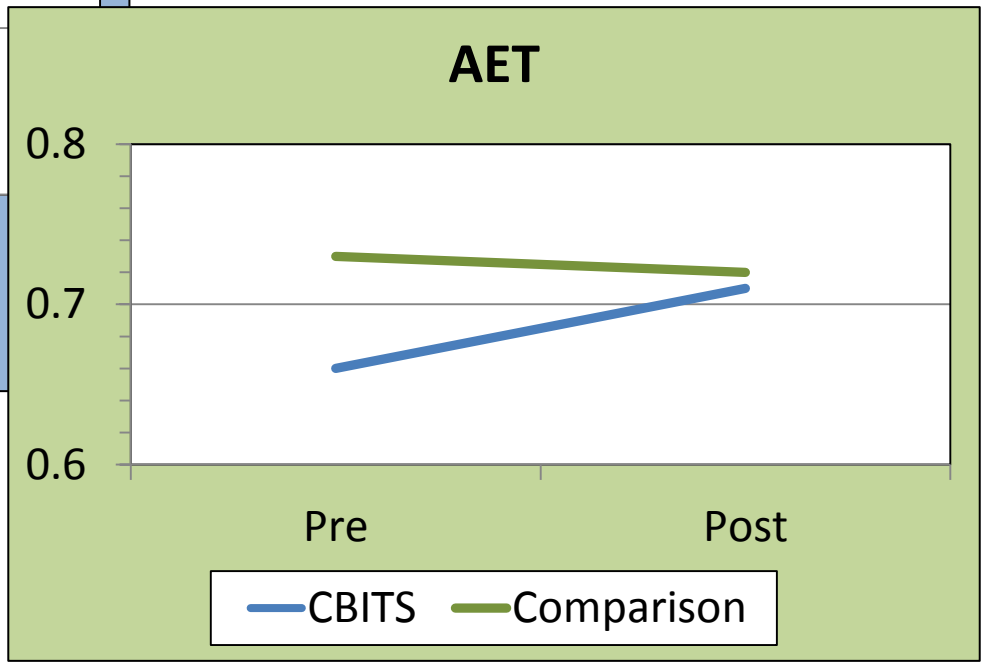


WJ3 LWI CBITS Δ $p < .05$

WJ3 AP CBITS Δ $p < .05$

Preliminary academic outcomes

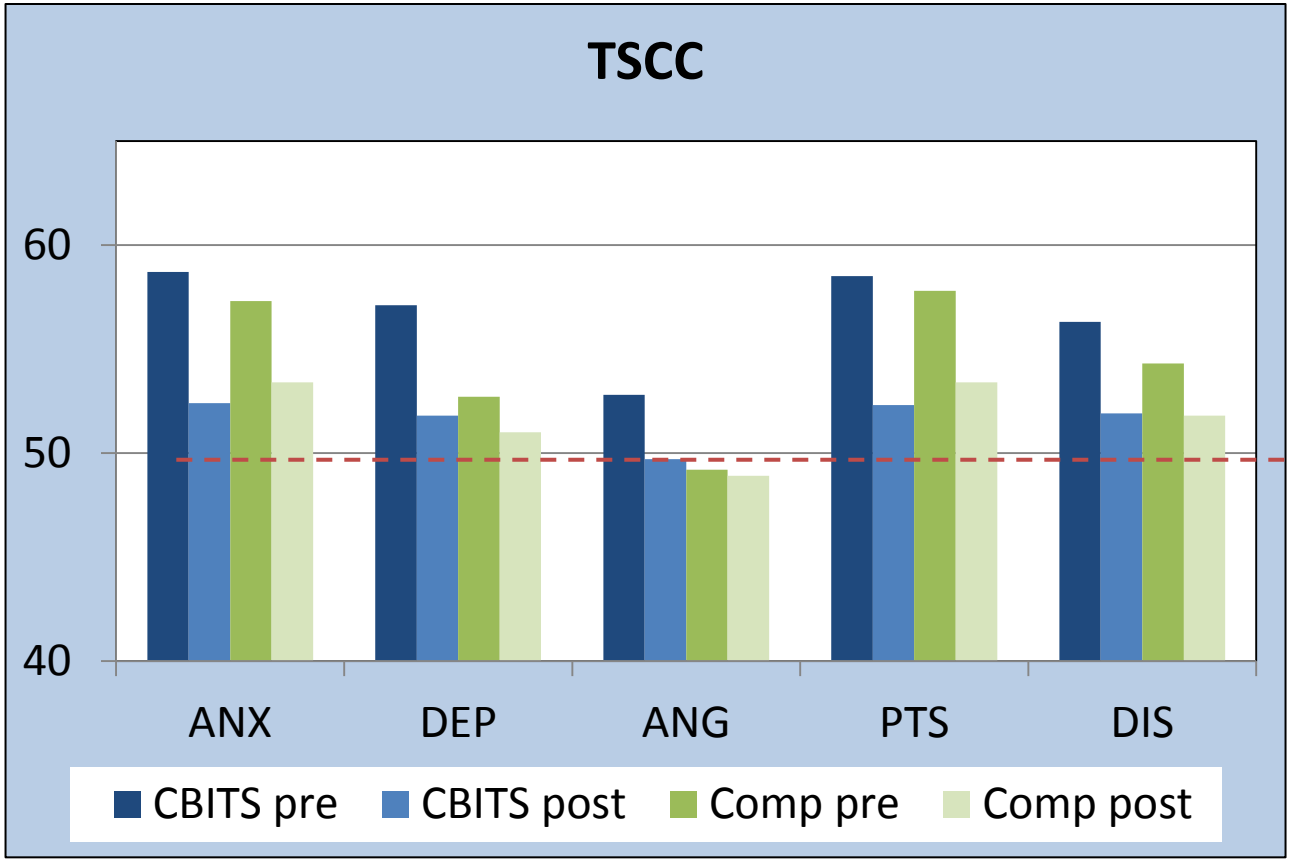




*WJ3 PC $p < .05$

AET CBITS Δ $p < .05$

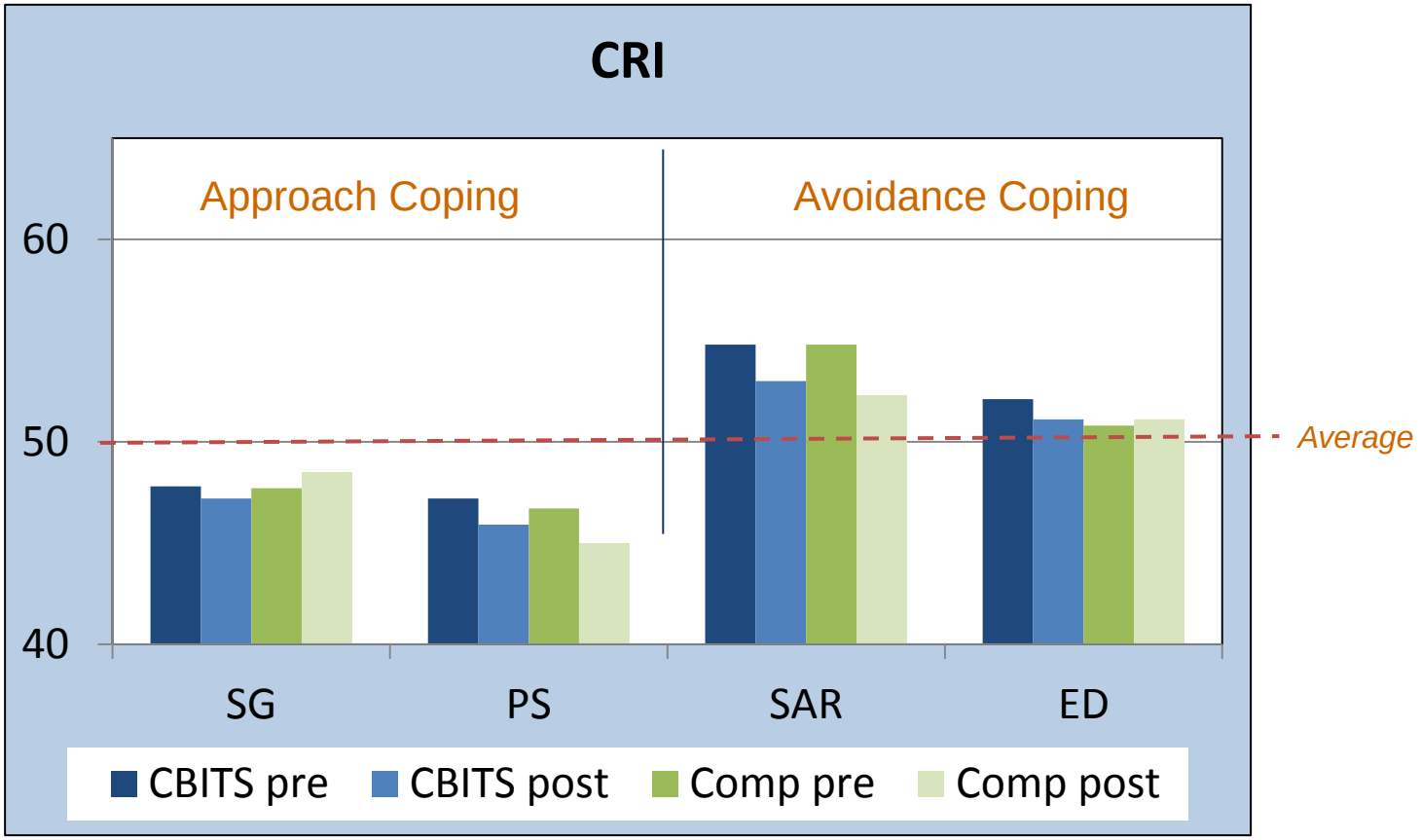
Preliminary trauma symptom outcomes



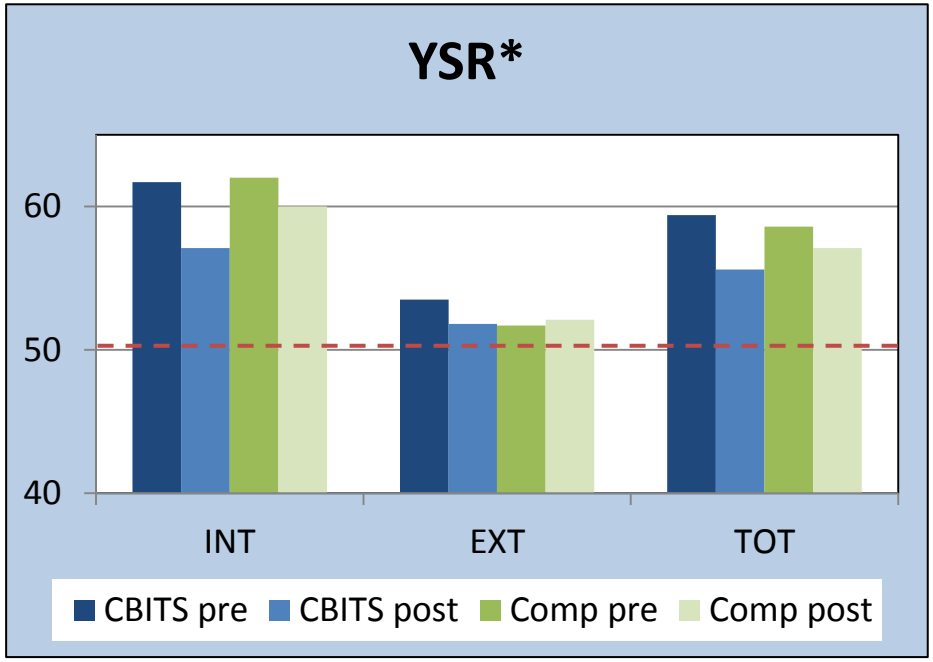
CBITS Δ $p < .05$
(ANX, DEP, ANG, PTS, DIS)

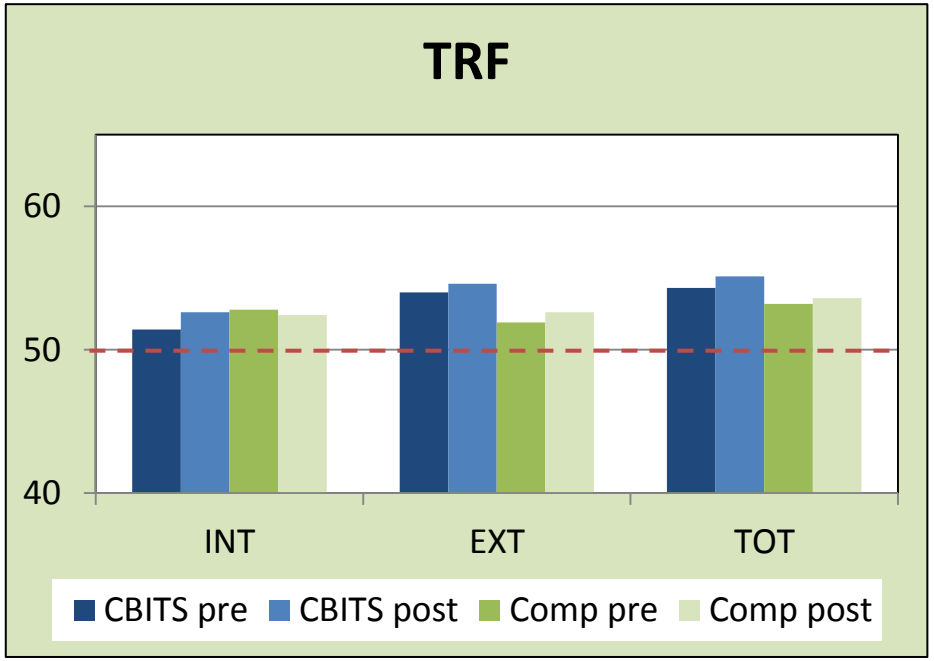
COMP Δ $p < .05$
(ANX, PTS, DIS)

Preliminary coping outcomes



Preliminary behavior outcomes





*YSR TOT $p < .05$

YSR INT CBITS Δ $p < .05$

YSR INT COMP Δ $p < .05$

Questions?