Recognizing Trauma in the Classroom

A Practical Guide for Educators

Certain at-risk behavior patterns are often associated with traumatic childhood experiences. With the role of schools evolving to shape children's developmental needs in today's world, educators across the globe bear an increasingly greater responsibility to identify and address these symptoms associated with childhood trauma. Given the differences in school infrastructure in various nations of the world, however, the services available to children through schools vary drastically. Nonetheless, the educators' position in respect to schooling and in shaping a society's future through education emphasizes their role as advocates for children experiencing trauma. In the article "Recognizing Trauma in the Classroom: A Practical Guide for Educators," Hope Bell, Dodie Limberg, and Edward "Mike" Robinson III address childhood trauma in the context of schools in the United States. Despite cross-national differences in educational settings and frameworks, teachers around the world may wish to consider these strategies for addressing symptoms of trauma evident in certain student behavior patterns. Given the differences across global regions, it is important to use context-based analysis of childhood trauma in instituting proper preventive measures.

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Educators (e.g., teachers, administrators, school counselors) are in an ideal position to observe behaviors and emotions that may result from childhood trauma; and may be the only adults present consistently enough in a child's life to distinguish trauma-related changes from the child's normal disposition (Cohen & Mannarino, 2011; Gelkopf & Berger, 2009; Openshaw, 2011). Without recognition by an adult, childhood trauma may go undiagnosed and untreated, causing many potential future problems in academia and beyond. Therefore, educators have an opportunity and a responsibility to be an advocate for children who have experienced trauma. All educators also have both an ethical and professional responsibility to promote a safe and culturally competent school climate to support the holistic development of all students (American School Counselor Association, 2010).

A trauma occurs when a child perceives themselves or others around them to be threatened by serious injury, death, or psychological harm. This in turn may cause severe stress, fear, and feelings of helplessness (Jaycox, 2006). Once traumatization has occurred, a child's natural ability to cope may be disrupted due to the overwhelming nature of the trauma (Terr, 1991). Childhood trauma may cause several realms of the child's school life to be affected, including interpersonal communication skills, peer relationships, and academic achievement (Jaycox, 2006). Children may be more comfortable receiving help from familiar faces and environments; therefore, educators are at the forefront of identifying and contributing to the treatment of childhood trauma, thus facilitating healthy personal, social, and academic development. The purpose of this manuscript is to: 1) provide a clear definition of childhood trauma through a school-based lens, 2) describe symptoms of trauma and their presentation within the school environment, and 3) provide effective strategies educators can apply in school to support children who have experienced trauma.

Types of Trauma

Traumas are generally divided into two categories: acute trauma and chronic trauma. The National Child Traumatic Stress Network (NCTSN, 2006a) defines acute traumas as "events (that) occur at a particular time and place and are usually short-lived" (para. 1). Terr (1991) identifies acute trauma as a "Type I" trauma and describes it as a single, unanticipated event. This includes such situations as natural disasters, car crashes, loss of a loved one, assault, and terrorist attacks. Characteristics of a Type I trauma include detailed memories of the event, the child looking for reasons or causes of the event, and visual hallucinations related to the trauma (Terr, 1991).

Chronic traumas, or "Type II," occur when related traumatic experiences occur over long periods of time. Examples of such traumas include long-term child abuse, neglect, domestic violence, and chronic illness. Characteristics common in those with Type II trauma include denial, dissociation, and rage (Terr, 1991). Whether acute or chronic, traumatic events hold the potential to create severe symptomology in children, affecting them mentally, physically, and academically.

Impact of Childhood Trauma

The effects of a traumatic event or series of events often have a widespread, long-lasting impact on a child's development. As educators come into contact with children daily, and are often trusted figures in children's lives, they are in a unique position to assist in children's recovery. Traumatized children have the potential to be affected long-term, both academically and in their mental health.

Unresolved trauma may leave a child open to several negative academic consequences. Research has linked trauma in childhood to a disruption in executive functioning, which controls the brain's ability to develop working memory and process and integrate new information, all vital to academic success (DePrince, Weinzierl, & Combs, 2009). Additionally, exposure to trauma has been connected to lower grades, decreased IQ, and higher drop-out rates (Delaney-Black et al., 2002; Grogger, 1997; Hurt, Malmud, Brodsky, & Giannetta, 2001). As one can discern, a trauma may affect a child from grade school through college.

Childhood trauma has been linked to several negative aspects of long-term mental health. These include decreased self-esteem and a loss of coping mechanisms later in life (Walter, Horsey, Palmieri, & Hobfoll, 2010). Additionally, as the number of traumatic events increases, the likelihood of alcoholism, drug use, and suicide also rises (Dube, Felitti, Dong, Giles, & Anda, 2003). Without intervention early on, children face many future life-changing adversities due to unresolved trauma.

Childhood Trauma Symptoms

As with adults, children have individual reactions to trauma and ways of coping with trauma. Some events may affect one child to the extreme, but not have any effect on another child; many different factors, such as biology, environment, and support, contribute to a child's reactions. Concurrently, different types of trauma may yield different

Trauma Symptoms and Classroom Examples

Symptom Category	Symptoms	Classroom Examples
Physical	Recurring physical complaints, may be prompted by a similar occurrence	Repeatedly complaining of a stomachache, lightheadedness, headaches, or other sickness when a similar prompt is given (i.e., working in groups or when the weather is bad)
	Hyper-vigilance/heightened startle reaction: an above normal state of alertness	Constantly looking around the room, checking behind oneself; may appear to jump or be startled at small or everyday noises
	Sleep disorders/recurring nightmares: sleeping too much or not enough	Consistently coming late to class, appearing exhausted or lethargic, resting head on desk repeatedly throughout the day
	Weight change: sudden gain or loss of weight	Clothes appear extremely tight or loose, change in type of wardrobe (i.e., usually wears fitted clothes but begins to wear only loose-fitting clothes)
Behavioral	Regression: returning to previous developmental behaviors	Younger children may return to sucking thumbs, older children may regress to temper tantrums or exhibit extreme separation anxiety from caregivers
	Changes in play: play patterns shifting to repeated play behaviors, role playing of the traumatic event, or restriction of play	Child who normally plays freely with different toys now plays solely with the blocks (building and knocking them down again and again), or does not play and instead sits alone, or assigns roles to other children or dolls to play out event
	Social isolation: withdrawal from normal social network	Chooses to sit alone, does not talk to others during breaks, avoids social interactions; quitting extracurricular activities
	Risk-taking: increase in behaviors that may cause harm to self or others	Hearing about child having unprotected sex, trying drugs, abusing alcohol
	Bids for attention: acting in a way to draw attention, through negative or positive actions	Suddenly becoming an overachiever or underachiever, acting out to draw attention
	Increased aggression	Yelling, becoming upset quickly, inability to stop aggression
Emotional	Difficulty regulating emotions/easily angered: emotions are not consistent or lack a logical flow	Mood swings, easily angered or irritated
	Fear: phobias that may seem connected and apparent to trauma or not	Fear of the recurrence of the trauma (i.e., rape victim afraid she will be raped again), fearing that one may not be able to heal
	Stress	Late or not turning in assignments, easily overwhelmed by new projects
	Distrust	Unwilling to work with partners or in groups, sitting apart from classmates
	Lack of self-confidence	Uncertainty in presenting knowledge verbally or in writing, lack of effort due to belief that it will not be adequate
Cognitive	Inability to focus	Fidgeting, frequently glancing around the room, not completing assignments/ readings
	Learning disabilities/poor skill development	Patterns of learning problems become apparent, accompanied by other trauma symptoms
	Trauma flashbacks: involuntary visual, auditory, and/or sensory memories of the traumatic event	May not see flashbacks within classroom; however, may see side effects such as low energy/motivation, lack of sleep, anxiety
	Dissociation: splitting off from current consciousness	Student appears to "blank out," poor memory, highly inconsistent work
	Changed attitudes about people in general, life, and the future	Expressions of how humanity is generally "bad," expectations that another trauma will soon follow, lack of planning for the future

Table 1

symptoms. For example, the child traumatized by rape may withdraw from physical contact, while the child traumatized by the loss of a loved one may utilize physical closeness as a coping mechanism. Overall, however, children are affected physically, behaviorally, mentally, and cognitively in some way by trauma, and symptoms may be exhibited in any or all of these areas. Table 1 provides a more complete picture of how these symptoms may manifest within the educational environment. It is not necessary for an educator to be sure that a child is traumatized, or know of the actual traumatic event to refer the child for mental health services. Recognizing the symptoms and referring the child for services is the first, critical step educators can take to aid traumatized children in their journey of recovery.

Physical Symptoms

Physical symptoms may include complaints that are seemingly normal in childhood, such as stomachaches and headaches (Jaycox, 2006). These become problematic, however, when they recur often or in certain situations, which may indicate presence of a stressor or trauma trigger. Additionally, physical complaints may include more complex reactions, such as appearing overly alert or hyper-vigilant, sleep disorders, recurring nightmares, sudden weight changes, and a heightened startle reaction (Brown, Brack, & Mullis, 2008; NCTSN, 2006b; Openshaw, 2011).

Behavioral Symptoms

Behavioral symptoms also may be easily apparent to educators spending large amounts of time with students. For younger students, signs of trauma may be regression and changes in play behaviors, such as restriction of play, repetitive play, and replaying the traumatic event (Lieberman, Chu, Van Horn, & Harris, 2011; NCTSN, 2006b; Terr, 1991). For older children, changes in social behaviors, such as socially isolating themselves through withdrawal or avoidance, as well as an increase or decrease in talkativeness, and an increase in risk-taking behaviors may occur. For all ages, recurring demands for attention through either positive or negative behaviors and an increase in aggression may be indicators of trauma (NCTSN, 2006b).

Emotional Symptoms

Traumatized children often are experiencing an abundance of emotion, although expression of that emotion will differ from one child to the next. Symptoms include difficulty regulating emotions, feeling easily angered or irritable, and depression (Jaycox, 2006; Milot, Ethier, St-Laurent, & Provost, 2010; Openshaw, 2011). The trauma may cause intense fear, which is often accompanied by stress, feelings of helplessness, distrust in others, and a lack of self-confidence (Milot et al., 2010; NCTSN, 2006b; Terr, 1991).

Cognitive Symptoms

Possibly the most difficult to discern, cognitive symptoms are often severe and accompanied by long-term consequences. These symptoms may begin as an inability to focus in school, but may lead to more severe consequences, such as poor skill development (Jaycox, 2006; NCTSN, 2006b). Other cognitive symptoms may include flashbacks of the trauma, dissociation, and changed attitudes about humanity, aspects of life, and their own future (Openshaw, 2011; Terr, 1991).

Educators' Roles in Trauma Intervention

Educators help children feel safe, connected, and supported. The role educators play in a child's mental health cannot be overstated, as they may be "the first and only adult to recognize children's PTSD (Post-Traumatic Stress Disorder) symptoms" (Cohen & Mannarino, 2011, p. 120). Jaycox et al. (2010) found that children receiving free trauma treatment within a school setting were much more likely to complete the treatment, with 91% completion, than those being treated in an outpatient mental health clinic, with only 15% completion; this suggests that the school environment may be ideal for such interventions. Additionally, the school environment can provide social support through school and peer relationships, which are vital to children's recovery from trauma (Ellis, Nixon, & Williamson, 2009). Within an educational framework, educators can support traumatized children individually or through a school-wide approach.

The Teacher's Role in Trauma Intervention

When intervening for traumatized children, teachers may assist in several ways: 1) identifying trauma symptoms and referring to the school counselor or a mental health counselor who works within the school, 2) participating in a school-based trauma treatment team, and 3) supporting traumatized children through the therapeutic process. Teachers interact with children daily and small changes in behavior, appearance, and social norms may be more apparent within a school than to caregivers at home (Cohen & Mannarino, 2011). It is not crucial for a teacher to be able to identify the specific trauma or to authenticate that a trauma has taken place; however, being able to recognize a child's trauma symptoms is enough to report to appropriate referral sources (e.g., school counselor, administrator, onsite mental health professional) for further assessment. This is a critical first step, as children cannot be treated until an adult first recognizes that a problem exists. If a teacher, or any educator, in the United States suspects the trauma may be child abuse, it is his or her legal obligation to report the suspicion to the local authorities. Laws and reporting procedures may vary; thus, educators are encouraged to explore and stay up-to-date on the laws that pertain to them.

Beyond identification and referral, teachers may choose, with permission from administration, to form trauma treatment teams within the school, comprised of a group of caring, supportive adults (Auman, 2007). These may include the child's

caregiver(s), primary teacher, school counselor, onsite mental health professional, medical professional, administrator, social worker, librarian, and/or others. The purpose of this team is to assist and support students individually, as they recover from childhood trauma. This team develops a child's treatment plan within the school environment and monitors progress and setbacks. It also may provide referrals and resources for the child to aid in the recovery process, such as support groups, individual counseling referrals, and age-appropriate literature. The team approach serves to offer a holistic view of the child's functioning as they work toward addressing the trauma.

Finally, teachers may choose to work in conjunction with the child's offsite mental health provider as a support through therapy. Trauma therapy is often characterized by Herman's three stages (1997): 1) establishing safety, 2) remembering and mourning the trauma, and 3) reconnecting with others. Within each of these stages, the teacher can play a vital role in supporting the child's recovery. During the first stage, in which the goal is to establish safety, the teacher can assist the child by protecting the confidentiality of his or her traumatic stress, fostering autonomy through class work and assignments, and making the school day as predictable as possible for the child. All of these things work well in establishing the sense of safety necessary for treatment to progress. The second stage of treatment often involves actively remembering and mourning the trauma and its after-effects. This can be an emotionally charged time; thus, educators can assist by being flexible with the child, watching for a recurrence of trauma symptoms, and offering support. During the final stage of therapy, the child is encouraged to reconnect with others. School is an ideal location for this goal, as teachers can facilitate peer relationships and offer mentorship. This support through the therapy process offers much-needed encouragement and care to children healing from trauma.

The School Counselor's Role in Trauma Intervention

All school counselors have an ethical obligation to provide effective and competent services to ensure students' safety. The ASCA (2010) Ethical Standards for School Counselors advocates that ethical counselors "support and protect students' best interest against any infringement of their educational program. School counselors are knowledgeable of laws, regulations, and policies relating to students and strive to protect and inform students regarding their rights" (Standards D.1.a, A.1.d). The ASCA National Model (2005) provides school counselors with a framework of effective strategies that enhance students' educational, academic, career, personal, and social needs, and ensures their safety.

Effective strategies to address childhood trauma include prevention, awareness, and response services. The delivery system element of the ASCA National Model (2005) provides school counselors with ways to implement these effective strategies. A comprehensive developmental guidance curriculum can provide educators a venue for facilitating developmentally appropriate discussions and activities, focused on prevention and awareness of childhood trauma (Gysbers & Henderson, 2012). The school counselor's role of prevention and awareness extends to the other stakeholders within the school community. School counselors should organize professional development opportunities for colleagues and provide parents with educational and community resources focused on childhood trauma. If a trauma already has affected a child or children within the school environment, the school counselor should provide responsive services, such as consultation, individual and small-group counseling, crisis counseling, and referrals (ASCA, 2010).

The School's Role in Trauma Intervention

When a large portion of students have been exposed to trauma, such as a death within the school community, a natural disaster, or neighborhood violence, an institution may wish to employ a school-wide trauma intervention. These interventions can be implemented in two ways: targeting children suffering the most from trauma through assessment and then providing treatment individually or in groups, or school-wide prevention/coping skills training through a developmentally appropriate classroom guidance curriculum (Gelkopf & Berger, 2009). Either method offers a variety of validated programs to assist educators (Jaycox, 2006).

When focusing on traumatized children identified through assessment, the entire school population may be assessed, or a referral system may be used to target students individually. When using a targeted assessment through referral, such referrals may come from the school counselor, a parent, or teachers (Jaycox, 2006). Programs that take this approach include Cognitive-Behavioral Intervention for Trauma in Schools (C-BITS), Support for Students Exposed to Trauma (SSET), and Healing After Trauma Skills (HATS). Classroom-based guidance for school-wide interventions include such programs as the School Interaction Project (SIP) and Enhancing Resiliency Among Students Expe-

riencing Stress (ERASE-S). Jaycox (2006) provides a complete list of school-based trauma programs, along with selection criteria, program delivery methods, and training requirements for educators.

Administrators also may play a critical role in facilitating individual and school-wide trauma interventions. Administrators may come into contact with traumatized students through disciplinary action as trauma symptoms may manifest in negative behavioral actions, such as risk taking and bids for attention (NCTSN, 2006b). Students also may come to the attention of the administration if a drastic decline in grades or attendance is noted. On this micro level, an administrator, as a fellow educator, may take many of the same steps as the teacher, such as referring to the school counselor, contacting parents, and serving on the trauma treatment team (Auman, 2007; Cohen & Mannarino, 2011). School-wide, administrations can bring in guest speakers for teacher workshops on trauma, encourage trauma treatment teams, create an atmosphere of safety within the school, and enact school-wide trauma interventions when necessary.

Case Illustration

The following case presents a teacher, Ms. Harper (all names are pseudonyms) employing the suggested school-based interventions with a student named Lucy. Lucy is an 8-year-old, White female in the 2nd grade. Ms. Harper is her primary teacher at a public elementary school that serves kindergarten through 6th grade. The case illustration presents school-based interventions used to identify and promote healing from a traumatic event; however, the case does not portray all the strategies that may be implemented when working with a child who has experienced childhood trauma.

Ms. Harper became concerned about Lucy when she noticed a decline in Lucy's grades over the last month. She also noted that Lucy seemed preoccupied during class, and often seemed lost when called upon to answer questions. When Ms. Harper attempted to discuss her lack of concentration and slipping grades with Lucy, she appeared withdrawn and unemotional, stating only that she would "try harder."

Over the next few weeks, Ms. Harper noticed Lucy would suck her thumb at times and lay her head down as if she were napping. When Lucy's grades did not improve, Ms. Harper decided further action needed to be taken. She had attended a workshop the previous summer about children's emotional issues and knew something was mentally and physically affecting Lucy, although she was unsure of what. Ms. Harper visited the school counselor, Mr. Turner, and discussed Lucy's behavior and slipping grades. Mr. Turner also agreed that it appeared something was affecting Lucy; together, they placed a call to Lucy's mother.

Lucy's mother was reluctant to come to school, but was willing to discuss Ms. Harper's concerns over the phone. When asked if anything had changed in Lucy's life over the last month or two, she said that she was splitting from Lucy's father and that the weeks leading to the separation had been violent at times. She did not believe Lucy had witnessed any of the violence, but could not be sure. Mr. Turner requested that Lucy's mother sign a consent form to allow him to assess Lucy for trauma, which she agreed to and returned to the school promptly.

Mr. Turner held a confidential session with Lucy in which he asked her questions via a semi-structured interview to assess for trauma. She stated that she had seen her father and mother hit each other, and her father attempt to choke her mother. She reported extreme anxiety over interactions between her parents, even though her father no longer lived at home. Her self-reported symptoms included nightmares and inability to sleep from fear of nightmares, lack of appetite, and lingering anxiety and fear.

As Mr. Turner was unable to provide in-depth mental health treatment in his school setting, he contacted Lucy's mom and set up a referral with an outside mental health counselor. Lucy began attending weekly individual counseling sessions. Additionally, Ms. Harper, Mr. Turner, Lucy's mother, the school social worker, the school librarian, and her counselor formed a trauma treatment team to collaborate on Lucy's progress and support her treatment. Through the team, the school social worker suggested a support group for children of domestic violence. Additionally, the school librarian and Mr. Turner provided Lucy and her mother with literature and age-appropriate stories to normalize Lucy's experience. Ms. Harper instituted classroom changes, including a detailed outline of their daily schedule, reminders and extra help with homework, and the encouragement of peer interaction and support through group activities.

Lucy remained in counseling for four months, working to establish positive relationships with her parents and learning coping strategies for keeping herself mentally and physically safe. After two months, when her counselor deemed it appropriate, she began attending the support group for children of domestic violence. There, she found her fears were shared by other children, making them seem not quite as scary as they previously did. Lucy's

trauma treatment team continued to meet monthly until her therapy was completed, with changes and adjustments made at home and in school to compliment her progress toward healing.

While not a seamless process, Lucy found support at home, in the community, and at school. Like all meetings involving multiple parties, trauma treatment team meetings occasionally needed to be rescheduled or conducted without one party present. Lucy's fears and trauma were brought into the open, allowing her parents to understand the repercussions of their actions, and thus preventing further traumatization. As she healed, Lucy's emotional progress was accompanied by higher grades and greater concentration in the classroom. Through the help of an attentive teacher, a dedicated school staff, parental support, and outside resources, Lucy was able to heal from her trauma and re-engage in her life.

Conclusion

Numerous factors influence children's performance and development throughout each school year. While many of these factors may be outside the influence of teachers, counselors, and school leaders, children living with trauma can be positively impacted by the involvement of educators. Whether acute or chronic, unresolved trauma may result in physical, behavioral, emotional, and cognitive symptoms and consequences. Although these symptoms and the underlying trauma may be difficult for parents and teachers to face, the reality of the child's inner world may be even more unbearable without treatment. Educators truly are a first line of defense for children dealing with issues beyond their control and recognition. Given the essential knowledge of symptomology and a plan of action, educators are able to help children receive vital trauma treatment and increase the likelihood of life-long success.

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