

Helping Traumatized Children at School

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Dear Reader,

To follow is a paper that discusses school interventions for traumatized children. It provides some of the guidelines and resources for use when youth's traumas affect their ability to function at school. By the end of the summer, we hope to add more information and resources. We look forward to any input that you would like to offer.

Best wishes.

Sincerely,
Kathleen Nader

For children and adolescents, exposure to traumatic events and the symptoms that follow may interfere with the ability to have a reasonably normal school experience. In fact, posttraumatic symptoms may make the school experience and other aspects of life intolerable for some children. Trauma's disruption of school life can take many forms. If the child feels stigmatized, frightened, or easily overwhelmed, s/he may resist returning to school. Relationships may be difficult because of symptoms or because of distrust related to experiences such as repeated abuse or violence. Posttrauma behaviors and attitudes, such as irritability, fears, rage, or increased reactivity, may alienate other youth and adults. Arousal symptoms may interfere with attention and concentration and may undermine academic performance. The youth may become unable to handle multiple stimuli such as chatter, multiple images, pages of print, and competing sounds. Normal school noises may be difficult to tolerate. The youth may overreact to stress or perceived threat. S/he may see threat or degradation when there is none intended. Traumatic reminders may trigger increased symptoms or behavioral outbursts that seem strange or disruptive.

Case Examples

- Months after part of her school came crashing down during an earthquake, killing several students, 7 year-old Kendra would jump under her desk every time there was thunder and when there was a rumbling noise of any kind. She had trouble concentrating on her schoolwork and became frustrated and cried easily.
- After a boy was badly injured and severely traumatized in a tornado, he found noise and the hovering of curious peers intolerable. He would sometimes cover his ears and begin to scream. He refused to return to school or to be away from his mother.
- After a school shooting, a previously well-liked girl's irritability and low stress tolerance resulted in rejection by her peers. Children said she had turned into a bully. She snapped at them frequently.
- After 9/11, a 9 year-old New York boy talked about the terrorist attacks repeatedly. His regressed behaviors made him seem strange to his peers. He drew pictures of the towers and of airplanes during class. He remained hypervigilant because he was fearful of another terrorist attack.
- During hurricane Katrina, for hours, twelve year-old Tanya was on the roof of a house with her sisters waiting for rescue. She saw bloated bodies float by and every time the water started to slap against the edges of the roof or spray on her, she feared that she would end up dead in the water, eaten by gators or killed by snakes. After she returned to school, she became particularly distressed on rainy days, especially if the streets started to have water buildup. She screamed and cried when anyone splashed water on her.
- Brandy was pretty and tough. Her father had abused her from the time she was 8 years old. She was angry all of the time. She expected aggression from others and saw threat and insult when it wasn't there. In her family, her abusive father held all of the power. She was reactively aggressive (e.g., reacted with aggression to perceived insult) and proactively aggressive (e.g., she bullied and insulted others). She had learned that the aggressor had all of the control. She sometimes did things in anticipation of needing to reduce someone's power or when she felt her control threatened. When they were changing for gym class, if anyone mentioned the scars on her legs, she slugged them. Some of the scars were from her father and some from her cutting.
- Sonny was picked on from the time he started school. He was average height and thin. Other children called him names like "nerdy boy" or "geeko". He was pushed around, and, in later school years, boys

threw things at him. Because he was identified as a victim, other children seemed to condone pushing him around. In his elementary school years, he was depressed and hated going to school. In middle school, he started to become angry. In high school, he began to read about the boys who shot at Columbine.

•Despite the term “army brat”, Jennifer, age 14, was a happy, responsible girl before her father’s deployment to Afghanistan. She was very close to her father. After her father’s deployment, one classmate’s father died in Iraq when an improvised explosive device hit his convoy. One’s mother died in their camp in Baghdad, when they were barraged with rocket-propelled grenades. In the hall of their high school is a wall where the men and women killed in action are honored. Each one has a set of pictures and other hanging items that celebrate his or her life. In English class, the names of hundreds of deployed soldiers are on the walls. The family car has bumper stickers reading, “Support our Troops” and “Half My Heart Is in Afghanistan”. Jennifer watched the news and listened for the information that might tell whether her father was among those killed. She sent him email every day, but he was not able to write back every day. She had become distracted and worried. Her grades dropped significantly. She was angry but didn’t know who to be angry with—the president or army for sending him, her father for leaving, the kids whose fathers had already come home. Her mother was also distraught and not always of much support for Jessica. After a military man started shooting at people at a base in Texas, her stress increased to include worry about her mother and friends. Her poor concentration worsened. It was difficult to do schoolwork.

A traumatized child may become easily overwhelmed. S/he may become disruptive or self-destructive. The youth may deal with distress by externalizing (e.g., conduct disturbances, defiance) or internalizing (e.g., anxiety, depression, suicidality, self-mutilation). Some children express their distress through both internalizing and externalizing. Additional traumas in a youth’s country or region may increase distress. For example, the news of children being hurt in another state may add to a youth’s fear and feel unsafe. For children whose parents are deployed to war zones, fears and worries about their parent’s safety may increase with news reports about war zones and deaths. Recent violence on an army base has brought the danger close to home as well. No matter what form school problems take, interventions must be tailored to the individual child or adolescent and to the specific situation and school. In order for interventions to be successful, relevant school staff must be willing and able to become a part of them. This article discusses some of the things to consider when developing an individualized intervention method and describes a few of the interventions that have been used.

GOALS

- It is important to discover what is possible and is needed within the child’s school, class, and situation.
- It is essential for school interventions to enable and restore the youth’s ability to function successfully at school, the youth’s positive self-image, the youth’s good image among her/his peers, and the youth’s ability to engage peacefully in schoolwork. Restoring some sense of personal control may be a part of this.
- It is important to prepare the child, her/his parents, the teacher, and, sometimes, the class and school staff for possible needs and problems, for transitions, and for possible regressions. In some cases, the youth’s permission will be needed before information is shared.
- Transitions should be made as easy for the youth and school staff as possible and should be well paced. For example, transitions may include those from home to school (if the child has been away from school because of injuries or distress), from a reduced study load to a normal one, from assisted work to independence, from stepped up support to normal support.
- The traumatized youth should be made aware of her/his available human resources (e.g., school psychologist, nurse, locations for calming or walking off stress) and of how to handle times when symptoms increase or it is difficult to control behavior.
- Efforts to help the youth should be well coordinated among therapist, school psychologist or counselor or other school staff, and parents.

Assessing the Situation

Parents, teachers, school psychologists, other school staff, and the child’s individual therapist may be a part of both assessment and intervention. Before information is shared with peers or teachers, it is important for the therapist and parent to prepare the youth and to have her/his cooperation, permission, and input

regarding what is shared with teachers and peers. In contrast, information shared with the clinician and with the school psychologist must be comprehensive enough to enable successful interventions.

What Parents Can Do

When a traumatized child is having a difficult school experience because of trauma symptoms, the parent can be instrumental in obtaining helpful interventions from the appropriate professionals. In order to be able to assist the child's recovery for as long as it takes, the parent must also keep her/himself in shape, physically, emotionally, and spiritually (at the core of self). A good support system is important for parent, child, and those who intervene.

•Find a good therapist

If the child is having posttraumatic symptoms severe enough to disrupt her/his school experience, it is likely that the parent has already found a therapist who is a trauma specialist for the youth. It is important to research therapists in order to find a good one. Some therapists will provide group or individual treatments for youth. The Sidran Institute (www.sidran.org) has a list of therapist/clinicians who treat trauma in your area. It is important to investigate a therapist's good standing and success with others by contacting other clinicians who know their work, licensing agencies, and individuals who have used trauma therapists.

•Request a school consultation

-The parent may ask the child's therapist for a school consultation. This consultation may include the therapist's meeting with the school psychologist or principal and/or obtaining permission to observe in the classroom.

-Depending on the school, the trauma-related skills of the school psychologist, and the methods of the child's trauma therapist, the parent (or parent and therapist) may request that the school psychologist meet with the parent and that the classroom situation be assessed.

•Help to determine the child's immediate and long-term needs

Is the child currently able to learn in the classroom setting? Can s/he be there without disrupting others' abilities to learn? Will the child's symptoms in the classroom damage the child's self-image, image among her/his peers, and ability to have success in (and out of) school into the future? If the answer is no to either of the first two questions or yes to the third question, a period of schooling at home should be considered.

•Investigate/assess recommended treatments

If you feel concern about any of the recommendations for your child, investigate them before they are implemented. For example, if medication is recommended, it will be important to weigh the benefits against the potential risks. Find out about potential long-term side effects and consequences of treatments. Ask if the effects have been studied. For example, ask if the use of a medication in early life may affect brain chemistry and development, other aspects of the nervous system, intelligence, long-term health, personality, skills, and skill development. Compare the results to the current and long-term consequences of not using the treatment or medication. If, for example, your child's problems are severe enough that she or he is a danger to himself and/or others, you will need to investigate hospitals to find a suitable one. There are good hospitals that protect and assist children. However, because some youths have learned bad habits or been exposed to other things as inpatients, one of the questions to ask is what other youth will be there and how the hospital or institution will prevent your child's learning bad habits from them (e.g., drug use; other illegal activities) or being additionally traumatized by them.

•Be available to assist school interventions

The parent may assist interventions by, for example, being present at the school for the child's support when needed, providing information that will help the mental health professionals to assist the youth, and helping the child to practice coping skills or to learn to identify posttraumatic triggers or reminders that set off difficult episodes. The therapist or school psychologist may be able to help with how to practice coping and how to identify triggers.

•Recognize your child's functioning age

In general, if the child has regressed or is functioning like a younger child (e.g., tantrums, low frustration tolerance for her/his age level and the normal demands of her/his environment), it might be important to use methods appropriate for a younger child in dealing with his or her behavior. The youth's therapist should be able to help you with this process.

•*Be cognizant of the needs of the rest of the family*

The wellbeing of other family members (including yours) may have been undermined by the intensity of reactions and needs of the traumatized child. Ask the therapist to help you assess your own and other family members' needs and how to assist them through the changes brought about by the trauma. A number of books are available to assist children with grief or other problem circumstances. An online search can elicit books and reviews of the books. (a list of some books will be added later to the appendix)

•*Engage in good self-care*

In order to assist the youth, it is important to take care of self. Self-care should include healthful, restorative behaviors (e.g., appropriate exercise, rest, nourishment, support from others) and times away from the traumatized child to restore energy and equilibrium. Pay attention to the needs of your spiritual or core self—the part of you that has qualities such as hope, faith, trust, and uplifting experiences.

What Clinicians and School Psychologists Can Do

Posttrauma school interventions require cooperative efforts in order to be successful. It is important for all helping professionals to engage in ongoing effective communication about the child and her/his progress. Preparation for effective interventions includes assessment of the child and the situation (see appendix).

•*Determine if a period of schooling at home is needed*

-As noted earlier, a number of questions should be addressed: Is the child currently able to learn in the classroom setting? Can s/he be there without disrupting others' abilities to learn? Will the child's symptoms and behaviors in the classroom damage the child's self-image, image among and ability to have relationships with peers, and/or ability to have success in (and outside of) school into the future? Will the responses of other children to the youth's symptoms increase the youth's distress, reactivity, and potential for aggression or self-destructive behaviors? If the answer is no to either of the first two questions or yes to the third or fourth questions, a period of schooling at home should be considered.

-If it is important to postpone the child's presence in the classroom, mental health professionals can set up a tentative guideline for the child's return to the school. Outline the indicators that the child is ready to be eased back into the school.

•*Assist Reentry and/or school functioning*

Prepare a method of easing the child back into the classroom.

-Does the child need a trusted adult's presence for a period of time? If so, how will the child be weaned from this supportive presence?

-How will classmates and teacher be prepared for the child's return to class and her/his needs in class until recovery? What information has the child given permission to share?

-What support systems are in place to assist the youth?

-What measures are in place to reduce distress?

-What time out locations will be available to the child while s/he is still recovering?

- Does the child need a reduced study load and a gradual increase in load as mental health is restored? If the child has moved from another school because of the traumatic experience, what is needed to get the child in sync. with the new classroom? How will a desirable peer support system be developed?

-How can the teacher be helped to deal with the child's special needs? Will the teacher recognize the youth's functioning age?

-What methods will be used to continue to assess progress and needs?

•*Assess the child's classroom behaviors*

-Meet with the youth's teachers and other relevant staff in private to make a list of the problem behaviors teachers/staff are observing.

- Observe the child in the classroom. In order to do so effectively, the observer must stay long enough and quietly enough to become an essentially invisible presence.
- Determine what problem behaviors occur. Make note of what triggers the problem behaviors (e.g., overwhelm because of the inability to concentrate, reduced frustration tolerance, and/or intolerance of multiple stimuli; traumatic reminders; noise; grieving; helplessness; sadness).
- Identify the child's currently functioning skills (e.g., coping abilities) and functioning age.
- Make intermittent re-assessments of the youth's symptoms, behaviors, and progress.

•*Assess resources*

- Assess the youth's personal resources for learning to cope and participate in planning intervention strategies. What were the youth's pre-trauma strengths and talents? What were her/his methods of coping with stress? Do pre-trauma methods still help or work for her/him?
- Determine whether or not there are sympathetic peers who can be of assistance or who will at least avoid exacerbating the problem.
- Determine whether teachers/staff will be willing and able to reduce stressors and triggers to the problem behaviors, develop a reduced load to be gradually increased with the child's increasing ability to function, provide feedback in a timely manner, and avoid exacerbating the problems through attitude or behavior.
- Assess other support systems (e.g., supportive parents, siblings, friends, relatives).

•*Set up support systems and time out locations*

- Pinpoint locations (and people) in the school where the child can go if s/he needs a time out (e.g., to use calming methods, exercise away agitation, rest, talk, engage in calming activities).
- Develop guidelines for when and how many times a day (then week) the child may use a time out.
- Has the child moved from another location because of the trauma? Will s/he need extra assistance to develop a support system and to develop helping friends among youth who do not know the youth's pre-trauma self?

•*Coordinate interventions for problem behaviors*

- Coordinate therapist and school psychologist's roles in the youth and teacher's learning the triggers that lead to problem episodes and how to cope with the youth's reactions.
- Coordinate the method and location of teaching the youth coping skills.
- Coordinate the enlisting of peer support.
- Assign methods of communicating regarding the youth and her/his progress.

•*Prepare for Transitions*

Prepare the youth, the teacher, and the parent (and, when needed, the class) for changes or transitions. Give the youth ample time to adjust to any upcoming changes without giving so much time that anticipation significantly increases stress.

•*Be aware of the impact of the youth's symptoms and reactions on other family members*

Having a traumatized child in the family can be trying for everyone. The traumatized or externalizing child may become the full focus of attention. Assess the needs of other family members. When needed, provide interventions or help to establish support and relief systems that help regain equilibrium.

•*Engage in Good Self-care*

Clinicians and school staff also need good self-care, in general and especially when working with traumatized youth. In addition to the information for parents on good self-care, a number of resources are available that discuss self-care (Boaz & Panos, 1998; Boaz, Panos, Panos, & Steele, 2006; Figley, ; Rothschild, 2006).

Interventions

There are a number of possible school based interventions for youth that may supplement the child's individual treatment for her/his posttraumatic reactions. Methods used successfully with traumatized children may be incorporated into school interventions or be a part of a youth's ongoing, separate individual treatment. For example, a Duke University protocol describes a group method that involves

“bossing back trauma” (March, Amaya-Jackson, Foa, & Treadwell, 1999). There are a number of cognitive behavioral methods (Cohen, Berliner, & Mannarino, 2000) and play therapy methods (Lehmann & Coady, 2001; Webb, 2002) available for use with traumatized children. Methods that have helped youth to deal with bullies in a nonviolent manner or to develop coping skills have been identified (Kalman, 2005; Nader, in press). If the child’s posttrauma school experience is greatly hindering her/his self-esteem, ruining her/his relationships and potential for relationships, and not enhancing her/his learning, then interventions are essential. The child’s symptoms can also disrupt the learning of her/his peers. A consultation between the therapist and school psychologist as well as the therapist’s subsequent meetings with other relevant school personnel or by the school psychologist in cooperation with the therapist can be helpful. Planning and interventions must take into account their future impact, what the school district allows, the child’s ability to engage in them and the resources available to the child (e.g., peer support, teacher skills and sympathy levels, parent’s energy and availability).

When School Life is Too Difficult

For some children or adolescents, an immediate return to school is ill advised. Factors that should be considered, when deciding whether schooling at home is advisable, are how it will affect the youth to return to school and how it will affect the classroom for the child to be in it. Are the child’s symptoms severe enough to make school life very difficult to tolerate without a period of intervention? Will the child’s symptoms permanently damage her/his self-image and/or her/his image among her/his peers? Will her/his behaviors disrupt the classroom significantly? Will the school experience be so bad that it interferes with the child’s future life at school, among peers, and later?

Some children will need a reduced set of learning demands and to be eased back into a normal load. The amount that is manageable and reasonable and the time it takes to return to a usual course will vary depending on the child and her/his symptoms. A youth can be eased back into her/his classroom as well as into her/his studies. For example, the child may begin with two hours of classroom time daily or a half-day with the parent in the classroom, and time may be gradually increased, as s/he is able.

Reentry. It is important to make transitions as easy as possible for the youth. When a traumatized child has been schooled at home for a time before reentry, the classroom can be prepared for her/his return and needs. What will be discussed with the class can be discussed with the youth beforehand. Trauma can make an individual feel like s/he has no control over her/his life. If it would not add unneeded stress, making the child a part of the decision making for the reentry can be therapeutic for her/him. The youth can help to decide what is okay for the other children to know and what needs to remain private. The clinician or school psychologist who assists reentry can then decide how to present the information in an age-appropriate manner and in a way that enlists the aid of the youth’s peers. For example, the clinician might say no more than that the youth was hurt or saw someone hurt in a very scary situation or the clinician or school psychologist may describe the situation, depending on what best assists the child currently and over time.

New to the school. The trauma may have resulted in relocation for the youth. If the youth is new to the school, assessment of previous learning in comparison to her/his current class will be needed at some point. It may not be possible to successfully assess the youth’s academic skills or level until her/his functioning age has been restored to normal or nearly normal. Extra efforts will be needed to construct a support system among peers, if the child is new to the school. If there was relocation, the child may be experiencing grief related to several different losses (e.g., home, friends, relatives, an expected life, status among peers, activities, opportunities). Losses may intensify traumatic reactions. With the child’s permission, the therapist and school psychologist will need to consider whether or not it would be helpful to the child to share things about the way the youth used to be and what s/he went through with a small number of potentially supportive peers or the teacher.

Case Example

When an earthquake partially collapsed an elementary school gymnasium, injuring twenty-three children and two teachers and killing five children, Tony (age 8) sustained a leg broken in three places and a

fractured hip (Nader, 2008). He was hospitalized for 3 weeks and required a period of physical recuperation after he returned home. Before the earthquake, Tony was a good student. He was well behaved and well liked by both peers and adults. Following the earthquake, he was nervous and jumpy. He became anxiously attached to his mother and refused to go back to school. To her distress, he would not let his mother leave his immediate area. He had periods of nervous quiet or of expressing fears of disaster recurrence. He was easily distracted by sounds or movement and became frightened when the windows rattled or a passing truck made the building shake. When his peers visited, he began to scream and cover his ears if they hovered or more than one of them talked at the same time. He couldn't stand for anyone, except his mother, to touch him. Tony had difficulty concentrating and frequently engaged in angry outbursts. He startled easily, cried out in his sleep nightly, and complained of stomachaches. After his physician approved his return to school, Tony refused to go. During home schooling, the teacher observed that Tony was anxious, exhibited poor concentration, and frequently displayed angry outbursts. He would not let his mother leave the room. Tony was treated for PTSD. With his and his mother's permission, his therapist met with his classroom to help them to understand his symptoms and needs. Among other things, they learned to avoid noisily hovering around him, to warn him of their approach, that he might become distressed if more than one person talked at a time or there were loud noises, that trying to concentrate might be hard some of the time, and he might periodically need their help. On his first day back at school, the therapist conducted a meeting with Tony and his class, so that he could help them understand how they could help him. His therapist and he talked about what would be discussed before the classroom meeting. Tony began with two hours a day in class. His mother's presence in his classroom helped him. She began by sitting in the desk next to him and then moved to the back of the class until a week after he was staying in class for the full school day. She then moved just outside the door, within his view. She moved to the school library until he could tolerate being at school without her. She began to regain some of her privacy and free time, which in turn improved her ability to assist her son. Meanwhile, he continued to make progress in therapy. For a period of time, he experienced a regression because of a televised disaster that renewed his fears and stress level. The school and his mother responded to this regression by again permitting his mother's presence at the back of the classroom and then her gradual withdrawal. Her progression out of the classroom took less time after the regression. Tony's peers were helped to understand his regression. In his individual therapy, he worked on the impact of seeing another disaster on television and the trauma issues it resurrected.

Small Peer Support Groups

When children are traumatized and/or suffering from traumatic grief, 30 to 45 minute small groups comprised of the youth and two or three peers (depending on the nature of the group) have proven to be effective supplemental treatments for some children. The classmates can help by serving as a support system for the child and a feedback system for the child and therapist. It can be of benefit for at least one of the peers to have previously resolved a trauma or loss. The peer's trauma or loss should be well resolved and a reasonably distant time in the past—enough so that the group does not threaten gains already made. Groups should be tailored to the needs of the individual child and engaged only if they will benefit the child's recovery and ability to function in school. They should not be engaged if they would make the child's image or self-image suffer significantly. The therapist may plan the topic of sessions in advance or have a basic structure and take the input of group members before sessions begin. The support peers should be well respected by their peers, be emotionally mature for their age group, be kind, and feel sympathy for the traumatized youth. Lists of students with these qualities can be obtained from teachers and from a peer nomination exercise (see appendix). Several different kinds of groups may be used. Among them are those that assist coping, recovery from grieving, learning to handle bullies, and improving self-skills (e.g., self-control, empathy, self-protection). A brief description of one kind of coping group and a grief group are described here.

Peer nomination is optional. If it is used, it should be presented as a separate study rather than as something having to do with the traumatized youth. The information can be useful to a number of discoveries that may benefit the school's youth, such as issues related to bullies and victims. Answers should be confidential and truth-telling should be enhanced. Results should not be announced.

Coping Groups. Coping groups have centered on learning coping skills. Although the main goal of the group may be to assist the traumatized youth, one focus can be on developing methods for the participants

to help each other in times of stress at school. With signed agreements for confidentiality, the 3 youth may share stories about what is hard to cope with and/or how they handled a difficult situation. It is possible that the traumatized youth will remember successes in handling past stresses. The group members may be able to help the traumatized youth (or all members of the group) to identify what triggers increased stress or meltdowns. A form in the appendix can help the youth to recognize triggers by writing down what preceded the noticeable distress. Group members can complete one of the forms, if the forms are used, to say what seemed to trigger the experience, from their perspective.

Grief Groups. Grief groups may be comprised of two grieving youth and two support peers or may be comprised of individuals with resolved and those with unresolved grief. It can be helpful when at least one of the support peers has resolved grieving a loss in the past. For a traumatically grieving youth, memories of the deceased may trigger traumatic distress and interfere with the grieving and coping process. The person who leads such a group should understand trauma, grief, and traumatic grief. It may be necessary for the youth to successfully complete some trauma treatment before being able to work successfully in a grief group.

Case Example

John, age 14, was late arriving at the restaurant where his family was meeting for his sister's birthday dinner. As he walked toward the restaurant door, he heard popping noises and looked up to see a car with a gun aimed out of the window. In a matter of seconds, his eyes followed a bullet as it flew toward the restaurant door; he saw blood pour out of a man leaving the restaurant who was hit by one of the bullets; and John dove for the ground behind the wheel of a car. He covered his head instinctively. The gunfire continued and flattened the tire he was hiding behind, whizzing past his elbow. He stayed flat on his face for what seemed like forever before someone told him it was safe and that he could get up now. There was blood on his shirt from the man who was shot. At school, John jumped every time there was a popping sound. The day that someone set off firecrackers in the hall, he dove for the ground. Everyone laughed, and he was really embarrassed as well as very shaken. Even though he knew that being on time might not protect him, he worried every time he was running late for something and yelled at anyone who was making him late. He refused to go to restaurants or the neighborhood where the shooting occurred. He was hypervigilant, had trouble sleeping, kept seeing the man with blood spurting out of his chest, and had trouble concentrating in school. He was used to being a good student with good self-control. Memories of his experience made him tense and short-tempered. His inability to focus on his schoolwork seemed to progressively worsen.

John needed several weeks in therapy before he was able to be a part of a school group. The boys met for 30 minutes during free period. John's best friend, Brad, remembered what John was like before the shooting. He was glad they asked him to be a part of John's peer support group. The other boy in the group had been through a drive by shooting two years earlier and had recovered successfully. The three boys shared the things that "threw them off their game" and agreed to help each other cope with things that distressed them enough to interfere with their functioning. John's reactions were a priority for them all, since he was suffering the most. They became really good at seeing what triggered John's distress in his studies as well as under other circumstances. Brad was allowed to move next to John in the classes they shared. The boys developed signals for each other—they had signals for different situations. One of the signals they used when they saw one of the three was distressed—a fist to the chest—meant "I'm here if you need me". They learned a number of coping skills in the group including some stress reduction techniques that changed as John was better able to do some of the newer ones. Some of the signals they developed to help each other meant "Use your coping skills." like the one for "Take a deep breath and look around" (breathe and assess the situation for real danger) and the one for "Find your center" (use stress reduction techniques). Their interactions increased the friendships among the 3 boys and helped all of them under conditions of stress. They especially helped John. Two times per class in the beginning (reduced to one a class, then every other class, then one a week), John was allowed to go out into the hall and walk fast back and forth down the hall for 3 minutes when he was too overwhelmed to do his schoolwork. When something stressful happened in Brad's home, the boys took the time to focus in on him in group. It was helpful to John to be able to help him.

Conclusions

There are a number of possible ways to assist a youth who is traumatized, including school interventions. The school interventions that are possible vary depending, for example, on the school, school district, traumatized child, teacher, and the mental health professionals enlisted to aid the child. Methods used successfully with traumatized children may be incorporated into school interventions or be a part of a youth's ongoing, separate individual treatment. This paper has presented a few methods that have been used at schools after mass traumatic events or a youth's single trauma. Effective school interventions require the cooperative efforts of the school staff, the youth's therapist, and the youth's parent or parents. They necessitate the flexibility to gauge and adapt with the youth's progress and regressions.

Note: Case examples have been disguised to protect the youth described and are often composite cases.

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APPENDIX

Assessing the Need for Home Schooling and the Manner of Reentry

TASK	ASSESSMENT QUESTIONS	NOTES
<p>Assessing the need for home schooling</p>	<ul style="list-style-type: none"> •Is the child currently able to learn in the classroom setting? Yes ___ No ___ •Can s/he be in school without disrupting others' abilities to learn? Yes ___ No ___ •Will the child's symptoms and behaviors in the classroom damage the child's self-image, image among and ability to have relationships with peers, and/or ability to have success in school into the future? Yes ___ No ___ <p><i>If the answer is no to either of the first two questions or yes to the third question, a period of schooling at home should be considered.</i></p>	
	<ul style="list-style-type: none"> •Tentative guidelines for when the child will be ready for a return to class. 	
<p>Assisting Reentry into the class</p>	<p><i>For a traumatized child who has needed home schooling, prepare a method of easing the child back into the classroom.</i></p> <ul style="list-style-type: none"> •How will classmates and the teacher be prepared for the child's return to class and her/his needs in class until recovery? What information has the child given permission to share? •How many hours will the child be able to tolerate in the classroom initially? On what schedule will the child's time in the classroom be increased? What mechanism will be used to determine when an increase in classroom time is feasible? •Does the child need a trusted adult's presence for a period of time? If so, how will the child be weaned from this supportive presence? •What support systems and time out locations will be available to the child while s/he is still recovering (e.g., to go to use calming methods, exercise away agitation, rest, talk)? •Does the child need a reduced study load and a gradual increase in load as mental health is restored? If the child has moved from another school how will the child's progress in relationship to the class be assessed? Who will determine how to bring the child up to current study and participation levels? •How can the teacher be helped to deal with the child's special needs? Will the teacher recognize the youth's functioning age? •What methods will be used to continue to assess progress and needs? 	

Classroom Assessment and Intervention

Assessing classroom behaviors, distress, and skills	<ul style="list-style-type: none"> •Problem behaviors reported privately by teachers and other relevant staff 	
	<ul style="list-style-type: none"> •Problems noted in classroom observation 	
	<ul style="list-style-type: none"> •Things that trigger problem behaviors or increased distress 	
	<ul style="list-style-type: none"> •Youth's observable skills 	
	<ul style="list-style-type: none"> •Youth's functioning age 	
	<ul style="list-style-type: none"> Date of next assessment 	
Assess resources	<i>Youth's pretrauma strengths:</i> <ul style="list-style-type: none"> •Coping methods •Adaptive skills •Talents •Ability to use the above currently 	
	<i>Support levels:</i> <ul style="list-style-type: none"> •Peer support •External support (e.g., family) •Teacher support •Other school staff support 	
	<i>Locations/People for time-out</i> <ul style="list-style-type: none"> •People (e.g., nurse, psychologist, other) •Locations (e.g., for resting, walking/exercise, talking things out, practicing calming/coping techniques) 	
Coordinating interventions for problem behaviors	<i>Assign tasks and coordination:</i> <ul style="list-style-type: none"> •To help youth and teacher identify triggers •To teach youth coping methods •To discuss with teacher methods of coping with youth's behaviors •To engage peer support •To prepare parent, youth, teacher, class, other for transitions •To advise relevant mental health professionals of progress •Other 	
Additional Interventions	<i>Identify additional interventions:</i> <ul style="list-style-type: none"> •Ongoing individual therapy •Groups (e.g., therapy, support, training in coping or other methods such as how to deal with bullies) •Training sessions •Classroom meetings or interventions •Other 	

Finding Triggers

If a problem occurred in class, it is important to learn what things trigger the problem. Here are some questions to ask to help figure out what happened.

1. What happened?

2. What happened right before the problem? (If a series of things led to the problem, list them.)

3. How did you or _____ feel right before and during what happened?

4. What do you think triggered the problem?

5. What else can you say about what happened?

Who's Who

Everyone has important qualities. Some people have qualities that other people like a lot. These are not the same qualities for every group or culture. Right now, we want to know which people in your class and in your grade have some of the qualities listed.

1. Name the 3 students in your class that you like best

2. Name the 3 students in your class that most students like best

3. Name 3 students in your grade (not just your class) that most students like best

4. Name all of the students in your class who are very kind

5. Name those who do the best job of helping when someone needs help

6. Name the students who are picked on

7. Name the students who are bullies

8. Name the students who are really intelligent

9. Name the students who are most talented and name their talent

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