A Public Health Approach to Supporting Students Who Experience Interpersonal Trauma

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Abstract

Adverse Childhood Experiences (ACEs), including experiences of interpersonal trauma such as abuse or neglect, are common amongst school-aged children as research has found that upwards of 80% of children report experiencing at least one interpersonal traumatic event (Schwerdtfeger Gallus, Shreffler, Merten & Cox Jr., 2015). Students who experience interpersonal trauma are at risk for a host of negative academic, social, and mental health outcomes. For these reasons, schools should use a public health model to address this epidemic using a multi-tiered system of supports. This paper will discuss outcomes related to experiencing trauma as well as evidence-based primary, secondary, and tertiary interventions for supporting students. Trauma-informed schools are considered a universal intervention as they requires systems level change. Discussions on the role of school psychologists in every tier are included after interventions have been outlined. Following the aforementioned topics, the paper will also discuss the NASP outlook on working with trauma in schools, future directions for research and implications for practitioners.

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During the 1990's, a group of researchers sought to discover how adverse childhood experiences (ACEs) might impact physical health outcomes (Felitti et al., 1998). The researchers found a strong relationship between the occurrence of abuse and some of the leading causes of death in the U.S. Furthermore, their findings showed that the rate at which people reported the number of traumatic events they experienced as children was staggering. The ACEs Study paved the way for future medical and clinical researchers to investigate the full extent of trauma in the populations they serve. It is clear that such an epidemic needs to be addressed in school, considering that nearly one in four children report exposure to at least one traumatic event in their school-age years (Child and Adolescent Health Measurement Initiative, 2013). In recent years, school practitioners and researchers in this field have identified this pressing caught on to the importance issue as there has been a trend in academic literature towards investigating trauma and ways in which schools can combat the adverse outcomes associated with it.

Interpersonal Trauma

Literature on trauma suggest that there is consensus that there is consensus that people can experience a range of types of trauma. Trauma can be experienced on an individual, group, community or mass level and the types of trauma within these levels typically involve distinct incidents or events (Center for Substance Abuse Treatment, 2014). Interpersonal trauma is characterized as traumatic events that occur between people. These events can include neglect, physical abuse, emotional abuse, sexual abuse, as well as partner violence and elder abuse (Center for Substance Abuse Treatment, 2014; Mauritz, Goossens, Draijer & van Achterberg,

2013). Instances of interpersonal trauma, such as "Sexual maltreatment/Abuse," "Sexual assault/ Rape," "Physical maltreatment/Abuse," "Emotional/Psychological maltreatment./Abuse," "Neglect," "Domestic Violence," and "Extreme interpersonal violence" were the most commonly reported ACE after "Traumatic [Losses]" and "Medical [Traumas]" (Grasso, Dierkhising, Branson, Ford & Lee, 2016). These results were generated from a sample of 3,485 children from the ages of birth to 18. Interpersonal trauma may overlap with other forms of trauma, just as one form of abuse may overlap with others. For instance, children who experience interpersonal trauma may experience other concurrent trauma, such as developmental trauma as interpersonal trauma may occur during a critical developmental period (Center for Substance Abuse Treatment, 2014).

In 2015, the U.S. Department of Health and Human Services reported that an estimated 683,000 children were victims of physical abuse, emotional abuse, sexual abuse or neglect, with younger children being the most vulnerable (Grasso et al., 2016). The CDC defines the broad category of child abuse as an "act of commission" in which the abuse (or threats of abuse) are intentional (2017). Neglect is defined as an "act of omission," when a child's needs or level of basic protection from harm have not been met (2017). Any one form of abuse or neglect is enough to be classified as an adverse, or traumatic, childhood experience; even so, the finding that if a child experiences one kind of abuse they are likely to simultaneously endure other forms of abuse, is more distressing. (Dias, Sales, Hessen & Kleber, 2015; Grasso et al., 2016).

Outcomes Associated with Interpersonal Trauma

The potential for harm is exacerbated when children who experienced interpersonal trauma know the person inflicting abuse on them, or the person purposefully subjecting them to

violence (Thornback & Muller, 2015). If children experience interpersonal traumatic events at home, they may have difficulty in compartmentalizing the trauma from the notion of perceived family support provided by other members of the family, thereby diminishing protective qualities of social support linked to resilience (Powers, Ressler & Bradley, 2009).

Grasso and his colleagues investigated the patterns of ACEs (including many that would be classified as interpersonal trauma) and the related psychosocial outcomes by certain epochs (2016). Some of the results in the study shed light on the complexity of trauma as a whole, and the impact it can have in later stages of life. A clear dose-response relationship became apparent between the number of traumatic events children experience and Post Traumatic Stress Disorder (PTSD) symptomology, with more experiences of trauma resulting in an increased amount of expressed PTSD symptoms. For individuals with PTSD, interpersonal trauma was found to be a predictor of suicidal ideation and suicidality (Yoo et al., 2018; Miller, Jenness, Oppenheimer, Gottleib, Young & Hanking, 2017).

Recent research suggests that significant statistical differences arise between the severity of adverse outcomes depending on the ACEs that were experienced. That is, while parental separation or divorce is undoubtedly an ACE, the psychosocial trajectory of a child who experiences parental separation is likely to be much different than that of a child who has suffered one, or many, interpersonal traumas. In examining different ACEs and their relationships with attempted suicides throughout the life-span, those who experience Emotional Abuse are more than twice as likely to attempt suicide as those who have experienced other ACEs, such as parental separation or divorce (Dube, Anda, Felitti, Chapman, Williamson & Giles, 2001). Moreover, those who had experienced a combination of traumatic events,

especially those that would be classified as interpersonal trauma, were two to five times more likely to attempt suicide than those with lower ACEs scores. This stresses the importance of intervening when children are known to have experienced a significant amount of traumatic events.

In 2016, Grasso and his colleagues conducted a study in which ACEs were not mutually exclusive to allow participants to report anywhere from one to seventeen experiences. Additionally, the researchers divided participants into developmental epochs by early childhood (0-5 years), middle childhood (6-12 years), and adolescence (13-18 years). In each epoch, those with higher exposure to ACEs, including interpersonal traumatic events, were associated with increased psychopathology, internalizing symptoms, externalizing behaviors, and involvement in the juvenile justice department. Moreover, children who had been "polyvictimized,"(having experienced a high number of ACEs) during early childhood, were more likely to continue to experiencing polyvictimization during middle childhood and their adolescence. The authors stress the growing importance of addressing the ACEs experienced by children of all ages since more than half of the participants in their study were identified as having been subject to polyvictimization in all three developmental epochs.

Schwerdtfeger Gallus, Shreffler, Merten, and Cox Jr. found that 87.5% of students in a South Central U.S. population of seventh-grade students reported experiencing at least one interpersonal traumatic event, with most students in the sample averaging around three (2015). Students that endured a greater frequency of interpersonal traumas had significantly higher depressive symptoms and lower rates of social support (i.e., parent and school connectedness). Early exposure to interpersonal trauma, including emotional abuse, neglect, physical abuse, and

sexual abuse, is associated with lower levels of developmental competence at the preschool and elementary school age, as well as more severe PTSD symptoms (Enlow, Blood & Egeland, 2013).

School-Related Outcomes of Exposure to Trauma

In addition to the staggering volume of outcomes attributed to experiencing interpersonal trauma outside of school, a great deal is also expressed within schools. A myriad of consistent school-related outcomes came to light tn a systematic literature review conducted by Perfect, Turley, Carlson, Yohanna, and Saint Gilles (2016). After experiencing traumatic events, school-age children were likely to experience challenges in three main areas of functioning: Cognitive, Academic, and Social-Emotional-Behavioral.

Perfect and her colleagues organized each of the areas of functioning into smaller patterns that emerged from their meta-analysis (2016). In the area of cognitive functioning, the authors found deficits in Intelligence, Memory, Language Ability, Verbal Ability, and Attention. Students who had experienced trauma were found to perform lower on both verbal and non-verbal intelligence subscales in comparison to students who had not reported trauma. Additionally, their review found that some students may suffer from dissociation following exposure to trauma, as well as impairments in visual, spatial and working memory.

Perfect and colleagues' gained valuable information on the Social-Emotional-Behavioral functioning of school-age children who experienced trauma by including teacher reports in their systematic literature review (2016). Teachers can provide unique insights into how traumatic experiences are manifested in the classroom and school environment. Across the studies, teachers consistently reported higher levels of both internalizing and externalizing behaviors.

According to teacher reports, students who had experienced trauma (specifically subsets of interpersonal trauma) exhibited a greater number of internalizing symptoms, such as sadness, anxiety, withdrawn behaviors and lower levels of self-esteem compared to students who had not experienced trauma.

Incidents of interpersonal trauma were also highly associated with externalizing behaviors, especially if the traumatic events included witnessing or personally experiencing violence (Perfect et al., 2016). Exposure to traumatic events was linked to clinically significant behavioral problems over more extended periods of time and across multiple settings, compared to youth who had not been exposed to trauma. Unsurprisingly, Oppositional Defiant Disorder was more likely to be reported in students who had traumatic backgrounds. For those students with ADHD who had experienced trauma, they were also more likely to exhibit an overall increase in externalizing behaviors in addition to their ADHD symptoms. School-age children who had been victims of physical abuse were more likely than their peers to be referred to the office for disciplinary action. In all, disruptive classroom behaviors, impulsivity, hyperactivity, aggression, and defiance were all more likely to be attributed to students who had experienced trauma than to the general student population. These classroom behaviors are likely to be associated with additional challenges in emotion regulation.

Self-reports, teacher reports, parent reports, as well as standardized achievement tests were identified in the systematic literature review as methods of assessing academic achievement outcomes in students who had experienced trauma (Perfect et al., 2016). Perfect et al. noted that students with exposure to trauma performed more poorly on tests of vocabulary, reading, math, spelling, and science on both standardized achievement measures and state tests. Additionally,

youth with severe trauma exposure, or those who had been chronically maltreated or neglected, reported lower overall achievement scores and achievement performance. Moreover, the studies in Perfect's meta-analysis also found that students who experienced trauma had poorer grades and lower educational attainment. Perfect and her colleagues identified other patterns in the research which indicated that experiencing trauma was linked to other areas of academic functioning, such as increased absences, higher levels of grade retention and involvement in special education.

Multi-Tiered System of Supports

The need for mental health services is evidenced in the research on the many effects trauma has on students in schools. Thus, adopting a public health model to address these challenges in schools is crucial. Public health models are ecological as they take into account student's interactions with a range of environments around them, such as their family, school, community and society (Stiffman, Stelk, Horwitz, Evans, Outlaw & Atkins, 2009). In addition to addressing treatment, public health models stress the importance of continuing levels of services, ranging from prevention to intervention. In recognizing the importance of a continuum of services, schools have adopted a Multi-Tiered System of Supports (MTSS) - a public health model in which schools proactively provide comprehensive, evidence-based supports and interventions to the entire student population (August, Piehler & Miller, 2018).

Tier one, or primary intervention, are considered universal and are effective in servicing support to around 80% of the student population. This tier aims to ensure effective instruction to all students, as well as professional development for teachers and staff, progress monitoring, and frequent and universal screenings for students (Fletcher & Vaughn, 2009). Tier two (secondary

intervention) provides a level of support for around 15% of students who may need additional small group instruction or interventions; determinations for further interventions at all tiers are data-based. The remaining five percent of the student population who need individualized or specialized services or supports are included in tier three, or tertiary intervention. In theory, each level should reduce the number of students who escalate to the next level of services or interventions as the challenges that said students face as a result of trauma are intercepted at the earliest possible stage. This problem-solving approach can be utilized in addressing the unique needs of students who have experienced trauma while still promoting a healthy and understanding climate at the universal school level, for the benefit of the entire student body.

Methods

Research articles for this paper were obtained through the Chapman University Library website through the database host ERIC-EBSCO as well as reference lists from articles that were relevant to the topic. Some research articles were also obtained from the Google Scholar database host. Some of the commonly used words in the searches included: "interpersonal trauma," "trauma outcomes," "school-related trauma outcomes," and "trauma interventions." In an attempt to remain up to date on recent research, most articles used were published no longer than 15 years ago. However, some older studies were included where more recent research has yet to be conducted in those areas. Abstracts were then read to determine articles that would be useful and relevant to understanding the current climate of research around the topics of interpersonal trauma and supporting students who have experienced trauma.

Primary Intervention

While preventing trauma from occurring in the first place may be challenging, there are ways schools can support both the general population of students and those who have experienced trauma by providing them with skills for resilience and fostering a healthy school culture. In the vast research of how schools may support the needs of students who experience trauma, many studies focus on the implementation of Trauma-Informed Schools. While MTSS may utilize aspects of trauma-informed school approaches, there are a number of other universal level services and interventions that may be used in addressing students mental health needs as they relate to trauma. Universal strategies at the tier one level may be implemented both within and outside of a trauma-informed school.

Trauma-Informed Schools

As research around trauma has grown over the years, so too has the knowledge around trauma-informed practices and trauma specific interventions. With this knowledge, trauma-informed schools have emerged in response to the need of providing trauma services for the many students who need them. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies four central concepts that are crucial to a program, organization, or system to be 'trauma-informed.' Trauma-informed schools must, "[*realize*] the widespread impact of trauma and [understand] potential paths for recovery; [*recognize*] the signs and symptoms of trauma in [those] involved in the system; [*respond*] by fully integrating knowledge about trauma into policies, procedures, and practices; and, [seek] to actively *resist* retraumatization" (SAMHSA, 2015). In addition, trauma-informed schools should create systems that include and empower safety, transparency and trustworthiness, peer support,

collaboration and mutuality, empowerment, voice, and choice as well as consider cultural, historical, and gender issues.

While the interventions that are crucial to a trauma-informed school may be more individualized, and thus implemented as secondary or tertiary interventions, the overarching goal of trauma-informed schools is to provide safe and caring environments for all students (Chafouleas, Johnson, Overstreet & Santos, 2015). The four R's of trauma-informed models (realize, recognize, respond and resist), fall into an MTSS framework. Realizing the impact of trauma has clear implications in tier one supports. At this level, trauma-informed schools should establish practices that understand the benefits of healthy and safe school cultures, foster resilience through the use of problem solving and social skills, and teach and demonstrate common school-wide expectations. While these practices may not be specific interventions for those who have experienced trauma, the adoption of these practices is made in an attempt to provide a stable base for more targeted trauma services at the secondary and tertiary level. Moreover, the entire school climate shifts from a perspective of blaming people for their behaviors to attempting to understand what they may have experienced.

Due to the high demand for trauma services, many programs have been created so that schools utilize trauma specific interventions and approaches and become trauma-informed. One example of a trauma-informed school model is UCSF HEARTS - Healthy Environments and Response to Trauma in Schools (Dorado, Martinez, McArthur & Leibovitz, 2016). The program aims to promote resilience in students affected by trauma and other youth in the school by creating safe and supportive school environments within a three tiered model of supports. It includes school-wide policies and practices, as well as classroom based trauma-informed

strategies, in addition to promoting the mental health and wellness of school staff, as well as training on trauma. Dorado and colleagues investigated the effectiveness of the UCSF HEARTS program in four diverse schools outside of San Francisco in low-income neighborhoods, between the academic years 2009-2010 and 2013-2014. After implementing and evaluating the program, the authors found a range of positive results including decreases in disciplinary office referrals, out of school suspensions, and acts of physical aggression in students. Moreover, students who had experienced trauma showed a decrease in trauma related symptoms, such as adjustment, emotional regulation, and dissociation.

The literature on trauma-informed schools consistently signified that safe schools and classrooms are the cornerstones of trauma-informed schools. Therefore, to implement any trauma-informed school model with fidelity, schools and classrooms should serve as a safe place - both emotionally and physically. Students reported that the degree to which they learn new information, and the amount they can retain is impacted by their sense of safety (Holley & Steiner, 2005). One such way of addressing the safety of schools at the tier one level is to develop a common language around expectations in school. School-Wide Positive Behavior Interventions and Supports (SWPBIS) is itself an MTSS, however, and has especially relevant implications for supporting behavioral challenges, regardless of if the students have or have not experienced trauma. While it may seem daunting to implement two MTSS programs in a school, many of the interventions and services that are essential to SWPBIS (especially those in tier one) may be easily included in trauma-informed schools.

Trauma Related Professional Development for School Staff

An essential part of trauma-informed schools is that those within them have a solid understanding of trauma and how it is manifested and expressed in schools - not simply with students, but everyone with whom school staff interact (Chafouleas et al., 2015). Many teachers report that they lack basic competency skills that are necessary for working with students who have experienced trauma (Alisic, 2012). Moreover, they report an increased need for professional development and technical skills that are specifically related to working with students with trauma. Those in trauma-informed schools must be equipped with a solid understanding of trauma and how it impacts all individuals - students, staff and parents alike (Chafouleas et al., 2015). Therefore, professional development (PD) is crucial in the adoption and establishment of a trauma-informed model and in maintaining a trauma-informed culture.

In the UCSF HEARTS program, teachers, administrators, and other school staff are required to attend trainings and be involved in consultation regarding trauma, trauma-sensitive practices, as well as secondary trauma, burnout and stress (Dorado et al., 2016). The HEARTS program acknowledges that those working with trauma may be especially susceptible to burnout or experiences of secondary trauma, which is why these additional issues are included in the training. The addition of discussing the impact of working with trauma on practitioners is common in other trauma-informed models, as well. After involvement in the UCSF HEARTS program, school staff reported an increased understanding of strategies to help students who experience trauma learn in school, overall knowledge about trauma sensitive practices, and avoiding burnout or secondary trauma. Moreover, teachers specifically reported increases in student attendance rates and their ability to learn.

By providing school staff with PD opportunities, a basis for trauma-informed care is established. In 2016, Phifer and Hull conducted a systematic literature review investigating the outcomes of three studies involving trauma-informed schools. Phifer and Hull noted that in order to implement trauma-informed services and practices effectively, schools should provide PD opportunities for staff, as well as students and their families. One of the main intentions of PD around issues of trauma is to "promote a culture shift by building the capacity of the current staff to respond to students in a trauma-informed manner" (Perry & Daniels, 2016, p. 179). By participating in PD, school staff was better at recognizing the extensive impact of trauma, the signs and symptoms of trauma, and how to transform their increased knowledge of trauma into a trauma-informed culture.

Students who are survivors of trauma may not report the trauma they experience, especially in instances of interpersonal trauma as many victims know the perpetrator of the abuse (Thrornback & Muller, 2015). If school staff are not made aware of the associated symptoms or signs of trauma, students in need of mental health services or interventions may go unnoticed (White, English, Thompson & Roberts, 2016). Therefore, regardless of schools' adoption of a trauma-informed model, school staff must have a sound understanding of trauma as it is necessary for recognizing students who have experienced trauma and are in need of more intense services and interventions.

Social Emotional Learning

For students to be successful in school, they need to acquire social and emotional skills - skills that are necessary for optimal academic, social and mental health outcomes (Jones, Barnes, Bailey & Doolittle, 2017). Social Emotional Learning (SEL) includes skills training for students

in the areas of cognitive regulation, emotional processes, and social/interpersonal skills. Cognitive regulation skills, such as attention and inhibition, help students attune their behavior towards a goal. Emotional processes aid students in recognizing, expressing and managing their emotions, as well as understanding the emotions of others. Similarly to emotional processes skills, social and interpersonal skills provide students with the ability to understand others' behaviors, demonstrate effective conflict resolution, and positively engage with peers and adults.

Schools have a range of options to choose from when picking an SEL curriculum for their students; these programs vary in their focus on the various domains of skill sets (Jones et al., 2017). Most programs, if not all, target skills in at least one domain (specifically social skills). Positive Action, MindUP, and 4Rs (among others) tackle cognitive and social skills, and PATHS, Fast Track PATHS, and Second Step attempt to teach skills in all three domains. SEL curriculums aim to produce long-lasting changes in each of the domains they address. As social-emotional skills are linked to academic and mental health outcomes, these programs also intend for the positive effects related to SEL to spill over into other domains outside of those directly targeted by the curriculum, such as academic achievement. As students who experience trauma are susceptible to challenges in social, emotional and behavior skills (Perfect et al., 2016), it is imperative that schools utilize their position of influence to teach children these skills.

After the implementation of an SEL intervention program for minority students in an urban setting, statistically significant results were found in self-regulation and self-competence skills (Graves Jr. et al., 2017). In a meta-analysis conducted by Jones et al. (2017), studies found implementing SEL curriculums had positive effects on the cognitive, emotional, academic, social and behavioral outcomes of students. Studies in Jones and colleagues systematic literature

review found an overall positive effect on a range of social and emotional skills, as well as some effects in improved academic outcomes and decreases in behaviors related to depression and anxiety. Schonfeld et al. (2015) found similar effects on academic achievement in a high-risk youth sample after the PATHS curriculum was implemented. Students considered to be at higher risk for social and emotional problems saw positive effects on inattention and prosocial behavior after implementation of the Incredible Years SEL curriculum (Murray, Rabiner, Kuhn, Pan & Sabet, 2018). All in all, SEL curriculums provide students with an opportunity to gain skills that aid in education and other relevant domains while simultaneously fostering students' ability to be resilient.

Role of The School Psychologist

The role of the school psychologist is vast at the primary intervention level. Tier one interventions are intended to deliver universal supports to the entire school population - encompassing school staff, families and communities. This includes promoting a healthy school climate and empowering students' adaptive skills (Chafouleas et al., 2015). School psychologists role in primary interventions is imperative as it is highly unlikely that schools will be able to prevent students' experiences of trauma. The first step that school psychologists can take in supporting students and staff alike, is creating a safe school climate. An essential aspect of trauma-informed schools is an understanding of the widespread impact of trauma. Therefore, school staff should work in viewing children through a trauma-informed lens. Working with students who experience trauma can be difficult for many reasons, despite teachers' best intentions. Despite teachers' best intentions, working with students who experience trauma can be difficult for many reasons. Firstly, if school staff are unaware of potential signs of students

experiencing trauma, they may regard disruptive classroom behaviors as disciplinary problems rather than a call for mental health services. Secondly, if teachers have knowledge of a student who is experiencing trauma, but do not know what resources are available or how they can help, these students may progress through their years in education without necessary and available mental health services. For these reasons, it is of the utmost importance that school psychologists teach school staff about trauma and how trauma impacts learning and behaviors.

In addition to teaching school staff, school psychologists have a responsibility to foster resilience by helping students build social, emotional, interpersonal and cognitive regulation skills. As data-based decision makers, school psychologists should research SEL curriculums and programs to implement that support their student body. While many SEL curriculums allow teachers, graduate students, or other school staff members to deliver the programs, school psychologists should play an active role in ensuring the fidelity of these programs. Moreover, school psychologists should do the same if they choose to implement a trauma-informed school model. Finally, school psychologists' role is to provide universal screeners for all students to identify any students who are at-risk for needing more targeted interventions or those who are in immediate need of intensive interventions.

Secondary Intervention

Targeted interventions at the tier two level aim to provide supports to around 15% of students (Fletcher & Vaughn, 2009). Students who may need more support than the general population may benefit from interventions used at this secondary level, so as to not escalate to services at the tertiary level. These strategies and interventions work with at-risk students and are more trauma specific than some general strategies that are used at the tier one level

(Chafouleas et al., 2016). In addition to providing school staff with information on trauma, and how trauma impacts behaviors, thoughts, and emotions, interventions at the secondary level also provide this psychoeducation to students. Moreover, students receive interventions that target self-regulation skills and increasing social support systems. Similarly to primary intervention, strategies and interventions that are utilized in tier two may be used as part of a trauma-informed school model or on their own.

Check In, Check Out

Check In, Check Out (CICO) is a commonly used tier two intervention aimed at addressing problem behaviors for at-risk students (Wolfe, Pyle, Charlton, Sabey, Lund & Ross, 2016). The process of CICO involves a student checking in with a mentor (who can be either a peer or a teacher), reviewing schoolwide expectations and establishing a performance goal which is recorded on a progress report. Goals should be written to promote adaptive behaviors - that is, goals are written from a strengths-based perspective. Moreover, mentors should use this opportunity to help get the student prepared for the day and provide consistent feedback (Andrews, Houchins & Varjas, 2017). Throughout periods or classes, teachers observe the student's behavior and record whether or not they met their performance goals on their report. At the end of the day, the student checks out with the mentor to discuss their performance throughout the day and if they have met their goals. At this point, the mentors may provide incentives for positive behaviors and use this opportunity to establish and maintain a positive relationship with the student.

As a tier two intervention, CICO has been found to have a range of positive outcomes for at-risk students (Wolfe et al., 2016). In addition to improving educational and behavioral

outcomes, students also gained skills in self-determination, such as the ability to set goals and effectively problem solve (Andrews et al., 2017). For students who experience trauma and are at-risk for externalizing behaviors (Perfect et al., 2016), or emotional or behavioral disorders, CICO was found to be an effective tool in addressing challenging classroom behaviors in both schools and in residential treatment facilities (Hawken, Bundock, Kladis, O'Keeffe & Barrett, 2014; Andrews et al., 2017).

CICO may be implemented by staff members who serve as a source of support in guiding behaviors. Peers, who have been trained in using CICO, may also serve as mentors for students who utilize this intervention. In peer-mediated CICO, overall positive effects were found for students who were found to be at-risk for internalizing behaviors (Dart, Furlow, Collins, Brewer, Gresham & Chenier, 2015). In addition to improving externalizing and internalizing behaviors of at-risk students, peer mentors gain a range of skills in the process of working with at-risk students. Students who are at-risk for negative outcomes associated with experiencing interpersonal trauma can use CICO as a secondary intervention at the onset of behavior problems rather than in response to them. Furthermore, CICO can be used to increase adaptive behaviors while developing a close relationship with a mentor - regardless of who that may be.

Supportive School Based Relationships

A number of factors have been found for students who experience trauma or are at-risk of experiencing trauma that aid in promoting resilience. Masten (2014) notes that close relationships with capable adults are associated with resilience as they impact two adaptive systems: attachment and social networks. In schools, there are an abundance of individuals who may serve as a source of support to their students - from administrators to teachers, school

resource officers, cafeteria and janitorial staff and more. Schools have the benefit of bolstering students' ability to be resilient by providing students with an opportunity to establish healthy and supportive relationships with adults.

Teachers find it difficult to ascertain how much time should be devoted in the classroom to students who have experienced trauma (Alisic, 2012). Moreover, teachers report feeling burdened by not being able to provide the necessary supports for these students. One way to counteract this burden is to acknowledge that teachers are a source of support to these students and can play an essential role in their journey of recovery after traumatic experiences. In 2013, Dods completed a qualitative research study on the perceptions of caring teacher relationships with students who had experienced trauma. After coding the semi-structured interviews, Dods identified four main themes in creating and maintaining supportive teacher-student relationships: a) relationships were individualized, b) relationships were teacher driven, c) relationships involved active interaction and d) teachers demonstrated authentic caring. Moreover, students in this study identified that they were seeking teachers who simply provided a safe place to communicate, and were willing to connect with them - regardless of their expertise in clinical skills. If teachers are equipped in trauma-informed practices, these relationships serve an even stronger dual purpose as a useful resilience tool for students and in decreasing teachers' perceptions about their inability to provide support for students who experience trauma.

In instances when students manifest their experiences of trauma through behavioral challenges in the classrooms, it may be difficult for teachers to instinctively respond in a trauma-informed manner. However, when teachers can recognize expressions of trauma in the classroom, an important first step towards building meaningful relationships is established

(Craig, 2016). In addition to understanding that challenging behaviors may be the result of trauma, teachers can work with students in their classes to remain attuned to their needs through the use of frequent check-ins and breathing breaks. Teachers, and other school staff for that matter, should also address student needs by collaborating with them to identify and maintain a safe environment and a comfortable level of arousal.

Teachers have an additional purpose at the secondary intervention level as they play a crucial role in identifying students who may need additional resources. Teachers may be the first to notice participatory, somatic or behavioral indicators of experiences of trauma; these can include forms of avoidance, being slumped low in a chair, or leaving the classroom during discussions of trauma (Frydman & Mayor, 2017). If teachers, amongst other school staff members, have close relationships with their students and are receptive to changes in their behaviors, they may be able to better respond more quickly to the needs of students who experience trauma.

Cognitive-Behavioral Intervention for Trauma in Schools

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) is an evidence based group intervention for students who have experienced trauma. CBITS uses a range of activities with students to address six main areas related to trauma: social skills & problem solving, stress or trauma exposure, real life exposure, cognitive therapy, relaxation training and psychoeducation (Little, Akin-Little & Somerville, 2011). CBITS program includes work with students who have been traumatized and can also include sessions with their parents and teachers. Students attend ten one hour group sessions, in addition to one to three individual sessions. Despite the use of individual sessions, CBITS is primarily a tier two intervention as the

bulk of the therapy that addresses the student needs is conducted in the group setting. CBITS employs typical cognitive-behavioral techniques in that students learn about the Thoughts-Feelings-Actions Triangle and are challenged to identify dysfunctional thinking patterns and automatic thoughts related to their traumatic experiences (Jaycox, Kataoka, Stein, Langely & Wong, 2012).

The informal structure of CBITS allows schools to tailor the program for whomever is intended to deliver the program and the students receiving the treatment (Jaycox et al., 2012). CBITS allows school personnel, such as teachers or school counselors, to facilitate the group sessions - unlike other treatments which can require a skilled clinician or therapist. The program may also be redesigned to allow those delivering the treatment to adjust the resources that are used and how much time is dedicated to each main area of treatment. Due to the flexibility of CBITS, it is an incredibly useful tool for schools to utilize for providing mental health services to students who experience trauma without needing to escalate to the use of tier three interventions, which is beneficial for both students and school personnel. In addition, CBITS bridges the gap between students who need mental health services but do not necessarily require intensive and individualized therapy.

In a study by Jaycox and his colleagues, CBITS was found to significantly reduce symptoms associated with both PTSD and depression (2012). These differences were even more profound for students who entered the program with greater symptom severity. Parents of children involved in CBITS reported a 35% improvement in psychosocial functioning, compared to only 2% in a control group. On top of proving useful in addressing trauma related symptoms and functioning, students who received CBITS at the start of the year were more likely to receive

higher grades than those who received treatment later in the academic year. Students with moderate needs, or those who are at-risk for becoming high need, can receive effective treatment that addresses the academic, social, emotional and behavioral challenges that accompany experiencing trauma by the implementation of CBITS at their schools.

Role of the School Psychologist

At the tier two level, school psychologists should be consistently monitoring the needs of at-risk students. School psychologists can help school staff take steps towards building healthy and supportive relationships with their students by establishing a positive school climate at the tier one level. CICO is an effective intervention in changing behaviors and creating helpful relationships for students with mild behavioral challenges. While these two go hand in hand, school psychologists should ensure that CICO as an intervention is proving useful to the student. School psychologists determine if this level of service is meeting the students' needs, or if they require tier three interventions by collecting data and interviewing both the student and those involved in the daily progress reports. Increasing at-risk students' social support systems and resilience skills, such as self-regulation, are essential to tier two trauma interventions (Chafouleas et al., 2015) and should be monitored by school psychologists.

Similarly, school psychologists should investigate the treatment fidelity of CBITS group sessions. School psychologists may play an active role in being the group facilitator, or should be consistent in monitoring how others' are leading the groups. As tier two aims to support at-risk students, or those with more moderate mental health needs, school psychologists should frequently monitor how services are being used. On top of that, they should note how effective

tier two services are in ensuring students who experience trauma are not over represented in tier three interventions by conducting frequent assessments and screeners.

Tertiary Intervention

Tier three interventions are used in select circumstances for students who have experienced trauma and are in need of highly intensive and individualized services (Fletcher & Vaughn, 2009). These interventions should be used for students who are not responding to tier one or tier two interventions and should directly address the adverse effects associated with experiencing trauma and also aim to resist re-traumatization (Chafouleas et al., 2016). As interventions and strategies at the universal and targeted levels are utilized, only about 5% of students should be in need of a tertiary level of intervention. These services require a lot of time and expertise by those administering therapy and focus heavily on trauma. Additionally, they may be tailored to better reflect the needs of students with experiences of interpersonal trauma. Students who experience interpersonal trauma experience high levels of emotional regulation challenges and internalizing and externalizing behaviors - even when compared to other forms of abuse (Perfect et al., 2016; Powers et al., 2009). Due to this, unique challenges related specifically to interpersonal trauma may arise and should be addressed by school practitioners working with students at this tertiary level of services.

While Cognitive-Behavioral Therapy (CBT) has been found to be useful in treating a myriad of challenges faced by school-aged youth, Trauma-Focused CBT is particularly useful in confronting issues related specifically to trauma. A search of the literature for treatment options for youth who experience trauma consistently finds TF-CBT to be the preferred method of practitioners for working with these students. Although other forms of CBT, such as Game-

Based CBT, have been found to be particularly useful for children who are survivors of sexual abuse (Misurell, Springer & Tyron, 2011; Springer, Misurell & Hiller, 2011) more research needs to be conducted into other tier three interventions that support students who experience interpersonal trauma.

Trauma-Focused Cognitive-Behavioral Therapy

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) falls under the broad umbrella of CBT in that it facilitates dialogues between therapists and clients around beliefs, emotions, and behaviors (Hayes et al., 2017). Therapists and clients work together to explore perceptions of the trauma they experienced, and the consequential emotions or beliefs related to those traumas. Therapists may also have clients create a trauma narrative by recounting their traumatic experiences, either verbally or in writing. Youth who experience trauma are at-risk for over-generalizing trauma-related beliefs or stimuli and for ruminative processing, in which they repeatedly have negative thoughts or re-experiences of the trauma, or traumas. TF-CBT therapists work with students who experience trauma to address the major challenges of automatic trauma-related thoughts and the concurrent emotions associated with them.

TF-CBT has been found to be effective for youth after being involved in any number of potentially traumatic experiences, but is especially effective for those who experience interpersonal trauma (Hayes et al., 2017; Thornback & Muller, 2015; Mannarino, Cohen, Deblinger, Runyon & Steer, 2012). CBT asserts that automatic thoughts and the emotions that are the result of these thoughts, are linked to an individual's underlying or core beliefs (Creed, Resiweber & Beck, 2011). Individuals attempt to handle these core beliefs by one of three compensatory strategies: maintaining, opposing, or avoiding. Students who experience

interpersonal trauma may frequently use avoidance behaviors in an attempt to divert their negative thoughts about the trauma they have experienced (Hayes et al., 2017). Due to this, TF-CBT therapists work to address how core beliefs are maintained and in turn, how these affect thinking patterns and behaviors. In investigating TF-CBT treatment outcomes in school-aged children who had experienced sexual abuse, physical abuse and/or interpersonal violence, Hayes et al. found positive effects both at the outset of treatment and at a 12 month follow up. Participation in TF-CBT was linked to significant decreases in PTSD symptoms as well as in challenges related to PTSD symptoms such as rumination and overgeneralization.

Students who are in need of intensive trauma services are likely to have additional challenges related to their symptomatology, such as emotion regulation skills (Thornback & Muller, 2015). TF-CBT was linked to improvements in emotion regulation in children who had experienced interpersonal trauma, such as maltreatment or abuse. TF-CBT decreased maladaptive emotion regulation skills, which, in turn, affected a reduction in the symptoms associated with them. Mannarino and colleagues (2012) studied the long term impact of TF-CBT with youth who had experienced sexual abuse. Gains from TF-CBT were sustained at both six and twelve months follow-ups. Some of the areas that were investigated at follow up include re-experiencing, avoidance, internalizing behaviors, externalizing behaviors, depression, fear, shame, and more. Overall positive effects were maintained across an array of outcomes for youth who had concluded therapy, suggesting that improvements are established during TF-CBT and can continue to provide necessary support to students long after therapy is terminated.

Role of the School Psychologist

It is clear that they play a crucial role in tier three interventions as school psychologists function as mental health experts in schools. Tertiary interventions for students who experience interpersonal trauma are centered around therapy and counseling which fall heavily into the duties of a school psychologist. School psychologists should first provide them with the counseling needed in addition to considering if these students meet criteria for special education eligibility for students who have severe challenges or symptoms related to trauma. If students already have an IEP (Individualized Education Program), school psychologists should already be aware of the services the child receives and how counseling goals fit into their existing IEP. If a child does not have an IEP, then their is an obligation to abide by Child Find and determine if they are eligible for special education services.

School psychologists should consider the level of treatment that is feasible in schools since they are limited in the amount of services they can provide. Furthermore, school psychologists should be aware of their limitations which include school, district, state or federal resources or boundaries, as well as their personal capabilities. This stresses the importance of collaborating with outside agencies, especially when students are in high need of trauma related services. School psychologists should be aware of community mental health resources that are available for students struggling with interpersonal trauma, and how they can support students in receiving them. Moreover, if students meet with mental health clinics for their trauma-related needs, school psychologists should communicate and consult with therapists or clinicians to provide a holistic, interdisciplinary approach to supporting the academic, social, and emotional skills of these students.

Discussion

The National Association of School Psychologists (NASP) recognizes that trauma is common and widespread in students and that school psychologists have a duty to respond to the needs of the students. While trauma may be unavoidable, schools have the opportunity to equip students with the resources they need to be resilient in the face of adversity through the implementation of MTSS. Children who experience interpersonal trauma, such as abuse or neglect, may struggle to find safety in their surroundings outside of school; due to this, schools should strive to create an environment in which all students find comfort in their emotional and physical safety while in school. As children spend a lot of time in school, NASP asserts that school psychologists are important figures in fostering a safe, collaborative and nurturing school climate and seeking out students who need trauma-related services. School psychologists have countless opportunities to intervene and change students' lives by using a public health approach to support students who experience trauma - especially those who experience interpersonal trauma.

Although the interventions in this study have a strong evidence base, school psychologists should strive to continuously investigate the efficacy of their interventions before choosing to implement them. In choosing school-based interventions, practices, and strategies to put into practice, school psychologists should use peer-reviewed research to investigate the fidelity of interventions in schools. While some interventions mentioned in this paper were specifically developed to be used in schools (such as SEL curriculums and CBITS), others were not. TF-CBT has been shown to be effective in addressing trauma-related outcomes, however,

little research has been done in the use of TF-CBT in schools. Therefore, school psychologists should be wary as treatment fidelity could be compromised.

Despite recent interest in services, strategies and interventions that schools can use to combat the effects of trauma, more research needs to be done. While TF-CBT has been shown to be effective in reducing trauma-related symptoms, future research should investigate other forms of counseling, such as Solution Focused Brief Therapy or Interpersonal Psychotherapy. As Game-Based CBT has led to improved outcomes in survivors of sexual abuse (Springer et al., 2012), it would be helpful to investigate if Game-Based CBT is effective in addressing challenges related to other forms of interpersonal trauma. It is also important to consider studying other adaptations of CBT, such as Mindfulness Based CBT, and their effectiveness on treating symptoms associated with diagnosable mental health disorders and in improving psychosocial outcomes with individuals who have experienced interpersonal trauma.

There is a dire need to investigate interventions that relate specifically to interpersonal trauma. As outcomes related to interpersonal trauma are vast and may be expressed differently than other forms of trauma, such as experiencing a natural disaster, schools should assess how interventions can address the specific mechanisms or outcomes related to interpersonal trauma. Child abuse, neglect, and other forms of childhood maltreatment should be considered in the creation of future interventions and research. Additionally, as previous research has indicated the importance of promoting positive relationships between school staff and students, future research should investigate specific strategies that close the gap between students and staff, while promoting skills that are necessary for resilience.

While more research in the area of interpersonal trauma still needs to be conducted, practitioners in the school have an obligation to use the extensive research that is already available to bolster resilience with students who have experienced trauma. As trauma is common in school-age children, providing universal supports is becoming increasingly necessary. It is clear that schools should make immediate steps towards implementing trauma-informed practices as all students can benefit from these strategies and interventions. Schools are forced to resort to timely and costly tertiary interventions for students who are high-need if they fail to address student needs at the primary and secondary intervention levels. In the long-run, establishing a system that promotes healthy, positive relationships and a supportive and safe environment, can reduce the excessive use of intensive interventions. Therefore, school psychologists have a clear role in supporting students - no matter how much trauma they have experienced - by setting up a framework that enables them be resilient.

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