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Responding to Students with PTSD in Schools

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The prevalence of trauma exposure among youth is a major public health concern,⁶ with a third of adolescents nationally reporting that they have been in a physical fight in the past twelve months and 9% having been threatened or injured with a weapon on school property.⁷ Studies have documented the broad range of negative sequelae of trauma exposure for youth, including posttraumatic stress disorder (PTSD), other anxiety problems, depressive symptoms, and dissociation.^{17,23,31,44} In addition, decreased IQ and reading ability, lower grade-point average (GPA), more days of school absence, and decreased rates of high school graduation have been associated with exposure to traumatic events.^{11,35} Evidence suggests that youth exposed to trauma have decreased social competence and increased rates of peer rejection.⁴³ Therefore, students who have experienced a traumatic event are at increased risk for academic, social, and emotional problems as a result of these experiences. Schools can be an ideal setting for mental health professionals to intervene with traumatized students, by supporting both their trauma-related psychological problems and their ability to learn in the classroom. The President's New Freedom Commission Report on Mental Health also highlights the need to improve access to services that address trauma-

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related mental health problems, especially in naturalistic settings such as schools where youth can readily receive these services.⁴⁹

Types of traumatic events that affect students

Students can experience a wide range of traumatic events that can impact their functioning in school. Some traumas can affect students more individually such as assaults, serious accidents, abuse, community or domestic violence. Other traumatic events impact the entire school community, such as a school shooting, terrorist attack, natural disaster, or a traumatic incident that occurs on campus. Differences in the type of traumatic experience may also influence whether the choice of an approach is a school-wide intervention, an individual or group treatment, or something targeted for certain school staff or students, each of which will be discussed in more detail later in this chapter. Understanding the types and extent of traumatic events students have experienced, as well as which events are perceived by the student to be the most salient can be a critical first step in the treatment process.

Posttraumatic stress disorder (PTSD)

Although students may experience significant traumatic events, not everyone will develop PTSD. For some, brief distress following a trauma without significant impairment in functioning may be characterized as a normal reaction to the event. For others, trauma-related symptoms will occur in the immediate period following a traumatic event, and if symptoms similar to PTSD are present within the first month following the trauma along with significant distress or impairment, a diagnosis of Acute Stress Disorder may be warranted.

It is estimated that approximately 4–6% of youth in the general population nationwide will meet criteria for a diagnosis of PTSD following a traumatic event, including symptoms such as poor concentration and intrusive thoughts, which can also severely interfere with school functioning.^{17,23,31,38,44,47} Since 1987, the childhood manifestations of PTSD symptoms have been described in the Diagnostic Symptom Manual (DSM) and have included specific characteristics that can be seen in children. Further refinement of the PTSD diagnostic criteria are being discussed for DSM-V, such as developmental manifestations of PTSD.^{3,36} Currently, for a diagnosis of PTSD the student must experience a traumatic event in which he/she perceives a threat to either self or others and must experience distress (horror, fear, helplessness).² For children, this distress can manifest in disorganized behavior or agitation. The three symptom clusters for PTSD include re-experiencing (for children, this can be repetitive play or re-enacting the trauma in play), numbing and avoidance (such as avoiding traumatic reminders and talking about trauma, not participating in activities previously enjoyed), and hyperarousal (such as irritability, anger, difficulty sleeping).

Following exposure to a traumatic event, some students may be more likely to develop PTSD than others. Risk factors for PTSD include characteristics of the trauma exposure (greater trauma severity, proximity to the event), individual factors (female gender, history of psychopathology), and parent characteristics (parental psychopathology including PTSD and other trauma-related symptoms, lack of parental support following the trauma). Those students who have had multiple traumatic events and those who experience interpersonal trauma such as an assault, can also be at increased risk for developing PTSD.^{17,23,31,38,44,45,47}

Of those with PTSD, 75% have additional mental health problems such as other anxiety disorders,^{15,33,44} depressive symptoms,^{23,28,31,34} dissociation,³⁵ substance use,²⁷ and aggressive and delinquent behavior.^{5,12,14,17,18,24,31} Students exposed to violence

subsequently may be violent themselves resulting in them perpetrating violence on others.^{4,13,16,19}

Evidence-based treatments for students with PTSD

The most well-studied treatments for PTSD in youth have been cognitive behavioral therapy (CBT) approaches. Studies have documented that CBT effectively treats PTSD due to child sexual abuse,⁹ intimate partner violence,¹⁰ single incident trauma,^{1,30} co-morbid PTSD and substance abuse³² and more general community violence.^{26,42,46} According to the practice parameters outlined by the American Academy of Child and Adolescent Psychiatry (2010),⁸ when treating PTSD in children, the interventions should include core components of cognitive behavioral therapy including direct exploration of the trauma, stress management techniques, and correction of cognitive distortions. Treatment should also include collateral sessions with parents for optimal treatment outcomes.⁸ One intervention that has been identified as potentially harmful following a traumatic event is holding therapy that forcibly restricts children who have experienced severe and chronic trauma.

Psychopharmacological treatments have been understudied. A recent review by Strawn and colleagues (2010) conclude that pharmacological agents should not be used as first line treatment for PTSD in youth.⁴⁸ SSRI's may be helpful, although a recent RCT found no difference compared to placebo.³⁷ Only open trials currently exist for other medications such as antiadrenergic agents, antipsychotic medications, and mood stabilizers.

School-based services may be particularly important for underserved ethnic minority youth who traditionally are less likely to receive such services. For example, a randomized study comparing two efficacious treatments for youth with posttraumatic stress symptoms in post-Katrina New Orleans found that 91% of the youth completed the school-based intervention compared to only 15% who completed the clinic-based intervention.²¹

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program, a brief, ten-session group school-based program, has been studied in a quasi-experimental trial (Kataoka) and randomized controlled trial (Stein), both delivered by school-based clinicians. Findings have demonstrated improvements in posttraumatic stress disorder (PTSD) and depressive symptoms among elementary and middle school students exposed to violence who have received CBITS compared to those on a waitlist.^{26,46} Preliminary findings also suggest that this program may have effects on school performance, with students who receive CBITS early in the school year doing better in math and language arts grades than students who receive the intervention later that same academic year.²⁵ The CBITS program was developed in collaboration and partnership with school and community leaders and was specifically designed for school-based delivery for greater fit and sustainability within the school environment. Support for Students Exposed to Trauma (SSET), is an adaptation of CBITS which can be delivered by non-mental health trained school staff (teachers, school counselors).²² Results of a small randomized controlled trial suggest that SSET can be delivered by school staff effectively, resulting in modest improvements in trauma-related mental health symptoms. Given the lack of mental health resources typically found in schools and the tremendous need for access to trauma interventions, SSET is a promising early intervention that can be feasibly delivered in schools.

Other trauma interventions have also been developed and studied in the context of schools. The Multimodality Trauma Treatment (MMTT) or Trauma-Focused Coping is a 14 session group intervention program that adapts basic cognitive behavioral techniques for students who have experienced a single incident trauma. Grounded in social learning theory, MMTT utilizes peer modeling of effective coping, storybooks, narrative exposure, and cognitive games to alleviate trauma resulting from a natural disaster, exposure to violence, murder,

suicide, fire, and accidents. The program is not suitable for children with chronic abuse related PTSD because the school-based protocol does not incorporate family sessions necessary to address interpersonal victimization.³⁰ Controlled studies conducted in elementary, middle and high school demonstrate a marked reduction in PTSD, depression, anxiety, and anger symptoms following the treatment intervention.^{1,30}

The University of California Trauma Grief Component Treatment (TGCT) program is designed for adolescents exposed to multiple types of violence and traumatic loss.³⁹ This intervention includes an extensive assessment protocol followed by 16–20 group psychotherapy sessions to mitigate functional impairment associated with PTSD, depression, and grief reactions. Results of a randomized controlled trial conducted with adolescents in post-war Bosnia indicate notable improvement in PTSD, depression, and complicated grief symptoms.²⁹ Another promising intervention implemented with war-exposed children in Israel is Stress-Inoculation Training (SIT). This school-based universal prevention program aims to prevent PTSD by teaching adaptive coping skills and fostering resilience. The curriculum is integrated into mainstream classrooms and teacher implemented. In a school-matched controlled study, results indicated lower levels of symptoms of posttraumatic stress, depression, and anxiety in those who received the intervention compared to those on a waitlist.⁵⁰

Practical Approaches

Supporting school personnel following a school-wide trauma

A trauma that affects the school campus can be a sudden, unexpected, or unanticipated event that not only can disrupt the school's daily functioning, but can involve short-term turmoil such as shock, confusion, and fear. Although each student, teacher, parent or other school community member experiences each crisis differently, a school-wide trauma can have a broad and immediate impact on many children and adults sufficient to interfere with teaching, learning, attendance, and behavior. A trauma that impacts a school can affect a single building or an entire district or community. The following are examples of school-wide traumatic events: an accident on or near the school grounds, a violent incident or crime on campus or near a school that jeopardizes the safety of students and staff, a suicide of a student or staff member, the sudden death of a student, staff member or one of their family members, a natural disaster such as an earthquake, hurricane or tornado, a man-made disaster such as a terrorist attack.

The impact of these traumatic events can be manifested at three distinct levels: the individual (student or staff), the school system, and/or the surrounding school community. The most obvious impact and easiest to identify are physical injuries to students and/or staff. Psychological and cognitive disruptions also occur frequently, but may be more difficult to identify. For example, interference with the ability of students and staff to focus on learning is a common reaction to a school-wide traumatic event. Disruptions to the school system frequently occur following a traumatic event with changes to regular school functions and routines (i.e. changes to safety protocols). In addition, traumatic events often raise significant concerns from parents and when not properly addressed, may prolong the disruption to regular school routines. Large scale events may garner concentrated attention from the community and news media. This can lead to prolonged disruptions across the broader community, with repeated exposure to media coverage potentially causing significant trauma-related symptoms in students.

One important role that the mental health professional on campus can play is being part of a multi-disciplinary school crisis team, often also composed of a school administrator, school counselors, school psychologists, nurses, lead teachers, a custodian, and other school or

district personnel. Their collective skills can ensure that critical services are provided for the school and the greater community such as: assessing the range of crisis interventions needed for a specific crisis situation; limiting the exposure to scenes of trauma, injury or death; advising and assisting the principal and teachers on how to restore regular school functions and routines as efficiently and quickly as possible; and providing psychological first aid to students.

Psychological First Aid for Schools

Psychological First Aid for Schools (PFA) are key skills that can be delivered by school staff following a traumatic event to help students acknowledge how the traumatic event has been disruptive to the school environment and to their own emotional equilibrium. By teaching school staff how to respond to students following a trauma, PFA helps stabilize the emotions and behaviors of students, school staff, and parents. It also allows students to return to a safe environment and calm routine in an improved psychological and emotional state. Through PFA, students are able to re-establish “social connectedness” with family, teachers and peers, as well as minimize the negative effects of trauma to all involved. The skills students acquire through PFA enable them to identify personal and commonly experienced trauma-related emotions and reactions. PFA can also improve the social support on the school campus, leading to constructive coping behaviors and resilience of students, parents and teachers, which can ultimately facilitate student attendance and participation in the learning process. Finally, PFA can help establish systems on campus to prepare students and teachers for future challenges and adjustments following the traumatic event that are frequently confronted by schools after a trauma.

The widespread use of Psychological First Aid (PFA) is evidenced by the fact that the Inter-Agency Standing Committee (IASC), an international humanitarian assistance forum, has developed *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* that recommend, “All aid workers provide very basic psychological first aid.”²⁰ The IASC guidelines further define the components of PFA to include among many others, the following actions:

- Protect survivors from further physical or psychological harm;
- Identify and provide support for those most distressed;
- Reestablish social supports:
- Return to school and familiar routines;
- Facilitate communication among families, students and community agencies;
- Educate those affected about the expectable psychological responses, and basic coping tools, to stressful and traumatic events;
- Identify basic practical needs and ensure that these are met;
- Ask for people’s concerns and try to address these;
- Encourage participation in normal daily routines (if possible) and use of positive means of coping; and
- As appropriate, refer to locally available support mechanisms or to trained clinicians.

Listen, Protect, Connect (LPC): An Evidence- Informed Model.^{40,41}

In keeping with IASC’s guidelines, LPC is a form of PFA strategies focusing on children, parents, families and community members. LPC uses parents, teachers, primary care and

“neighbor-to-neighbor” providers to give basic psychological support. A version of PFA specifically designed for children to be used by educators and other adult staff in schools is available. In the immediate aftermath and during the early phases of recovery in this version, “Psychological First Aid for Students and Teachers: Listen, Protect, Connect—Model & Teach,” (hereafter, LPC—Model & Teach) is a five-step crisis response strategy designed to reduce the initial distress of students or adults and to help students return to school, stay in school and resume their learning. It is not a single session recital of events, but a model that can guide the interactions of students and educators over time through the process of their recovery. Teachers, counselors and other adults can use their discretion to apply these guiding principles in a flexible manner.

Step 1: Listen

During step one, teachers or adult school staff should provide students with an opportunity to share their experiences and express feelings of worry, anxiety, fear or other concerns about their safety. Speaking with students can occur one-on-one if a teacher and student find themselves in a relatively private place to talk. The adult should convey interest, empathy and availability, and let students know they are ready to listen. The teacher can open the discussion by acknowledging what has happened and letting students know that it is not only acceptable to share their experiences, and establishing that the school is a safe place to do this.

Adults should avoid making judgments and predictions, such as “You’ll get over it,” or “Only the strong survive.” It is important to validate the students’ life experiences without probing students for more details than they are willing to share. Forcing students to go over their experiences in too much detail, especially immediately after the crisis, can re-traumatize the student and may cause more emotional and psychological distress to themselves and to others who may hear additional details about the event.

Step 2: Protect

For this second step in the LPC—Model & Teach intervention, adults should try to reestablish students’ feelings of both physical and emotional safety. They can honestly inform students about events surrounding the crisis, such as sharing with them information about what is being done in the community and school to keep everyone safe. This information should be provided in a developmentally and age-appropriate manner. In the classroom, or around school, adults should maintain structure, stability and predictability, and make efforts to reestablish routines, expectations and rules. For example, bell schedules should return to normal as soon as possible. If shortened days are required, keep them to a minimum. Traumatized students may experience more confusion when disruption comes to their school routines, including after school activities, by too many changes to their regular schedules. Concerns about separation from parents or caregivers are frequently children’s paramount concern. Parents can help stabilize children’s reactions by resuming mealtime, homework, and bedtime routines as well as community or church activities disrupted by the crisis or emergency. It is also important at this phase to protect students from further physical harm or psychological trauma which can occur through their viewing or hearing repetitive media reports on the incident or through bullying by peers at school.

Step 3: Connect

One of the most common reactions to trauma or fear is emotional and social isolation and the sense of loss of social supports. It can occur automatically, without students or adults realizing that they are withdrawing from their teachers or peers, respectively. The third objective of LPC—Model & Teach is to help students reestablish their normal social relationships and stay connected to others in order to experience social support. Restoring

and building connections promotes stability, recovery and predictability in students' lives. A student's classroom and school is a safe place to begin restoring normalcy during a crisis or disaster. Through the eyes of children, adults can identify the "systems of care" that are part of their everyday life, move from beyond the classroom and school to the family and then to other community anchors including preexisting faith and cultural supports. This objective serves to help students reconstitute the relationships between the key community systems or "anchors" in their lives. Teachers or other school staff that reach out and check in with students on a regular basis can do this reconstitution, sometimes several times a day. Students also can be encouraged to interact, share "recovery" activities and take on team projects with other students, friends or teachers. With this type of interaction, students feel the caring and consistent support of adults in their lives, even during a difficult time of coping.

Step 4: Model Calm and Optimistic Behavior

Adults can model calm and optimistic behavior in many ways, including the following:

- Maintain level emotions • and reactions with students to help them achieve balance;
- Take constructive actions to assure student safety, such as engaging in a safety drill to remind them of how to stay safe, or planning a project that improves the physical or social climate of the school;
- Express positive thoughts for the future, like "Recovery from this disaster may take some time, but we'll work on improving the conditions at our school every day;" and
- Help students to cope with day-to-day challenges by thinking aloud with them about ways they can solve their problems.

Step 5: Teach

To support and facilitate the coping process, it is important to help students understand the range of normal stress reactions. School counselors, nurses, psychologists or social workers can take on this task. They can help students become familiar with the range of normal reactions that can occur immediately after a traumatic event or disaster and teach relevant coping and problem solving skills.

With early intervention and psychological first aid, the majority of students and adults may be able to resume a new normality of function and routine. However, those with a "trauma history" of previous exposure and experience with violence may require follow-up care and treatment for PTSD, depression, severe behavioral disorders, or suicidal ideation.

School staff must be made aware of the risk factors that may indicate a mental health evaluation is warranted. These risks factors include:

- Loss of a family member, schoolmate or friend
- Fear for their lives, observing serious injury or the death of another person
- Family members or friends missing after the event
- Getting sick or becoming hurt due to the event
- Home loss, family moves, changes in neighborhoods, changes in schools or loss of belongings
- Being unable to evacuate quickly
- Past traumatic experiences or losses

- Pet loss
- Past history of post-traumatic stress disorder (PTSD), anxiety or mood disorders coupled with any of the above

Talking to Parents about PTSD

Parents and other caregivers play an important role in supporting school efforts to help children with PTSD and other sequelae of trauma exposure. In this section we highlight some of the information that is most useful to share with parents to help them in supporting the efforts of schools to assist their traumatized children.

When a child is suffering from PTSD or other trauma exposure, it is helpful for parents to understand that their child's behavior can be affected in a variety of different ways, not all of which are obviously related to the experience. In preschool aged children, in addition to the classic symptoms of PTSD, parents may notice the child exhibiting separation anxiety from parents or teachers, regressing in previously mastered stages of development such as bedwetting, having difficulty at naptimes or bedtime, and having increased physical complaints or new fears. Elementary school aged children may also exhibit many of these same symptoms, as well as asking questions about death and dying, having more difficulty with authority and overreacting to criticism, being more jumpy, and showing less trust in others. Parents of older children in middle and high school may also notice their children having more physical complaints and difficulties with authority and criticism, as well as noticing that their child may appear to be more focused on topics of death and dying as well as being less optimistic about their own future. Parents of older children should also be aware that their child is at greater risk for using alcohol and illicit drugs.

Parents of children suffering from PTSD or other sequelae of traumatic events should know that they can play a very important role in supporting school efforts to assist their child. Things that parents can do to support their child with PTSD include helping their child to reestablish a sense of safety, providing their child with the opportunity to talk about their experience in a safe, supportive environment, by expressing positive thoughts about the future, by helping their child to cope with day to day problems, and by providing predictable routines, clear expectations, consistent rules, and immediate feedback.

Parents should also be aware that they can also be affected by their child's PTSD, both through helping their child cope with their experience, as well as if they were also exposed to the same trauma that their child was. Sometimes parents find that they can't stop thinking or dreaming about their child's experience. In other cases parents may have trouble concentrating or sleeping, are more irritable than normal, or find that they are feeling numb or detached. In these situations, it is important that the parent seek someone to help them with their own feelings.

Clinical strategies in working with students with PTSD

As described above, evidence-based models for treating childhood PTSD typically include the cognitive behavioral components described below. First, it may be helpful to think about a case example.

Veronica, a 12 year old middle school student, is referred to the school-based mental health clinician-by her Language Arts teacher. Her teacher explains that Veronica is typically a conscientious student, especially in language arts, and has a number of friends. Over the last few months, however, her teacher has noticed that Veronica has begun to miss class, which is negatively impacting her grades. Her teacher reports that she seems withdrawn from her friends, sad, and distracted in class. When the teacher provided minor verbal feedback on an

assignment, Veronica became tearful and angry and subsequently asked for a pass to the nurse's office saying that she felt sick to her stomach. When you meet with Veronica, you ask if she has recently experienced any frightening, difficult, or very stressful events and she replies that 3 months ago, she and her friends witnessed a boy being beaten up and held at gunpoint by a gang in the park. Since then, she can't stop thinking about what happened and worrying that it could happen to her, her friends, or her family and feeling sick to her stomach. She feels upset each time she sees her friends and feels sad and alienated from her peers in general. "How do they expect me to concentrate on grammar and essays when I can't stop thinking about the boy with a bloody face and the gun in the gang member's hand when he spotted us before we ran?"

Working with the parent—During your initial meeting and assessment with Veronica, you find that she meets criteria for a diagnosis of PTSD. You get permission from her mother to provide her with mental health treatment at school. Although her mother is not aware of this incident, she knows that they live in a neighborhood with gang activity, and also shares that the family has been struggling financially since her husband lost his job last year. She also reports that Veronica has been more sad and tired, has been asking for medicine to calm her stomach over the last few months, easily loses her patience with siblings, and does not like to go to school. She agrees that she would like Veronica to receive support and learn coping skills so she can feel better. Her mother works 2 jobs and has 2 younger children, making it feel impossible to accompany Veronica or provide transportation for services, so she is grateful that she can receive such services at school and free of charge. While you have her on the phone, you provide Veronica's mother with brief information about the treatment components likely to be included in your work with Veronica, and convey that it will be helpful to have her mother involved to the extent possible. She agrees to do her best to get time off to attend 1–2 sessions and to support Veronica's practice of coping skills at home as she progresses through treatment. You give her your contact information and ask her to provide you with any alternative contact information for her and best times to contact her if needed.

Creative approaches to communicating with parents can help overcome obstacles associated with parents being able to come to the school for sessions. Information may be conveyed via telephone calls, exchanging notes and treatment materials (back and forth) and/or via the child sharing and even demonstrating treatment elements for their parents and caregivers. If parents transport their children to or from school, you may be able to catch them at drop off or pick up times or arrange to meet briefly during those times in advance. It is also helpful to identify times when parents may already be on campus, such as for a school assembly or evening performance, open house, or a school-wide parent meeting. For example, with Veronica's mom, you arrange to meet on one of her days off just after drop off. You review common reactions to stress and trauma, have her engage in the same relaxation training exercises you will do with Veronica, discuss the link between thoughts, feelings and behaviors and the rationale for the PTSD treatment, and review problem solving. You highlight the issue of avoidance and why it is important for youth to be able to process and digest their traumatic experiences by telling their stories. You emphasize that Veronica will be practicing skills between sessions at home, and may need support in doing so, especially as she works toward getting back to doing things that she may have been avoiding.

Treatment Rationale and Psychoeducation—One way to convey the rationale for cognitive behavioral intervention for PTSD to students is to create a triangle with thoughts, feelings, and behaviors at each of the corners and discuss that scary or traumatic events affect everything about us—all 3 of these things-- and provide an example of how they are linked and affect each other. For example, given the experience that Veronica has had, she can see how she now *thinks* that if she goes to the park with her friends or family, one of

them could get beaten up or shot and that makes her *feel* very nervous and afraid, so she doesn't hang out with his friends anymore near the park or want her family to go out of the house (*behaviors*). You validate that those thoughts and feelings and behaviors make sense given what Veronica has been through. You can impart the idea that the intervention you are providing helps students who have been through difficult things like Veronica to think and feel and act in a way that makes them feel better so they can get back to doing what they like and need to do that is safe. You ask Veronica about the goals that she has for treatment and agree together on a treatment plan including information about the different treatment components so that Veronica knows what to expect. You provide Veronica with information about common reactions to stress and trauma and explore what symptoms have been coming up for her and hope for how treatment may help it improve. For example, Veronica offers that she has not wanted to go places or see people that remind her of what happened. You state that "avoidance is common and makes sense because you may feel better for the moment, but just like not wanting to talk or think about the trauma, avoiding situations or people that remind you of the gang incident in the park can keep you from doing normal things that are an important part of your life, right? In treatment, we'll be learning about how to cope with some of these bad feelings so you can get back to doing those things." You ask Veronica to share a worksheet on common reactions to stress and trauma with her mother and to share some of the symptoms that she has been experiencing. You leave a space where her mother can add any comments or questions that Veronica can bring back to you.

Relaxation Training—Teaching different forms of relaxation training, such as deep breathing, progressive muscle relaxation, positive imagery, and/or mindfulness can help students with affect regulation as they manage their PTSD symptoms. Moreover, it is an easy skill to transfer over to the classroom setting and for young people to practice in the classroom and at home when they are struggling with anxiety, frustration, or irritability/anger. You explain the idea of a feeling thermometer (0–10; where 0 is feeling okay and 10 is feeling very, very upset/anxious/scared) and ask for ratings before and after the relaxation exercises. Veronica is asked to practice the different relaxation techniques during the week and to teach mom how to do them with her at home, if possible. Veronica quickly recognizes that relaxation could also be something she could try when her stomach is bothering her at school, before asking for a pass to go to the bathroom or the nurse's office.

Cognitive Restructuring—Cognitive restructuring for children and adolescents with PTSD focuses on ways in which the experience of traumatic events may have affected the young person's cognitions about him or herself, other people, and the world around him/her. These negative or threat cognitions can generalize to many people, situations, and things which can lead to a great deal of functional impairment in school, socially and within the family. It is important to allow students to practice first being aware of the automatic thoughts that they have in various situations (including those that are anxiety provoking) and how those thoughts can fuel their feelings and actions. Then, students can practice replacing negative thoughts with more helpful and accurate thoughts and logging situations where they are able to do so between sessions. You can ask students to write down a couple of helpful thoughts on a small card to carry with them and pull out in situations when their thoughts may be getting in their way. Veronica became so familiar with these statements that she would just touch the card inside her pocket to remind herself to check her thoughts and see if she needed to replace them with a more helpful or realistic thought.

Trauma Narrative—Developing a narrative of the child's traumatic experience enables them to process and digest their story and what they have been through. It is not uncommon that this opportunity in treatment is the first the child has had to recount their story. The

trauma narrative can be done in writing and/or pictures and then read and processed aloud or it can be a verbal recounting of the trauma memory. In either case it is important that the child is able to tell or review their story several times in order to decrease the amount of anxiety that the trauma memory provokes at present. Explaining that being able to talk about what happened and work through some of the thoughts and feelings associated with parts of the story as it was happening and in the present time, can make it less difficult to think or talk about what happened now. As a clinician, you are able to bear witness to the child's memory of their experience, providing support and assistance in reframing some of his or her maladaptive thoughts about what happened and his/her role in it. You will need to determine the number of sessions to focus on the trauma narrative, but you typically don't want it to be more than a third of the total sessions, so that many sessions focus on the present and skill-building for the future. By the second session of the trauma narrative with Veronica, she has created some drawings and narrated her traumatic experience several times and it is much easier for her to talk about what she went through. Veronica thinks that she is ready to share her story with her mother. You help her think through and plan a good time to talk to her mother and role play how it might go. You let her know that you will be calling mom to give her an update on Veronica's progress and that you will talk to mom about how to be supportive if/when Veronica shares the story with her. You also offer to invite her mother to join you for a session next week in case she doesn't find a time to do it herself during the week, or after she has shared the information, either way. You encourage Veronica to do something fun this week to take care of herself because she has been working through difficult issues.

In Vivo Gradual Exposure to Trauma Reminders—This component focuses on the creation of a hierarchical list of things that the student may be avoiding since their traumatic event. Students make a list of things they have been avoiding that they would like to be able to do again and you assist them in refining a hierarchy of gradual approach steps, getting feeling thermometer ratings for each of the steps. Each week you can assist the student in selecting 1–2 things that can feasibly be practiced over the next week that are rated at 3–4 or under on their feeling thermometer. Typically once a student gains mastery over the items lower on their list they are ready to move onto items that were once rated a bit higher. This is something you want to start by the mid point in treatment so that there are several weeks of in vivo exposure practice and a sense of accomplishment in moving up the hierarchy. For example, Veronica has stopped letting her siblings play outside when she cares for them, which is frequently due to mom's work schedule. After assessing for the safety of having siblings play outside ("Do other children in the neighborhood play outside?" "Did they used to be able to play outside safely?" "Is there a place it is safest to be while playing outside?" "Is it safe to do so during the day/evening/weekends?"), you help Veronica list the following steps for allowing the kids to play outside and she assigns each a rating of how anxious it will make her feel to do so (at present):

Siblings outside in yard while Veronica is inside (weekdays)	8
Siblings outside in yard with Veronica (weekdays)	6
Siblings outside in yard while Veronica is inside (weekends)	5
Siblings outside in yard with Veronica (weekends)	4
Siblings play outside at cousin's house	3
Imagine siblings playing outside with Veronica supervising	2

Veronica decides that this week she will practice letting her siblings play outside at her cousin's house 1–2 times. She will also imagine them playing outside with her a few times over the week.

Problem Solving—Teaching problem solving skills can be a key part of intervening with students with PTSD. Clearly, the physiological arousal, hypervigilance, increased anger and irritability, and cognitive threat bias associated with PTSD can sometimes lead students to react with increased aggression or impulsivity. Also, given the real problems that children and adolescents may face, taking the time to look at options for handling difficult situations, and managing social, academic, or familial problems can be a powerful tool that can start having an impact right away. In session(s) covering problem solving you will again link feelings, thoughts and actions by working through examples and listing potential actions one could take and making links to the underlying thoughts and feelings. You will want to ascertain the problems that the student may be encountering in daily life. Examples of these types of situations may include: someone tagging something bad about you on the bathroom wall, a teacher yelling at you, and parents fighting with each other. You then engage the student in brainstorming options/solutions, rating each option in terms of how effective it may be in solving the problem with as few negatives as possible (i.e., without hurting anyone or getting themselves in trouble), and selecting potential actions to try for the situation.

Conclusions

Intervening with traumatized youth on school campuses is a much needed role for the school mental health consultant. As this chapter illustrates, there are important roles in terms of working with the school staff and addressing the needs of children and families following a traumatic event. Whether a trauma occurs on the school campus, in the surrounding community, or to individual students and families, teachers and administrators may be uncertain how to best support the affected students. A key role that a mental health professional can play is giving school staff the tools in which to support and refer students who may be suffering with PTSD and other trauma-related mental health conditions. School-based clinicians can and should be aligned with the educational mission of schools. By providing early intervention services to students who have PTSD symptoms, clinicians can not only help in improving the social-emotional well-being of students, but also their academic performance in the classroom.

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