6 Schools as retraumatizing environments

Wendy E. Shaia and Shanda C. Crowder

Many African-American children in urban environments arrive at school experiencing the effects of complex trauma from their homes and communities, only to find that schools are environments where their trauma goes unrecognized and may be inadvertently exacerbated. In some school settings, the entire school community is exposed to trauma through a variety of events on a daily basis. In other cases, children experience new trauma in schools, as school staff attempt to discipline children for what they believe to be inappropriate behavior, as opposed to responses to the effects of trauma. Often, African-American children experience more punitive consequences than do their peers of other races for the same behavior. This chapter will provide case examples of how children and school communities are retraumatized in schools, provide the context for their trauma, and offer potential solutions, using a trauma-informed perspective.

CHILDHOOD TRAUMA IN THE URBAN ENVIRONMENT

Many children in urban environments, particularly when those urban environments are poor, are exposed to adverse experiences, which may also be traumatic. The National Child Traumatic Stress Network (NCTSN) defines childhood trauma as a child having (1) experienced a serious injury him- or herself or having witnessed a serious injury to or the death of someone else; or (2) faced imminent threats of serious injury or death to him or herself or others; or (3) experienced a violation of personal physical integrity. Child traumatic stress occurs when children are overwhelmed by their experiences of traumatic events or situations, and when that sense of being overwhelmed impacts their ability to cope with their day-to-day lives (National Child Traumatic Stress Network, 2015). Not every child who experiences traumatic events or experiences also experiences childhood traumatic stress.

Adverse childhood experiences (ACEs) may impact children into adulthood, and include verbal, physical, or sexual abuse, as well as many types of household/family dysfunction, such as having a family member who is in prison, mentally ill, substance abusing, absent from separation or divorce, or
experiencing domestic violence (Centers for Disease Control, 2010). A survey of over 8,000 individuals conducted by a large HMO asked about ACEs and health outcomes. This study found a relationship between the exposure to ACEs and disease, including some of the leading causes of death as adults. The prevalence and risk increased for smoking, severe obesity, depression, and suicide attempts as number of childhood exposure to ACEs increased. Additionally, although there were a relatively small number of African American participants in the study, these participants reported a higher number of two, three, and four ACEs than White participants (Felitti et al., 1998). A later study by Finkelhor, Shattuck, Turner, and Hamby (2015) concluded that additional factors, such as exposure to community violence and low socioeconomic status (SES) are also important predictors of physical and mental health problems, although low SES alone was a predictor of health status, but not significant in predicting psychological distress.

It is becoming increasingly clear to researchers, child health practitioners, and social service workers that many children and youth are exposed to violence at staggering rates in their homes and communities. In a national sample of families, 60% of children and youth reported having experienced or witnessed victimization of some type in the previous year; almost half had experienced physical assault, 10% some type of child maltreatment, 6% sexual victimization, and a quarter had witnessed or experienced some other type of indirect victimization, including 10% witnessing assault within their own families. More than one-third had experienced two or more direct victimizations, more than 10% had five or more, 2% had 10 or more (Finkelhor, Turner, Ormrod, & Hamby, 2009). Other studies have found that up to 90% of children in some environments have been exposed to family and/or community violence (Crusto et al., 2010; Slep & O’Leary, 2005).

Beginning in the 1970s and 1980s, urban communities saw a dramatic increase in concentrated urban poverty, as racial housing restrictions in the suburbs eased, and upwardly mobile African Americans moved into the suburbs, leaving behind a concentration of very poor families and individuals. Other theories about elements contributing to the increased concentration of poverty in urban communities include the loss of manufacturing and other local jobs, economic and social disinvestment in cities, blight, and decay (Sessoms & Wolch, 2008; Yang & Jargowsky, 2006). Additionally, African American and Hispanic children are much more likely to live in poverty than their White counterparts, and those African American or Hispanic children are overwhelmingly more likely to live in communities made up mostly by people of the same race (Drake & Rank, 2009). This concentration of poverty is seen most clearly in older, industrial cities in the Northeast, such as Newark, New York, and Baltimore (Ricketts & Sawhill, 1988).

While concentrations of poverty decreased in the 1990s, these Northeast cities still see a significant concentration of very poor people living in certain neighborhoods. In fact, urban poverty should consistently be considered within the neighborhood context, even more than in the family context since,
even if a particular family is not impoverished, that family will experience a number of significant disadvantages, and the children will be exposed to the cumulative effects of multiple risk factors, simply by virtue of living in a neighborhood with concentrated poverty (Drake & Rank, 2009).

In some urban settings, children may be exposed to the cumulative effects of multiple risk factors, including the effects of poverty, maltreatment, violence, and parental stress, which often coexist (Appleyard, Egeland, VanDulmen, & Sroufe, 2005; Wadsworth & Santiago, 2008). Children, as young as preschoolers, often carry the weight of poverty-related stress, either because they are directly impacted by food insufficiency and inadequate housing, or because they are cared for by frustrated, irritable, worried parents (Ackerman & Izard, 1999; McLoed, 1990; Wadsworth & Berger, 2006; Wadsworth & Santiago, 2008).

According to the National Child Traumatic Stress Network (2015), children experiencing traumatic stress often have difficulty regulating their emotions and/or behavior, and may be easily frightened, clingy, fearful, and/or aggressive and impulsive. Other symptoms include being withdrawn, difficulty concentrating, having memory problems, excessive anger or acting out, physical symptoms like headaches and stomach aches, difficulty trusting others, and demanding attention through both positive and negative behaviors. Children may also experience appetite or digestive issues, difficulty sleeping, or bedwetting. Many of these symptoms are evident for children at home, out in their communities, and at school.

THE IMPACT OF TRAUMA ON BRAIN DEVELOPMENT

Childhood is a critical time for brain development, and determines how the child will progress through adolescence and into adulthood. The human brain develops in a systematic, hierarchical manner, and requires certain “organizing experiences” at specific times in order to develop in a healthy way. Disruptions during critical periods, such as lack of sensory experience or abnormal neuronal activity due to extreme experiences, such as child maltreatment or trauma, may lead to major abnormalities or deficits in neurodevelopment (Cross, 2015; Perry, Pollard, Blakely, Baker, & Vigilante, 1995).

When a person perceives a threat, the mind and body have a deeply ingrained, primal response, very similar to those of other animals. An alarm is sounded, and the body prepares to fight or run away from the perceived threat, or freezes to become hidden. All noncritical information is turned out, the person becomes hypervigilant, the heart rate increases, and the body diverts its energy to muscles and respiration in preparation for action. In the case of the child who has experienced trauma, this reaction may be activated by anything that reminds him or her of the traumatic event, or simply by thinking about it. The child may have this state consistently activated. Over time, the child may become in the fear response state so frequently, that he or she may remain in a persistent state of whole-body hyperarousal (Cross, 2015; Perry, 2009; Perry et al., 1995).
Reexamining school policies

School systems need to intentionally reevaluate school policies in light of the needs of traumatized children. It is important that policies on confidentiality, discipline, and instruction be reexamined to ensure they meet the needs of all children (Finkelhor, Ormrod, Turner, & Hamby, 2012). School systems need to ensure policies, such as reporting child abuse, interactions with parents, safety planning, and schoolwide interventions and practices, are trauma responsive (Finkelhor et al., 2012). School discipline policies are trauma responsive when they balance accountability with an understanding of traumatic behavior. For example, including discipline strategies that promote positive behavioral interventions and strategies, encourage prevention, and embrace restorative practices, shift discipline from a punitive process to one that is more supportive in nature (U.S. Department of Education, 2014b).

Adapting school curricula to be trauma responsive

Schools need to adapt instructional curricula and materials to be trauma responsive. Educational researchers have just begun to critically examine trauma-specific methods for teaching core subject areas such as reading, writing, and math (Carello & Butler, 2015; Courtois & Gold, 2009). However, research exists indicating that children who have experienced trauma can benefit from interactive teaching approaches (Courtois & Gold, 2009).

Recent studies on childhood trauma have established that a child’s body keeps track of traumatic memories (Perry, 2009). The neurobiological effects of experiencing trauma are clearly as impactful as the emotional effects (Perry, 2009). This research will have implications for instructional curriculum as it pertains to the importance of physical education and arts programming in both elementary and secondary schools. School systems and educational curriculum developers need to enhance and create innovative curriculum in the core subject areas that incorporate these findings. This research may have vast implications for educational curricula, particularly as it attests to the value of physical education and arts programs in elementary and secondary schools. Innovative curriculum development in academic areas, such as reading, that incorporate these new findings must be piloted and funded at the state and local levels (Carello & Butler, 2015).

In addition to overall changes to reform curricula to be trauma responsive, educators should incorporate conflict-resolution skills and the development of empathy into the regular instruction (West, Day, Somers, & Baroni, 2014). If children who have been exposed to trauma continue to develop the ability to understand and deal with the perspectives of peers and adults, they may be more capable of responding to situations appropriately. Conflict-resolution skills help children understand and name their emotions (West et al., 2014).
Developing procedures for early identification and services

Since the development of trauma-responsive curricula is in the beginning phases, schools must develop procedures and protocols for early identification of children who have experienced trauma. School systems may offer opportunities for school psychologists, social workers, school-based mental health clinicians, and families to partner with educators to identify these practices (Walkley & Cox, 2013). Together they can also develop effective school-based mental health interventions for serving this population. In order to see lasting impact, it is imperative that interventions focus on the entire family (Langley et al., 2015). Serving the child alone will not be effective. Every attempt should be made to serve the entire family, at home, if possible, in order to address the entire system (Oehlberg, 2008). This can be done systemwide but should also be done on the individual school level. Each school community has its own culture, and schools must ensure that interventions respect the culture and the confidentiality and safety needs of these children and their families.

In addition to developing protocols for early identification, school systems need to take a look at special education evaluations. These evaluations must also be trauma responsive and consider the traumatic aspects of a child's disabilities and offer trauma-related services as necessary. Special education teams must work collaboratively to appropriately diagnose the symptoms of trauma (Perry, 2009). Schools need to be careful not to misdiagnose traumatic symptoms as attention deficit hyperactivity disorder (ADHD), emotional disturbances, or other learning disabilities, or vice versa (Perry, 2009). Misdiagnosis can result in the retraumatization of children or the development of programs that fail to meet their needs because they do not address the traumatic symptoms interfering with the child's ability to access instruction (Langley et al., 2015).

Funding trauma-responsive collaboration

School systems must have adequate funding at the local level to support the trauma responsive work that must be done. Funding must be provided for the development of community-based services that will meet the needs schools are facing. These funds should be allocated to organizations that can bring together experts to collaboratively problem-solve and develop community-based, trauma-responsive strategies. In order for schools to become trauma responsive, it is important to have opportunities for teachers, school-based mental health clinicians, parents, and school administrators to be able to collaborate directly, without fiscal or confidentiality barriers (Carella & Butler, 2015).

IMPLEMENTING TRAUMA RESPONSIVE APPROACHES IN SCHOOLS

Becoming a trauma responsive school takes organizational change. It is not something that happens overnight but takes time and a philosophical
paradigm shift to occur and be sustained overtime (Carello & Butler, 2015). When a school becomes trauma responsive it provides an educational environment that is safe, stable, and understanding for students, staff, and families (Nadeem et al., 2011). The main goal is to prevent retraumatization. Two states, Massachusetts and Washington, have undertaken a full-scale system approach to creating trauma-responsive schools. A description of these states’ approaches by Stevens (2012) follows.

Massachusetts

The work in Massachusetts began with a statewide policy agenda in 2005. Through the policy work, the state launched "Helping Traumatized Children Learn." Instead of adopting a rigid model, they adopted a flexible framework that allowed schools to implement a variety of trauma-sensitive practices and supports. The framework was comprised of six domains: school culture and infrastructure; staff training; links to mental health professionals; academic instruction for students who have experienced trauma; nonacademic strategies; and school policies, procedure, and protocols.

In addition to the implementation of the flexible framework, Massachusetts used a legislative platform to encourage funding support for this work. They were able to successfully legislate the development of a grant fund to support the implementation of trauma-responsive interventions and supports in schools. Through these funds, schools were able to develop and implement innovative strategies to train staff and support students and families within their schools.

Massachusetts continues to implement a systemwide trauma-responsive schools system. It has been able to sustain this practice through the support of the Trauma Committee that was created to provide guidance and technical assistance to schools. The system continues to assess the needs of the children and families it serves in an effort to ensure the strategies align.

Washington State

Washington has worked collaboratively to bring attention to the needs of children who have experienced trauma. They have developed resources and tools that are currently being used in many states. Washington calls its trauma responsive approach the “Compassionate Schools Initiative.” It has released the handbook The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success. The book provides an overview of trauma in schools, importance of self-care, and outlines six principles that should guide interactions with children who have experienced trauma. The six guiding principles are always empower, never disempower; provide unconditional positive regard; maintain high expectations; check assumptions, observe, and question; be a relationship coach; and provide guided opportunities for helpful participation. The Compassionate Schools Initiative has developed a series
of training modules that can be accessed by the public and used along with the handbook.

INVOLVING FAMILY AND COMMUNITY

Research has shown that closeness to and involvement with family members provides protective factors for African American children and youth exposed to risk factors, such as community violence and other types of trauma (Hammack, Richards, Luo, Edlynn, & Roy, 2004; Henry, Lambert, & Smith Bynum, 2015). The community, and the social supports within it, also provide strong supports for children and families, and may help to counteract some of the effects of the risk to which children are exposed (Bachus, 2014; Nebbitt, Lombe, Yu, Vaughn, & Stokes, 2012). For this reason, engaging parents and community members as important assets and stakeholders should be an integral component of transitioning a school or school system from being trauma uninformed to becoming trauma informed to being trauma responsive. Developing trusted partnerships with parents and community members, which will allow for open discussions about the risk factors to which children are exposed, will be educational for school administrators and staff, provide them with valuable insight into what children and families need, and will help them avoid potential pitfalls created by their ignorance of community norms and realities.

This type of organizational transformation will require a complete change in thinking for many school leaders. It requires expanding educators’ ideas of what happens in school; that school is about more than reading, writing, and math. It requires widening many educators’ thoughts about who is required to sit on the team to help a child learn; that team now includes a range of partners, including clinicians, parents, and community members. It requires setting a standard within schools for teachers and school staff that punitive discipline is not acceptable, because it does not achieve positive results, but alienates some children and pushes them into a school-to-prison pipeline from which there is no return. It requires shifting from a paradigm where adults ask children, “What’s wrong with you?” to one where adults ask children, “What has happened to you?” (National Center for Trauma Informed Care, 2015).

REFERENCES


80 Linking health and education for African American students’ success


