Introduction

Students exposed to traumatic experiences during childhood may manifest these experiences in the school setting in academic, behavioral, and emotional ways that are not productive, and these adversities often severely diminish the process of psychological, social, and emotional development (Larson, Chapman, Spetz, & Brindis, (2017). A traumatic event is a shock, wound, or violent experience that creates a threat to bodily or psychological safety (SAMHSA, 2015). Trauma exposure often results in "fight" or "flight" survival responses that curtail focus and concentration in the classroom. Moreover, trauma impacts brain development and can negatively impact cognitive functioning in the areas of organizing and planning, emotional regulation, and interpersonal relationships. Traumatic experiences can cause anger, intrusive thoughts, distorted inner representations of the world, memory problems, and lead to social withdrawal (Callahan, 2009).

Children are frequently triggered by reminders of traumatic events and can have a wide range of responses to these triggers ("NCTSN Core Curriculum", 2012). Adverse childhood experiences (ACEs) are traumatic events that can have negative and long-term effects on the health and well-being of an individual (Zeng & Hu, 2018). These experiences are considered stressors and can include both individual events and ongoing or chronic circumstances, commonly referred to as Type I and Type II traumas, respectively over which a child has little or no control (Callahan, 2009). Type I (acute or "single blow") events occur at one time and place and are usually short-lived (e.g. suicides, homicides, natural disasters, school shootings, and the sudden death of a family member, teacher, or classmate). Type II (multiple or chronic) events occur repeatedly over long periods of time (e.g. prolonged childhood and adolescent physical and sexual abuse, school and community violence, parental divorce, removal from parents/guardians, parental incarceration, poverty, war and other forms of political violence). There is strong evidence that even witnessing stressful events can be traumatic (Callahan, 2009). Additional academic and social-emotional stressors that may be a chronic trauma, such as being retained, breaking up with a dating partner (in school), "coming out", or bullying (as it is repetitive), may also cause significant risk for mental health disorders, poor academic achievement, and adolescent delinquency (Larson, Chapman, Spetz, & Brindis, 2017; Fagan & Novak, 2017). Moreover, socio-economic stressors for children include family impoverishment, food insecurity, homelessness due to lack of affordable housing, parental drug addiction and mental illness, parental incarceration, and the family upheaval associated with domestic violence (SAMHSA, 2018). All of the traumatic stressors mentioned above, coupled with socio-economic struggles often severely constrain or erode a student's ability to be academically successful (Boyd-Zaharias & Pate-Bain, 2008); this is complex trauma, which is exposure to varied and multiple traumatic events. Building on the previous literature, we will examine the impact of trauma and the assessment of traumatic stressors in students, and describe an intervention to assist schools to intervene early to address the needs of young persons who are trying to negotiate a difficult life path ("NCTSN Core Curriculum", 2012).

Impact of Trauma

Experiencing trauma can result in a cascade of effects ("NCTSN Core Curriculum", 2012). Secondary hardships include separation from family in home/foster-care placement, needing treatment for health or mental health concerns, becoming labelled and stigmatized, being forced to move and change schools; and ongoing involvement with law enforcement, child protective services, and court systems. Other common experiences of and responses to trauma are

emotional dysregulation, numbing, physical symptoms (i.e. gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological problems) ("SAMHSA Trauma-Informed", 2015).

These traumatic events have adverse consequences on children and adolescents. Felitti and colleagues (1998) determined that individuals who had experienced one adverse childhood experience (ACE) were more likely to experience more than one ACE. The investigators discovered that 25% of their sample had experienced two or more types of ACEs. In concert with this study, Fagan and Novak (2018) revealed that the higher the number of ACEs high risk children experienced, the greater their likelihood of self-reported alcohol use, marijuana use, violence, and arrest.

Copeland and his colleagues' (2018) population study of North Carolina children with a sample of approximately 1400 students supported the earlier findings of the Felitti study. The research once again showed that traumatic events are quite common in childhood and have lasting effects on adult psychological health and functioning. Due to the frequency of traumatic events and severity of health consequences, these researchers argued there is strong evidence that trauma is a major public health issue with early intervention being essential to prevent poor long-term health outcomes (Copeland, et al., 2018). An example of a student with multiple traumatic stressors or ACEs (who appears in the classroom as not being prepared or committed to learning) is a student who is a member of a household with an incarcerated parent who committed domestic violence, whose mother is working a second job to provide economically for the family and absent from the family home until late at night.

Multiple traumatic stressors will change the course of the student's life and place them at higher risk for adolescent delinquency, health disparities, incarceration, and early death (Felitti et al., 1998; Fagan & Novak, 2018). Trauma responses are complex, and children exhibit a wide range of responses to trauma stressors they have experienced. Environmental factors totally outside the control of children can have a significant impact on functioning and well-being. It will be important to consider the impact of traumatic events and especially chronic stressors on functioning of students in trouble in the classroom.

Assessment of Trauma

The National Child Traumatic Stress Network (NCTSN, n.d.) provides an overview of different screening and assessment tools that can be used to help school service practitioners identify the needs of students and families. The screening tools are brief and focused measures used to determine if an individual has experienced one or more traumatic events; the assessments consist of clinical interviews, standardized measures, and observations used to examines the nature, timing, and severity of the traumatic events (NCTSN, n.d.). Some of the tools and assessments include the following: Child Abuse Potential Inventory, Child Behavior Checklist, Child PTSD Symptoms Scale, Child Trauma Screening Questionnaire, and many more that may fit a student service practitioner's population. Additionally, the website provides an overview of the measure, which includes instructions on the administration of, and the training needed to administer this measure, the types of report forms, the psychometrics, as well as the population the measure was developed for; additionally, some of these measures have a cost associated with its use.

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)

There are numerous evidence-based teaching and counseling programs that address traumatic stressors (e.g. UCLA Trauma/Grief Curriculum; School Intervention Project of the Southwest Michigan Children's Trauma Assessment Center; and Trauma Center at Justice Resource Institute) that have been created for implementation in schools. Cognitive Behavioral Interventions for Trauma in Schools (CBITS) is an online training program (cbitsprogram.org) for mental health professionals (i.e. school social workers and other student service personnel-SSPs) that work with students in grade school through high school who have experienced traumatic life events ("Cognitive Behavioral Interventions", n.d.). The goals of this program are to decrease current symptoms related to trauma; build skills for handling stress and anxiety; and build peer and caregiver support (Jaycox, Langley, & Hoover, 2018). This program utilizes cognitive behavioral theory, which contends that thoughts and behaviors can influence how you recover from traumatic events, as thoughts, feelings, and behaviors are seen as interrelated and influence each other (Jaycox et al., 2018). Traumatic experiences can interfere with normal functioning of students, especially those experiencing multiple traumas.

The CBITS program uses cognitive-behavioral techniques such as psychoeducation, relaxation, social problem solving, cognitive restructuring, and exposure. The techniques are geared towards changing maladaptive behaviors, patterns, and thoughts through different techniques (i.e. challenging negative thoughts, stopping automatic negative thoughts, and/or creating a trauma narrative and processing the traumatic event) (Jaycox et al., 2018). Furthermore, CBITS is beneficial for students, as well as faculty and staff, and it is specifically designed for the school setting. The program teaches students to deliberately approach traumatic stressors that cause anxiety (i.e. people, places, or things). Students are gradually exposed to these stressors and endure them without anything bad happening, and they gain a sense of mastery over the situation and anxiety decreases. Moreover, these effects can lead to academic gains that were once negatively influenced by traumatic stressors.

CBITS has been implemented and evaluated continuously since its initial development in 1997 (Jaycox et al., 2018), and there are studies that find this program is effective for youth with symptoms resulting from a traumatic stressor. In an experimental study, 126 participants were selected, screened, and received caregiver permission to participate. Results indicated that students in the CBITS intervention group had reduced self-reported symptoms of PTSD and depression at post-test (Stein et, al., 2003 as cited in Jaycox et al, 2018). In another study, 198 participants were selected (caregiver permission received) and screened. Findings revealed that students in the CBITS intervention group (N=152) had significantly greater improvement in PTSD and depressive symptoms compared to those on the waiting list (N=46) at a 3 month follow-up (Katoaka, 2018 as cited in Jaycox et al., 2018). These findings indicate that the CBITS program is effective with the study populations, and can be adopted and implemented in many different environments for different traumatic stressors.

Accessibility and Implementation of CBITS

Practitioners can learn how to implement CBITS through with training guidelines, training modules, and online assistance for implementation provided on the website, cbitsprogram.org. The websites provides guidelines and requirements, recommendations, and minimum standards for training: read the CBITS manual; complete the five-hour web-based course (CBITS Provider Training Course: Part 1 for 2 hours & Part 2 for 3 hours); review the website quick tips and roleplays; and attend a one-day condensed live training with a certified trainer ("NCTSN Training Guidelines", 2016). The CBITS program also has online pre-training activities that

include implementation preparation (i.e. Ready to Adopt Questionnaire, Session Overview, Sample CBITS Schedule, and Frequently Asked Questions), education materials (i.e. Child Trauma Facts, NCTSN Toolkit for Educators, and Trauma Awareness for School slides), and a Students and Trauma DVD.

The CBITS Provider Training Course has two parts: Part 1 includes seven modules, a chapter quiz for each module (except the introduction), and a final test; Part 2 includes eight modules, a chapter quiz for each module, and a final test. These modules provide an introduction and overview of CBITS and address different aspects of trauma-informed practices for students, parents, and teachers, through individual and group counseling, as well as professional development training. After completion of this online training the school social worker can access implementation assistance through the CBITS online community, such as Ask an Expert and general discussions on the Discussion Board.

CBITS Intervention Techniques for Teachers and Other School Practitioners

School social workers, once trained, take on the responsibility of training other school practitioners and parents. Jaycox and colleagues (2018) have found that CBITS training for teachers focuses on teacher support and understanding of their students' experiences with trauma, and the understanding and acknowledgement that students may experience multiple traumatic stressors that place them at-risk for lower academic achievement. Another objective for the Teacher Education Program in CBITS is to enlist teacher support (teacher buy-in) as it is extremely important for successful application of the CBITS program. Teacher support can be demonstrated as class schedule flexibility, such as allowing the student to miss instruction time in order to participate in the CBITS (individual or group) counseling.

Prior to the implementation of the program, teachers should receive training (possibly during a teacher's workday) to prepare them for what to expect from CBITS and promote student recruitment for the program. This training should cover confidentiality, which is a different concept in education than in mental health (school social work); also, teachers may need help understanding boundaries, how long the trauma may last, and what to expect to see from a child experiencing trauma. During this training, teachers will learn the benefits that the CBITS program can offer (e.g. improved concentration in class and/or better focus in class). Teachers will also be provided with tips on how to work with students that have experienced traumatic stressors. These tips include maintaining consistency, having fewer surprises in class as it makes them less anxious (i.e. having lights off, loud noises, approaching the student from behind, and increased voice tone of the teacher).

This training will assist teachers in recognizing trauma symptoms and help the school social worker with referrals for student participation in CBITS counseling. This training for teachers and other school personnel may utilize the manual directly/verbatim, or after training they can develop an adapted version that meets the needs of unique school environments. School social workers should implement a professional development training to other school personnel, such as administrators, other student support practitioners, and staff. A professional development training agenda could include the following objectives: (1) describe common reactions to trauma and provide a model for thinking about trauma, (2) describe elements of the CBITS program, and (3) offer tips for teaching and interacting with students who have been traumatized (see Appendix A: Adapted from CBITS Teacher Education Program).

CBITS Intervention Techniques for Parents/Caregivers

CBITS entails two mandatory training session for parents/caregivers and two follow-up sessions. This training for parents has two objectives: to reduce stigma around trauma exposure and reactions, and to lay the groundwork for improving caregiver-child communication (Jaycox et al., 2018). This program recognizes that parents/caregivers experience vicarious trauma because their child has been traumatized, and sometimes parents have also been involved in a traumatic experience and they have their own symptoms; therefore, helping their student may also be helping them with some of the same skills the student is being taught in the CBITS program. Parents/caregivers are taught about the link between thoughts, feelings, and behaviors, and how they can support their student. Moreover, the use of the *Fear Hierarchy* activity requires parent/caregiver support as the parent is usually motivated to have life return to "normal". Also, the use of the problem-solving technique, such as the Hot Seat, is an activity that focuses on real-life problems that are currently interfering with their lives. The parent's help is essential for this activity as it asks the student to generate new ideas for how to handle the problem

School social workers that implement this training need to be aware that it can be difficult to engage parents/caregivers. There are techniques that could be used to get parents/caregivers to participate: (1) consider morning and evening sessions as a flexible schedule is needed; (2) if possible, provide childcare services for siblings; (3) consider transportation and food; and (4) phone conversations are also an option for the follow-up sessions, as some contact is better than no contact, and CBITS techniques can be provided during these conversations (Jaycox et al., 2018).

CBITS Intervention Techniques for Students

One role of school social workers (or other school service practitioners) is developing and/or implementing prevention and intervention methods for different traumatic stressors, such as divorce, parental incarceration, truancy (which is typically associated with other traumatic stressor), et cetera. CBITS has been shown to be an evidence-based practice program at the *Response to Intervention-Tier II and III* levels for the above mentioned traumatic stressors that are often seen in the school setting. The program provides a detailed description of the ten-session group counseling. A description of the one to two individual counseling sessions is also described as individual counseling sessions for each group participant is required. During these individual counseling sessions, the Feeling Thermometer and Trauma Narrative are activities used to describe in detail their traumatic experience, and the feelings rating associated with this experience in order to prepare the student to share their story with the group. These sessions include activities and assignments for the counseling participants to help with the traumatic stressors the student has experienced.

Prior to the implementation of the CBITS program, the Readiness to Adopt Questionnaire should be administered to determine the successfulness of other programs implemented in the school social worker's school environment within the past 5 years, and the time that the school social worker (or student service practitioners) would spend on implementing the CBITS program. This assessment is used to determine if the unique school environment is suited for implementation for the CBITS program. Afterwards, consent and assent should be attained for the screening measure, and later for participation in the group.

The process for selecting students for eligibility for the CBITS program starts with the selection of the screening instrument. This instrument should be administered at the Response to

Intervention (RtI) Tier I level (entire school), taking into consideration the unique aspects of the student population and the school environment (SAMHSA, 2015). This instrument will be used to identify students that might benefit from this program. Teachers can also refer students that they believe may be experiencing traumatic stressors that are interfering with equal access to the school curriculum. This is why it is important to train teachers and other school personnel prior to formation and scheduling of the CBITS group. After selection of participants, groups should be formed with six to eight students, taking into consideration a balance of genders, ages, and cultural background. Groups should last about 45 minutes per week, for ten sessions. As stability is important for this group, the time of day and a private meeting place should be kept consistent (if possible).

Implications for School Social Work Practice

After the preparation for the CBITS program, i.e. obtaining permission, and the formation and scheduling of the groups, a school social worker might choose to customize the CBITS program for their unique school environment and population through removal/addition of items. They may also choose to use this program for a specific traumatic stressor. Appendix B describes an adapted version of the CBITS curriculum for group counseling for students who have been traumatized. However, a student service practitioners can develop an adapted version of the CBITS program for other traumatic stressors to fit their unique school environment, keeping in mind the participants, administration and teachers, time, as well as the overall school environment. For example, some trauma stressors that are prominent in the lives of students are suicide, homicide, natural disasters, substance abuse, et cetera. This template in Appendix B describes possible group counseling sessions with the chronic stressor, bullying, used as an example. CBITS counseling sessions can entail the definition of traumatic events, and explanations and examples of the different traumatic stressors; reactions to trauma; thoughts and feelings, as well as how to combat negative thoughts about trauma experiences; avoidance and coping techniques; and experiences of exposure to stress or trauma through imagination, drawing, and/or writing (Jaycox et al, 2018, p.6). Although the authors of the CBITS curriculum do not explicitly state the intervention can be used for bullying, this stressor can be categorized as chronic trauma because it is defined as a *repetitive* and aggressive act, with difficulty defending oneself ("Olweus Bulling Prevention," n.d.). CBITS focuses on chronic trauma, and can be adapted by school social workers in a six session format to help students who are bullied (see Appendix B). However, the use of this CBITS manual (Jaycox et al., 2018) is essential in helping the school social worker or other student service practitioners with the adaptation of this curriculum for bullying or any other traumatic stressor, acute or chronic.

Another practical aspect of the CBITS program is self-care. Vicarious trauma is typically experienced by people who help trauma and crisis victims, as the symptomatology that students can bring into the classroom can be contagious. School social workers can provide training to school personnel that help them recognize and address vicarious trauma stressors through self-care such as planning for time off, athletic activities, or mindfulness activities. Additionally, the use of the ACEs questionnaire ("SAMHSA ACEs Questionnaire", n.d.) for teachers, school social workers, and other student service practitioners can make one aware of their past experiences with trauma, and how it might affect their work with students and overall life.

Conclusion

This article provides new and valuable information on how and where to receive training on a free trauma-informed curriculum via online. This article provides student service practitioners a detailed description of CBITS, and also explains how to adapt this curriculum to the busy schedules of student service practitioners, i.e. school social workers. Although the original 10 counseling sessions set forth in this training are needed and applicable for some school social worker's clientele, it might not fit all schedules. The logistics involved in the implementation of the entire CBITS curriculum as developed might not be logistically feasible for some school social workers due the time required for full implementation (i.e. the ability to pull students out of class for non-academic work, and designing a schedule that can adapt to the other duties and requirements of the school social worker). Hence the use of this information detailed in this article provides a guide on how to modify this curriculum to the unique environments of student service practitioners, all while considering time constraints, student population, and school administration, faculty and staff.

The overarching benefit of CBITS is to promote a caring school environment for all students, no matter their membership in differing at-risk groups. The professional development training and counseling intervention proposals addressed in the appendices provide information for access to available resources necessary to address the traumatic stressors, as this program can help schools by providing an evidence-based intervention to students who have been traumatized. Research has found that children who participated in CBITS reported significantly fewer symptoms of trauma and depression following the intervention, and it is most beneficial for children with high symptom severity in terms of reducing posttraumatic stress disorder symptoms and disengagement coping such as truancy (Allison & Ferreria, 2017; Santiago, Lennon, Fuller, Brewer, & Kataoka, 2014).

However, when implementing CBITS there should always be an emphasis on the need for each practitioner to implement CBITS in a way that applies cultural and contextual knowledge of the student population to effectively convey core treatment concepts (Ngo, Langley, Kataoka, Nadeem, Escudero, & Stein, 2008). Students who are perceived as different from their peers (or are members of certain at-risk groups that are vulnerable and oppressed) are often at risk for other traumatic stressors. Additionally, some students may experience multiple traumatic stressors at once (i.e. food insecurity, homelessness, special education eligibility, and be a member of the LGBTQIA+ community), and continued research on the effectiveness of the CBITS curriculum with this population would be beneficial.

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Appendix A

Below is a sample agenda for professional development training that a school social worker may conduct for teachers and other school personnel to recognize the trauma. This example has been adapted for bullying, which can be considered a Type II-chronic traumatic experience. This is not an all-inclusive list of what should or could be included in the development of a training that will address bullying as a traumatic stressor, and how teachers and others can deal with this issue.

I. Define bullying and the reactions to bullying (i.e. academic, mental, physical, etc.)
II. Define trauma as it applies to bullying
    a. Type 1
    b. Type 2
    c. Vicarious trauma
III. Reactions to trauma
    a. Internal
    b. External
IV. Explanation and Elements of CBITS
    a. First type of traumatized student: Those who have been diagnosed and are in treatment (or received treatment)
    b. Second type of traumatized student: Those who have NOT been diagnosed and treated
V. Teaching and interacting with students that have been traumatized
    a. Trauma-informed lens
    b. Choices and consistency
    c. Trauma expressed through play
    d. Trauma triggers
    e. Self-care (avoid burnout)
VI. Conclusion: What can teachers and other school personnel do with this training?
    a. This training will help teachers and other school personnel become more aware of possible signs of exposure to bullying and violence
        i. Look for students becoming more aggressive, old fears reemerge, apprehension about going home, student expresses they wish the teacher were their parent

b. Listen to the child's story…do not assume there is a "one size fits all" solution to their issue(s)
c. Provide a safe environment …you may be the only adult in that student's life that they feel safe with)
    i. Talking corner in the classroom (with bean bag chairs, and books on bullying and trauma)
    ii. An emotionally safe environment for all children to learn helps traumatized children begin their journey to healing
d. Understanding that you can offer the student compassion, but you cannot offer confidentiality. You are a mandated reporter.

- Provide the CBITS handout that teachers can give to parents so they can understand the many different ways their child may react to trauma stressors (Jaycox et al., 2018).

Adapted from CBITS Manual… (Jaycox et al, 2018)

Appendix B

Below is an outline that can be used for the development and implementation of group counseling sessions for traumatized students (possibly bullying victims). If time permits, individual sessions should be conducted for the trauma narrative. This is not an all-inclusive list of what should or could be included in the development of a counseling curriculum for different traumatic stressor. The school social worker may choose to add or remove some items based on time constraints, student population, (i.e. age, gender, SES, ethnicity & community factors, etc.), or the academic requirements/restraints.

I. Session 1: Introductions, confidentiality, development of group rules, and ice breaker; definitions and examples of bullying; and reactions (physical and mental) to bullying.
    a. Contact parents and ask for meeting (training)…be flexible with meting times.
II. Session 2: Education about common reactions to stress or trauma from being bullied…avoidance, psychosomatic symptoms, depression and anxiety, and other internalizing and externalizing experiences (use current news articles as examples).
III. Session 3: Thoughts and feelings (fear thermometer handout), the link between thoughts and feelings (see CBITS manual Appendix; Jaycox et al., 2018).
    a. Combating negative thoughts about traumatic events (use examples of negative thoughts that lead to internalizing and externalizing behaviors)
        i. Internalizing: "I'm always going to be picked on"…student begins to skip class where they are picked on.
        ii. Externalizing: "Those students don't like me"…student begins to pick on the students they believe don't like them.
    b. "We All See Things Differently" (Horton, 2014)
IV. Session 4: Avoidance and coping (Use Trauma Narrative & Fear Thermometer)
V. Session 5: Exposure to stress or trauma through imagination, drawing, and/or writing (next session is final session)
VI. Session 6: Final session, practice, party, graduation, explanation of open-door policy for relapse prevention, etc.

Adapted from CBITS Manual… (Jaycox et al., 2018)