

How Trauma Affects Student Learning and Behaviour

Stephanie Frieze

Abstract

Each year, more and more students are entering the school system having experienced different forms of trauma, such as violence, death, abuse, and illness. Children who are exposed to trauma run the risk of facing negative long-term effects that include mental illness, depression, and anxiety. This literature review provides an overview of how exposure to trauma affects children's mental health, as well as student learning and behaviour. Academic performance, school attendance, and overall intelligence are affected by exposure to trauma. Suggestions for supporting students with trauma exposure range from everyday interactions to intensive intervention programs, which include traditional and non-traditional practices as well as group and individual programs.

Throughout my teaching career, I have observed children entering school with a variety of traumatic experiences that teachers cannot imagine facing themselves. Such experiences may cause students to live in fear and pain, and may also lead them to struggle in areas such as learning and behaviour. As a teacher in a school where many of the students have experienced situations such as abuse, violence and loss, it is important for me to educate myself on how to support these students in coping and working through such detrimental experiences.

My passion is to make a difference for students and to guide them to reach their always expanding potential. My goal is to learn more about the different effects of trauma on student learning and behaviour. In order to help students affected by trauma, I hope to acquire strategies to connect with them, understand their home and community life, and provide guidance for coping with their experiences. I want to provide a supportive environment in which my students feel safe expressing their concerns. As this environment is nourished and sustained, my goal is to work with students to debrief in relation to their experiences and to develop coping strategies. As I become more skilled in supporting students with exposure to trauma, I would also like to provide ongoing support for other teachers and students division wide. I hope that the information I acquire through my research will help me, and others, to support students with trauma exposure. My first step in supporting my students is to learn how trauma exposure affects mental health.

The Effects of Trauma Exposure on Mental Health

Trauma exposure includes witnessing and/or being involved in one or more of a broad range of traumatic experiences. Such experiences affect children in many different ways. Some children suffer negative long-term effects from trauma exposure, often resulting in symptoms of posttraumatic stress disorder (PTSD). These symptoms are similar to the symptoms of people who attended residential schools, for example, because residential school survivors continue to experience negative long-term effects from their experiences.

Traumatic events include a vast range of experiences. Jaycox et al. (2009) defined trauma as "a sudden, life threatening event, in which an individual feels horrified, terrified, or helpless" (p. 49). While exposure to, and experiences with, violence are detrimental to mental health, violence is only one type of experience that is considered to be traumatic. Duplechain, Reigner, and Packard (2008) considered traumatic events to include "hearing gunshots, witnessing muggings, stabbings, or shootings; or seeing a dead body" (p. 118). According to Kuban and Steele (2011), traumatic events also include "medical procedures, drowning accidents, house fires, car fatalities, substance-abusing parents, divorce, and living with a terminally ill relative" (p. 41). Experiences are considered to be traumatic if they happen to the child directly, but also

if they happen to their loved ones or to other people around them. These experiences include, but are not limited to, divorce, death, injury, sexual and physical abuse, severe accidents, cancer or life threatening illness, natural or man-made disasters, war, terrorism, physical punishment, female genital mutilation/cutting, child labor, prostitution, pornography, bullying, and suicide (Little, Aiken-Little, & Somerville, 2011). Living in poverty, displacement from homes, and having a parent serving in a war zone are also experiences that are considered to be traumatic for children (Sitler, 2009).

Witnessing, or being a victim of, any of the previously mentioned traumatic events can have detrimental effects on children's mental health and well-being. *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) describes a traumatic experience as "a serious threat to a person's physical and/or psychological being" (as cited in Duplechain et al., 2008, p. 118). After experiencing trauma, children often view themselves and the world differently, because they lose their ability to make sense of their experiences (Kuban & Steele, 2011). Not only is their rational thinking altered, but their emotional brain is also affected. Symptoms of trauma include "posttraumatic stress disorder, anxiety problems, depressive symptoms, and dissociation" (Jaycox et al., 2009, pp. 49-50). Further effects of trauma include "school drop-out, violence perpetration, internalizing problems (i.e., posttraumatic stress disorder), alcohol-related problems, and illicit drug use" (Zahradnik et al., 2010, p. 409).

The most damaging experiences with violence affect a child's microsystem, such as physical and sexual abuse, because they involve violence that is directed at the child (Voith, Gomoske, & Holmes, 2014). Voith et al. (2014) examined both the individual and cumulative effects of the following domains of violence: direct violence, family violence, and neighborhood violence. The results revealed that children with experiences in more than one of the domains displayed greater symptoms of trauma and depression when compared to those with experiences in only one domain. For example, the symptoms of a student who has witnessed his/her mother being abused may be less severe than the symptoms of a student who has been directly physically abused him/herself, because the direct physical abuse affects the child's microsystem. A student who has witnessed his/her mom being beaten, and who has been beaten him/herself, may have more severe symptoms than both of the previously mentioned students, because this student has had violent experiences in more than one of the domains.

As noted, traumatic experiences can have long-lasting effects. First Nations residential school experiences are an example of a traumatic context that has not only negative long-lasting effects on the people who attended the schools as children, but also negative multi-generational effects on the survivors' children and grandchildren (Dionne & Nixon, 2014). First Nations residential school survivors continue to experience trauma as a result of their experiences at residential schools. The students at residential schools were stripped of their beliefs and were often abused by the adults at the schools. An example of a multi-generational effect of the residential school experience is a lack of parenting skills. When the schools were closed, or when the students went home, they no longer knew what good parenting consisted of because they had been deprived of their parents for most of the year, just as their parents had been deprived of them. The lack of parenting skills resulted in residential school survivors often raising their children in neglectful and/or abusive circumstances. It is possible that students in today's schools are still being raised in neglectful or abusive homes due to the influence of their grandparents' or great grandparents' experiences in residential schools.

While it is important to understand the effects of trauma exposure on children's mental health and well-being, as teachers it is also important to explore the effects of such experiences on children's learning and behaviour in school.

The Effects of Trauma Exposure on Student Learning and Behaviour

Exposure to trauma can "impact learning, behaviour, and social, emotional, and psychological functioning" (Kuban & Steele, 2011, p. 41). Maslow's Hierarchy of Developmental

Needs suggests that children whose physical needs are not met, such as the need for safety, struggle to achieve to their full potential (as cited in Duplechain et al., 2008). If children are focused on basic needs – such as physiological needs, a sense of security, and emotional needs – they are more likely to be unable to concentrate in school. These children tend to have “attention problems, lower cognitive functioning, behavioural problems, decrease in school attendance, grade repeats, [and] achievement problems,” including lower reading achievement (p. 119). Clearly, trauma exposure can lead to “impairment in school functioning and aggressive and delinquent behaviour” (Jaycox et al., 2009, pp. 49-50). In terms of achievement, children who have experienced trauma have “poorer school performance, decreased IQ and reading ability, lower GPA, and more days of school absence” (Kuban & Steele, 2011, p. 41). Confirming the research, it has indeed been my experience that students who have experienced trauma display poor academic performance overall, with poor attendance and low reading levels. In examining classroom behaviours, researchers have found that students suffering from the effects of trauma may present with behaviours such as passivity, inability to concentrate, verbal and physical blow-ups, frequent absences, and “spacing out” (Sitler, 2009, p.120). I have observed that students with trauma exposure do, in fact, display these behaviours.

It is evident that exposure to trauma has negative effects on student learning and behaviour. Student achievement is highly affected by students’ experiences with traumatic events. Duplechain et al. (2008) found that exposure to violence specifically has a negative impact on reading achievement. The researchers attributed low reading achievement to the fact that after being exposed to trauma, students’ experiences cannot be left outside the classroom, and are brought into their reading situations. Furthermore, children cannot concentrate on their school work when they do not feel safe, and as a result are anxious, fearful, and focused on suppressing the traumatic memories. Moreover, after being exposed to a traumatic event, children struggle with motivation, concentration, focus, and personal connections, all of which are essential in promoting reading achievement.

Surprisingly, Duplechain et al. (2008) found that students with moderate exposure to trauma had lower reading achievement than students with high exposure to trauma. They attributed the lower reading achievement to the fact that educators recognize students who experience high exposure to trauma more easily than students who experience moderate exposure due to the high exposure students’ “low achievement, grade repeats, discipline problems, attention problems, and poor school attendance” (Duplechain et al., p. 129). When it is recognized that a student is overtly experiencing trauma, educators may identify the problems and work to help the student. When the needs of the high-exposure students are addressed, their reading achievement may also improve. The reading levels of the most at-risk group – the moderate exposure group – progressively declined over the three-year period of the research by Duplechain et al. Educators may not notice these children as at-risk because they may not overtly exhibit school-related concerns like the high exposure students. Due to this lack of identification of the students in the moderate exposure group, and thus less attention to addressing their needs, their reading achievement is more negatively affected by violence exposure than students in the high exposure group. The researchers did observe a decrease of achievement in the high exposure group from year two to year three. It is suggested that these inconsistent results indicate that over time, students with high exposure to violence become less able to adapt and may become exhausted, which affects their long-term reading performance.

Student behaviour and learning are affected by exposure to trauma. Deficits in meeting Maslow’s Hierarchy of Needs can have a major impact on students. Educators strive to meet the needs of all learners, so it is important to provide recommendations for supporting students.

Supporting Students Through Everyday Interactions

Some children are more resilient than others and may not develop the symptoms of post-traumatic stress after a traumatic experience (Little et al., 2011). Other children, however, may

develop a number of post-traumatic symptoms, and if intervention is not implemented, the severity of the symptoms of PTSD can worsen. Post-traumatic symptoms negatively impact student learning and behaviour.

It has been my experience that most teachers are not trained in supporting students who suffer from trauma exposure. To help students with trauma exposure, teachers need “a greater understanding of how trauma manifests itself in learners” and they also need to “pay greater attention to learners as whole persons with physical, emotional, and cognitive needs” (Sitler, 2009, p. 122). For children who have experienced violence, undesirable classroom behaviours can often be attributed to students wanting “teachers to engage them at Maslow’s third level of caring” (p. 122). Researchers have suggested many recommendations for engaging students at this third level of caring. Some of these recommendations include asking how a student is feeling, helping students to stay focused on tasks, and offering positive outlets for students to express their concerns. Teachers can also display attention and caring by making sure that students have the physical tools needed to be successful, such as a lunch and school supplies. Additionally, teachers can show that they care by greeting students when they arrive, encouraging students, and giving students strategies to cope when they become overwhelmed.

Duplechaine et al. (2008) provided suggestions that teachers can use to help students whose struggles to read have been exacerbated by trauma exposure. Their suggestions include increasing one’s awareness and attention to such students by referring them to school counsellors, developing a professional awareness of the harm traumatic exposure can have on school achievement, and monitoring students for exposure to traumatic events. As well, teachers can help by providing students with a role model or a mentor, by encouraging students to read books that show people who have overcome difficult situations, and by providing opportunities for students to journal or express their emotions through other forms of creativity.

It is important for teachers to get to know their students and to interact with them daily in order to help them cope with their experiences. Having said that, sometimes those everyday interactions are not enough to help children who have been exposed to trauma, and more intensive intervention is required.

Supporting Students Through Intervention

Researchers have studied programs that have been effective in supporting traumatized children. Some have recommended the following intervention programs: traditional and non-traditional practices, the Support for Students Exposed to Trauma (SSET) program, Trauma Focused Cognitive Behaviour Therapy (TF-CBT), Cognitive Behavioural Intervention for Trauma in School (CBITS), Project Fleur-de-lis, and the Structured Sensory Intervention for Children, Adults, and Parents (SITCAP) program. Furthermore, with a variety of initiatives, communities can support young people and provide opportunities for them to develop resilience, which will help them to overcome response symptoms of exposure to traumatic events.

Dionne and Nixon (2014) suggested that a combination of traditional and non-traditional practices may be beneficial in helping First Nations people “gain spiritual wholeness” (p. 335). Traditional healing practices include the medicine wheel and sweat lodge ceremonies, face painting, and pow-wows. Non-traditional healing practices include one-on-one counselling and Alcoholics Anonymous (AA) meetings. Non-First Nations teachers may not be able to implement the suggested traditional practices, but they could recommend that students whom they are concerned about take part in such practices by connecting them to traditional people with the help of school division personnel or organizations as the local Friendship Centre.

In the Support for Students Exposed to Trauma (SSET) program, teachers or school counsellors engage students who have been exposed to traumatic events in 10 lessons designed to reduce symptoms of PTSD and depression (Jaycox et al., 2009). The 45-minute lessons focus on “psycho-education, relaxation training, cognitive coping, generalized anxiety, processing traumatic memories, and social problem solving” (Jaycox et al., p. 50). The lessons

are divided into four sections: review the previously taught skill, learn a new skill, take part in activities to master the new skill, and create a plan to practice the new skill every day. In measuring the outcomes of the SSET program, Jaycox et al. (2009) observed a decrease in students' symptoms of PTSD and depression. The students were identified as having either high or low symptoms, based on their scores on the Child PTSD Symptom Scale. Children with scores of 11 or higher were identified as having low symptoms, and children with scores of 18 or higher were identified as having high symptoms. Children with scores lower than 11 were ineligible to participate in the study. The intervention effects were more distinct among children with high symptoms, and there was no significant change in students with low symptoms.

One limitation of the work done by Jaycox et al. (2009) is that the researchers did not measure the long-term effects on the students who participated in the SSET program. Also, students of specific ethnic minorities were predominant in this study; therefore, the results may not generalize to schools with students of different ethnicities. Furthermore, the study did not evaluate the effectiveness of the program in relation to school performance and behaviour, but in relation only to changes in presentation of symptoms.

Trauma Focused Cognitive Behaviour Therapy (TF-CBT) is specifically designed to meet the needs of individual children and their families, while respecting the families' religious and cultural beliefs. The sessions include "relaxation training, reviewing the traumatic event, and creating a permanent product," such as a journal (Little et al., 2011, p. 452). A study done by Roberts and colleagues in 2009 revealed that for people with a clinical diagnosis of PTSD symptoms, the only intervention to make a significant difference within three months of a traumatic event was TF-CBT (as cited in Little et al., 2011).

Cognitive Behavioural Intervention for Trauma in Schools (CBITS) is a group intervention program for children ranging from ages 10 to 15 who have been victims or witnesses of traumatic events (Little et al., 2011). The group sessions begin with a review of the previous session and then the introduction of new activities. The six main components of the group sessions are "education, relaxation training, cognitive therapy, real life exposure, stress or trauma exposure, and problem-solving" (Little et al., 2011, pp. 453-454). Little et al. (2011) found that the children involved in CBITS showed lower levels of "psychosocial dysfunction, PTSD symptoms, and depression" (p. 454).

CBITS may be a good intervention program to consider for schools with First Nations students. Morsette et al. (2009) studied the effects of the program on Native Americans who lived on reserve and displayed symptoms of PTSD and depression (as cited in Little et al., 2011). The results of the study revealed that symptoms of PTSD and depression were significantly reduced through the implementation of CBITS.

Project Fleur-de-lis is a three-tier model that was designed in response to the needs of children who were exposed to traumatic experiences during and after Hurricane Katrina (Little et al., 2011). Project Fleur-de-lis incorporates the TF-CBT and CBITS intervention models. Schools, social services agencies, trauma researchers, and clinicians were all involved in developing Project Fleur-de-lis. Tier 1 of the intervention, entitled Classroom-Camp-Community-Culture Based Intervention, was intended to support as many children as possible in a short amount of time. If students needed further intervention, they were referred to Tier 2, which was the Cognitive Behavioural Intervention for Trauma in Schools (CBITS). If PTSD and depression symptoms were not alleviated after 10 months, the students were referred to Trauma Focused Cognitive Behaviour Therapy (TF-CBT).

In order to overcome their traumatic experiences, children must feel safe and have a sense of control. The Structured Sensory Intervention for Traumatized Children, Adolescents, and Parents (SITCAP) program is intended to help traumatized individuals to think more clearly and develop positive coping strategies. Kuban and Steele (2011) described the goal of the program as turning traumatic memories into a resilience resource rather than a trigger for panic. The main idea of the SITCAP program is to have individuals experience their traumatic memories in a safe environment on a sensory level. The sensory activities include drawing and specific

questioning that “target the sensations which are experienced in a traumatic event,” such as terror, fear, worry, and powerlessness (Kuban & Steele, p. 42). Re-experiencing the event allows individuals to think differently about what has happened, eventually moving from “victim thinking” to “survivor thinking” (Kuban & Steele, p. 42). Once the individuals develop a survivor mindset, they become “actively involved in their own healing process” (Kuban & Steele, p. 42). If the individuals can see themselves as survivors, they strive to heal, and the healing process becomes a more positive experience. The intervention is implemented over 8 to 10 sessions that address the following major themes: “fear, terror, hurt, worry, anger, revenge, guilt, accountability, absence of safety, powerlessness, and victim thinking versus survivor thinking” (Kuban & Steele, p. 43). Kuban and Steele claimed that with the support of school counsellors, social workers, and psychologists, the reduction of PTSD symptoms in children with trauma exposure will have long-term effects.

The SITCAP program is concerning to me, because making witnesses or victims of trauma relive the event re-victimizes the person and thus seems needlessly frightening. If children need to feel safe and in control in order to overcome their traumatic experiences, making them relive the event is perhaps not the best approach. Kuban and Steele’s (2011) article addresses only the results of one student’s intervention, which does not present sufficient evidence of the program being successful. It is possible that Kuban and Steele’s purpose was promotion, because Kuban is the director of the National Institute for Trauma and Loss in Children (TLC), and Steele founded the institute.

While some youth experience severe PTSD symptoms from being exposed to violence, others are resilient, and continue to succeed despite their trauma. Zahradnik et al. (2010) discovered that resilience can protect children from PTSD symptoms. Communities can help children to develop resilience by teaching them how to access community resources such as “education, economic security, cultural traditions, and housing” (Zahradnik et al., p. 409). Zahradnik et al. recommended that communities with youth who have experienced trauma develop programs that offer “involvement with community and cultural traditions, thus experiencing the community as fair” (p. 418). It is important for communities to provide resources and support for youth with exposure to violence, because resilience “protects from the development of more severe PTSD” symptoms (Zahradnik et al., pp. 416-418).

As an educator, I have taught students with both high and low levels of resilience. For example, one student’s father had been in and out of jail multiple times for domestic violence. It was highly likely that this student had witnessed the violence, and had possibly been a victim of the violence him/herself. The student worked hard, was polite, had friends, and was academically successful. He/she would be considered to have a high level of resilience, because despite the exposure to trauma, he/she continued to be successful. Another student in the same class had witnessed his/her mother being abused and had been abused him/herself. This student was aggressive with other students, was disrespectful, and struggled academically. He/she would be considered to have a low level of resilience, because his/her behaviour and academic achievement were negatively affected.

Klasen and Crombag (2013) reviewed the literature to “identify the most promising interventions as well as most urgent research gaps in the area of global child and adolescent mental health (CAMH) interventions” (p. 596). Group and individual interventions showed hopeful results in reducing the symptoms of anxiety and depression in children and adolescents. Klasen and Crombag recommended involving parents when treating children who experience anxiety and depression. Klasen and Crombag found that community, group, and individual treatments, as well as prevention strategies, are effective; however, they were unable to determine when, why, and with which children and adolescents specific interventions should be used. Their final suggestion is to use a multi-tiered approach that touches on different intervention techniques. There were very short follow-up periods in many of the research reports that Klasen and Crombag reviewed. Without long-term follow up, it is difficult to know whether the programs and interventions had significant effects on the children and adolescents.

It is hoped that through the implementation of one or a combination of traditional and non-traditional practices – the SSET, TF-CBT, CBITS, and/or SITCAP programs – educators can address the needs of children who have been exposed to trauma, and help the children to develop resilience. Supporting teachers in developing an awareness of the effects of trauma, and providing them with supporting strategies, would be beneficial for the children in need.

Discussion

Teachers need to have an awareness of how trauma affects children. Not until I researched the effects of trauma on the mental health, learning, and behaviour of children did I truly realize that students' negative behaviours and learning deficits may be caused by underlying issues in their personal lives. Prior to my research, I responded to misbehaviours by immediately serving consequences, often involving the principal. Now that I am aware of the effects of trauma on children, I meet with students following behavioural incidents, and we work together to identify why they have behaved that way and to come up with a plan for working through their feelings the next time (instead of yelling or fighting, for example). Our plan often includes the strategies suggested in this review, such as journaling, drawing, and other avenues to express their feelings and to achieve a sense of self-control, such as deep breathing and intensive exercises.

I have also changed how I interact with students on a daily basis. Before conducting my research, while my students arrived at school in the morning and got ready for recess, I would prepare for my next lesson or spend time in the staff room. My research has taught me that taking time to greet students in the morning and asking them how they are can make a big difference in showing the children that I care about them. Since I have started greeting students in the morning, I have found that I can help the students start their day on a positive note. If a child has had a bad night or morning at home, I can recognize the negative emotions when the child enters the school, and can help turn the child's day around by simply saying good morning, asking the child if he/she is all right, and giving the child an opportunity to talk to me.

I believe that the changes I have made in interacting with students have made a difference in their behaviours and their learning achievement. I have seen improvements in the behaviours of my most challenging students. I also anticipate seeing improvements in my students' learning achievement over time, because they are now receiving some of the attention and caring from me that they may be lacking at home or from their peers. Also, by providing a safe learning environment, it is hoped that the children will be able to focus on their learning rather than being in a constant state of fear and worry.

Numerous articles recommend specific intervention programming to support children who have been exposed to trauma. While aspects of the programs that I researched have been successful, it is not possible in my current context to increase my expertise to the point when I know how and when to implement such programs, and which programs are most appropriate for my students. Little et al. (2011) confirmed my suspicion that teachers and school personnel are often not trained in supporting students with trauma exposure, and that only clinicians typically receive this type of training. Clinicians are rarely in our schools, and students suffering from the effects of trauma need to meet with someone more than a few times throughout the year.

My learning about the lack of training for teachers, and my feeling of inadequacy in supporting my students with trauma exposure, have motivated me to continue my research in this area. I have taken it upon myself to continue my studies in guidance and counselling. I hope that by furthering my education, I will become trained in implementing programming to support students who are suffering from the effects of trauma exposure. In the future, I would like to teach educators about the effects of trauma on children, and to provide them with strategies that they can use to support their students with such experiences.

Educators can apply the recommendations made in this review for everyday interactions with students. However, due to a lack of training, most teachers will be unable to implement the programs suggested. Further educator training would help to address this problem.

Conclusion

Teachers struggle to support children in coping with the effects of trauma exposure. Children who have had traumatic experiences display various types of mental health, behavioural, and learning challenges. Classroom teachers are not trained in implementing the intervention programs suggested to support students in overcoming the effects of trauma. There are changes that teachers can make in their everyday teaching practices and interactions with students, in order to help children to be successful despite their traumatic experiences. As a teacher, I have implemented some of the suggestions and have noticed positive changes in students who have been affected by trauma. Through further teacher training regarding the impact of trauma on student learning and behaviour, teachers will feel more confident in recognizing, supporting, and meeting the needs of all students.

References

- Dionne, D., & Nixon, G. (2014). Moving beyond residential school trauma abuse: A phenomenological hermeneutic analysis. *International Journal of Mental Health & Addiction*, 12(3), 335-350. doi:10.1007/s11469-013-9457-y
- Duplechain, R., Reigner, R., & Packard, A. (2008). Striking differences: The impact of moderate and high trauma on reading achievement. *Reading Psychology*, 29(2), 117-136. doi:10.1080/02702710801963645
- Jaycox, L. H., Langley, A. K., Stein, B., Wong, M., Sharma, P., Scott, M., & Schonlau, M. (2009). Support for students exposed to trauma: A pilot study. *School Mental Health*, 1(2), 49-60. doi:10.1007/s12310-009-9007-8
- Klasen, H., & Crombag, A. (2013). What works where? A systematic review of child and adolescent mental health interventions for low and middle income families. *Social Psychiatry and Psychiatric Epidemiology*, 48(4), 595-611. doi:10.1007/s00127-012-0566-x
- Kuban, C., & Steele, W. (2011). Restoring safety and hope: From victim to survivor. *Reclaiming Children and Youth*, 20(1), 41-44.
- Little, S. G., Akin-Little, A., & Somerville, M.P. (2011). Response to trauma in children: An examination of effective intervention and post-traumatic growth. *School Psychology International*, 32(5), 558-563. doi:10.1177/0143034311402916
- Sitler, H. C. (2009). Teaching with awareness: The hidden effects of trauma on learning. *Clearing House: A Journal of Education Strategies, Issues, and Ideas*, 82(3), 119-124.
- Voith, L., Gomoske, A., & Holmes, M. (2014). Effects of cumulative violence exposure on children's trauma and depression symptoms: A social ecological examination using fixed effects regression. *Journal of Child and Adolescent Trauma*, 7(4), 207-216. doi:10.1007/s40653-014-0026-8
- Zahradnik, M. M., Stewart, S. H., O'Connor, R. M., Stevens, D., Ungar, M., & Wekerle, C. (2010). Resilience moderates the relationship between exposure to violence and posttraumatic reexperiencing in Mi'kmaq youth. *International Journal of Mental Health and Addiction*, 8(2), 408-420.

About the Author

Stephanie Frieze has recently started her Master of Education, focusing on guidance and counselling. While having taught children who have been traumatized, and experienced the feeling of helplessness in knowing how to support these students, she has developed a passion to further her expertise in this area.