Support for Students Exposed to Trauma (SSET): An Evidence-Based Intervention

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Abstract

Less than half of school-age children who experience trauma receive needed supports and services. Often there are access to treatment barriers and other factors that preclude appropriate treatment. One possible solution is offering trauma-informed school-based mental health services onsite at the schools thereby reducing transportation barriers for youth. Onsite services offer an opportunity to engage in a collaborative manner with school personnel and community behavioral health agencies. More specifically, researchers have discovered two evidence-based trauma models for school-age youth, Cognitive Behavioral Interventions for Trauma in Schools (CBITS) and Support for Students Exposed to Trauma (SSET). Both model demonstrate efficacy in reducing trauma symptoms in youth and increasing pro-social behavior and functioning. SSET is an adaption of CBITS whereby school teachers and counselors are trained to deliver the model in a group setting. Some localities experience a shortage of mental health providers therefore SSET offers an approach that capitalizes on use of school personnel to work with students who have been exposed to trauma. This article will review school-based mental health services and the literature on implementation of SSET across multiple populations.

Keywords: trauma, school, youth, cognitive-behavioral therapy

Support for Students Exposed to Trauma (SSET): An Evidence-Based Intervention

An estimated 20% of school-age children have diagnosable mental health or substance use conditions; however, less than half of these youth receive treatment (Powers et al., 2015; Villarreal & Castro-Villarreal, 2016). In addition, COVID-19 placed an increased strain on school systems which often struggle to help student learners address behavioral health problems, including trauma. For example, Elharake and colleagues (2022) found that school-age children reported increased feelings of anxiety, depression, fatigue, and distress compared to before the COVID-19 pandemic. Furthermore, parental substance use is a factor associated with child welfare cases. Substance use can strain the child welfare system, with up to 80% of all child welfare cases involving parental substance use (Freisthler et al., 2021).

Taken together, these findings suggest that there is a need for a school-based intervention to address trauma and related mental health problems experienced by school-age youth. In absence of a coordinated intervention approach, many school systems are challenged to manage the social, emotional, and behavioral issues that present in the school setting. Some of these issues relate to trauma experience by school-age youth. These problems can manifest in difficulty focusing in class, disruptive behaviors, labile mood, and externalizing behaviors including defiance, tardiness to class, and inability to follow school rules. These issues interfere with student learning and impact youth wellness and the path toward social and academic achievement. Often the response to such behaviors is punishment, removal from class, and/or suspension from school without addressing the root cause of the behaviors.

One promising approach to increase access to treatment for youth in schools is embedded counseling and behavioral health services in the school system. A cross-sector collaborative approach with public behavioral health organizations and the school system can result in a

coordinated referral and treatment process for the early identification, screening, and triage of students who have experienced trauma or other mental health concerns (Smith Ramey & Duis, 2022). From a biblical perspective, the words of Christ in Isaiah 61:1-8 acclaim: The Spirit of the Lord GOD is upon me; because the LORD hath anointed me to preach good tidings unto the meek; he hath sent me to bind up the brokenhearted, to proclaim liberty to the captives, and the opening of the prison to them that are bound ...(*King James Bible*, 1769/2008). Taking a kingdom approach, the lord calls the healers and counselors to mend and heal those who have experienced trauma, including children and school-age youth. Collaboration among helpers heeds God's call to heal those who have experienced trauma, including children and adolescents. Feedback from a child welfare (e.g., social services) director in Central Virginia underscores the importance of a coordinated response:

> In a geographically large county with no public transportation, meeting families locally is a wonderful solution. Children are able to get counseling on a regular basis when at school. Counseling services provided at school help address individual and family issues in a proactive way, preventing escalation to the level of protective services.

More specifically, Support for Students Exposed to Trauma (SSET) has been identified as an evidence-based approach that can be implemented within a school system as a coordinated response. Conditions necessary for implementation of SSET include training and collaboration among school personnel and community partners with a shared vision of improving student wellness and health. The purpose of this paper is to describe the need for SSET, the methodology and research-base of the model, the target population, and expected outcomes. Related information will include applications of SSET in different school systems in the United

States and abroad. Strategies to embed SSET in a public school system will be offered along with implications for counselors, clinical supervisors, and school personnel.

Background and Methodology

SSET is a modification of Cognitive Behavioral Interventions for Trauma in Schools (CBITS). CBITS is a 10 session group model delivered in the schools designed to target minority and low-income children who may have difficulty accessing needed intervention for trauma (Cohen & Mannario, 2010). Components of CBITS include psychoeducation, relaxation and affect modulation skills, cognitive coping, breakout sessions to develop a trauma narrative, and safety planning. Psychoeducation is woven throughout the trauma model as a principle of treatment is gradual exposure for the youth. As psychoeducation is introduced the clinician begins to teach, model, and practice relaxation skills. Some examples of relaxation skills include guided imagery and breathing exercises. Cognitive coping may include learning effective problem solving skills. The youth is taught separate and distinct steps of problem solving (i.e., identify the problem, brainstorm solutions, eliminate unwanted solutions, etc.) and they apply the problem solving model to a real-life situation. The goal is to generalize the skill to address a variety of problems that the youth may encounter. Upon receiving psychoeducation and learning coping skills, the counselor will help the youth develop a trauma narrative.

SSET is an adaptation of the CBITS model for non-mental health professionals to provide an intervention to youth who have experienced trauma. Schools professionals delivering SSET may include teachers, school social workers, school psychologists, and school counselors. CBITS and SSET share many similarities in their approach. More specifically, SSET is similar to CBITS in the focus on skill-building and psychoeducation; however, SSET facilitators do not assist with the development or processing of the trauma narrative (Cohen & Mannarino, 2010).

Framework

SSET falls within a larger approach by public school systems to address student emotional and behavioral health. Within the past decade the public educational system in the United States has increased its focus on student mental and emotional wellness (McInerney & McKlindon, 2014). Some of these areas of focus include depression, anxiety, and trauma. Nationally, multitiered systems of support (MTSS) have been developed in the public educational system to guide youth on the path toward improved functioning in the classroom (Weist et al., 2018). MTSS is part of a larger framework joined by positive behavioral interventions and supports (PBIS) and school mental health services (SMH). The organizational framework aligns with a Christian worldview of empowerment as stated in 2 Timothy 1:7: For God hath not given us the spirit of fear; but of power, and of love, and of a sound mind (*King James Bible*, 1769/2008). The MTSS framework underscores the Christian view of loving others through provision of multiple layers of support for many of the most vulnerable population.

PBIS

PBIS uses a behavioral approach to shape positive youth behavior in the school-setting through incentives and provision of positive reinforcement (Weist et al., 2018). PBIS is based on behavior shaping principles to provide immediate rewards to desired behavior to increase the likelihood of desired behavior occurring over negative behavior. One example of a PBIS strategy is a reinforcement system to provide a tangible reward (e.g., a trinket or token) to a student who exhibits positive social interactions. Other examples of positive reinforcement may include verbal praise from school staff or recognition in a large group setting (e.g., assembly, homeroom). SMH is anchored in cross-sector community collaboration and has linkages to PBIS

in its approach to improve wellness, functioning, and positive behavior in youth (Weist et al., 2018).

School Mental Health (SMH)

One example of SMH is a local partnership between Bedford County Public Schools in Central Virginia and Horizon Behavioral Health, the local public behavioral health organization. Horizon is one of forty Virginia Community Service Boards (CSBs). CSBs establish, maintain, and promote development of mental health, developmental disabilities, and substance use services. As a CSB, Horizon is the single point of entry into publicly funded mental health and substance use services. Furthermore, Horizon is mandated to provide emergency services, case management, same day mental health screenings, and monitoring services for physical health indicators (Virg. Leg. Code ch. § 37.2-500, 2017).

As previously stated, the two organizations developed a coordinated referral process to identify, screen, and refer youth with mental health and/or substance use issues to treatment or other interventions (Smith Ramey & Duis, 2022). In addition, Horizon embedded outpatient counselors and case managers in the schools to increase access to care and linkage to other resources (e.g., medical care, food, housing) for youth and families in need. The overarching goal of this framework is to prevent and intervene with youth who exhibit internalizing issues (Weist et al., 2018). Feedback from an assistant principal at Bedford County Public Schools' Staunton River High School, highlights the importance of purposeful collaboration between the two organizations: "There is a tremendous need for intentional mental health support for students in our community. Many students are unable to locate services, are unsure how to receive services, as well as unable to access services due to transportation or other issues. Having Horizon in our school on a daily basis to support specific mental health needs of students through

intentional therapy sessions has made an observable difference in our student's academic and behavioral successes."

MTSS Organizational Tiers

MTSS is organized into three tiers of intervention, each designed to target a specific student population. In Tier 1, behavioral expectations are developed by each school and social-emotional (SEL) learning programs are implemented among the student learners. Tier 1 strategies focus on widespread efforts across the entire student population to reinforce behavioral expectations. One example of an SEL program is teaching youth self-management skills with a goal of reinforcing a school community with a safe and supportive environment for learning. Often Tier 1 strategies are delivered through school assemblies and lessons provided in student homeroom classes. As stated, Tier 1 is a universal approach aimed to target the entire student body.

Tier 2 addresses youth with risk factors or internalizing concerns but who have not experienced problems with functioning in the school setting. A youth matched for a Tier 2 strategy may be a student who has been removed from their family and placed in foster care due to parental abuse or neglect. The youth may not have experienced problems in the school setting; however, the risk factors suggest that a Tier 2 strategy is warranted. An example of a Tier 2 intervention is purposeful positive contact with adults for students who exhibit signs of discouragement or other early indicators of behavioral problems. SSET falls within Tier 2 and can be delivered by school personnel for youth who may benefit from learning emotion regulation skills.

Tier 3 focuses on youth who exhibit notable functional impairments in the school setting. These impairments may include, but are not limited to, tardiness, truancy, verbal and physical

aggression, refusal to comply with school rules, and disrespectful behaviors toward authority figures. An example of a Tier 3 intervention is CBITS, the treatment model that SSET was adapted from. Tier 3 interventions align with a SMH cross-section collaborative approach. Community-based counselors can be embedded in the school system to provide individual and group counseling with students who have experienced trauma and require a Tier 3 intervention. For example, Horizon counselors are trained in trauma approaches that are provided to students after assessment, case conceptualization, and collaboration with parents and school personnel (Smith Ramey & Duis, 2022).

Reinbergs and Fefer (2017) provide a literature review of assessments, interventions, and practitioner support broken down by each tier. Examples of Tier 1 assessments include the Child Trauma Screening and Strengths and Difficulties Questionnaire. Social emotional learning curriculums are offered as part of Tier 1 and practitioner support includes the Child Trauma Toolkit for Educators. The Trauma Symptom Checklist for Children is part of a Tier 2 assessment with CBITS as a related Tier 2 intervention. In Tier 2, consultation from SMH clinicians may be provided. Lastly, the University of California at Los Angeles PTSD Reaction Index is offered in Tier 3. Trauma-Focused Cognitive Behavioral Therapy is a Tier 3 intervention and practitioner support includes outside referrals to community-based clinicians (Reinbergs & Fefer, 2017).

Target Population for SSET

As a Tier 2 intervention, the SSET target population includes middle school youth who have been exposed to traumatic events (Jaycox et al., 2009). Some examples of traumatic events may include exposure to domestic violence, abuse, or neglect. More specifically, the youth may live in a household or neighborhood where violence, substance use, or criminal activity occur.

Alternatively, the traumatic event may be a natural disaster such as experiencing a tornado or hurricane. The target population for SSET includes both males and females.

SSET includes ten lessons/sessions designed to reduce traumatic and depressive symptoms. The overall goal is to improve the functioning of the student (Jaycox et al., 2009). The core components include: psychoeducation, relaxation training, cognitive coping, gradual in session mastery of trauma reminders, processing traumatic events, and problem solving skills. SSET is conducted in a group environment and does not include break-out sessions. The sessions are conducted with the youth only (no parents or caregivers). The length of an SSET session is about 45 minutes or one class period. The sessions are structured and follow a similar format for each group. Each session begins with a review of the previous session's skills and homework or home practice. The session structure includes a didactic component, engagement/skills practice, and a homework assignment (to practice or generalize the skill).

Research on SSET

The first clinical trials of SSET occurred in Los Angeles, California among 6-8th grade middle school students in 2008-2009 (Jaycox et al., 2009). The sample of students studied was relatively small (N=76); thus, statistical power was not detected. SSET sessions were audio recorded to measure fidelity and parents and youth were given satisfaction surveys to measure their level of satisfaction after the intervention. Jaycox and colleagues (2009) found that SSET was feasible to implement in school systems that lacked clinical mental health clinicians. These findings suggested that there was an opportunity to test SSET in other school systems both in the United States and abroad. These findings also signified a shift in the service delivery model by equipping teachers and other school staff to deliver a mental health/trauma intervention to students.

A more recent study used an experimental design to test the effectiveness of SSET among children in Pakistan impacted by a natural disaster (i.e., flooding). Researchers randomly assigned children affected by flooding to the intervention (SSET) or control group (Armin et al., 2020). The numbers were evenly assigned to each group. The research team hypothesized that the group of youth receiving SSET would have a reduction in symptoms of PTSD compared to the control group. The Child PTSD symptoms scale was used as a measurement. The results suggested that the experimental group reduced symptoms of PTSD, increased resilience and social support when compared to the group that did not receive the SSET intervention.

Miller and Berger (2020) argue for SSET implementation with the population of Aboriginal and Torres Strait Islander youth in Australia. Historically, this group has been at increased risk for trauma and exposure to family violence and substance use. While an increased emphasis has been placed on trauma-informed models with Aboriginal and Torres Strait Islander people, continued areas of advocacy and focus are required to ensure that models like SSET are accessible to school-age youth (Miller & Berger, 2020). The research on international students suggests that SSET may be feasible for delivery across cultures and across a variety of traumatic experiences (Armin et al., 2020; Miller & Berger, 2020).

SSET and Foster Care Youth

With the increase in drug-related overdose deaths and related child welfare involvement, a specialized population experiencing trauma is school-age youth in foster care (Schultz et al., 2012). Youth in the child welfare system often face complex trauma and difficulty with emotional regulation and behavior management in the school setting. SSET is a feasible option for youth in foster care to receive appropriate mental health services to address their behavioral health needs (Schultz et al., 2012). There are no modifications of SSET for youth in foster care.

These youth can be incorporated into the SSET group format alongside youth living with a biological parent or parents.

Implications for Counselors and School Personnel

Extant literature highlights the need for expansion of SSET programs across the public school system in the United States and abroad (Armin et al., 2020; Miller & Berger, 2020; Schultz et al., 2012). SSET appears to be feasible to implement across different settings and cultures with acceptable outcomes in reducing trauma symptoms among middle school youth who have experience trauma exposure (Miller & Berger, 2020). Partnerships between school systems and public behavioral health organizations offer an opportunity to leverage shared resources and expand the knowledge and skill set of school personnel to deliver SSET. Training and mentorship between staff in these two organizations can promote an increase in access to mental health care for a vulnerable population. These organizations may collaborate through formal partnerships, networking on cross-sector coalitions, and individual level relationship development. Schools and community behavioral health agencies have a history of collaboration resulting in deliverables such as a coordinated referral process to identify, assess, and triage youth with mental health or substance use treatment needs (e.g., Smith Ramey & Duis, 2022). The behavioral health agency may serve as a consultant or offer technical assistance to school personnel in delivery of SSET. This arrangement would also ensure that youth who need a more intensive intervention or higher level of care would be appropriately linked to that service. Implications for helping professionals are closely tied to a biblical perspective as Isaiah 54:10 provides a reminder of God's promise to heal with kindness: For the mountains shall depart, and the hills be removed; but my kindness shall not depart from thee, neither shall the covenant of my peace be removed, saith the LORD that hath mercy on thee (*King James Bible*, 1769/2008).

Conclusion

SSET was developed as an adaptation to the evidence-based CBITS model to reduce problematic trauma responses in school-age youth. CBITS is a school-based trauma model delivered by trained mental health clinicians. Because many communities and school systems lack trained mental health clinicians, SSET was developed for school teachers and school counselors to provide a trauma intervention for youth exposed to trauma. Trauma exposures may be familial or environmental violence, abuse, or neglect or a natural disaster. Overall, researchers have found that SSET when delivered to fidelity is associated with improved functioning within the school setting (Jaycox et al., 2009). With its efficacious research base, school systems may wish to consider training teachers and school counselors in this model and collaborating with partners in behavioral health to meet the needs of youth who have experienced trauma.

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