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The Effects of Trauma-Focused Therapies on School Performance: A Systematic Review

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The Effects of Trauma-Focused Therapies on School Performance: A Systematic Review

by

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Trauma is something many different youth go through in their lives. However, those who've experienced trauma are affected within their school settings and need trauma-specific interventions to be successful in their school performance. The purpose of the of this study was to examine the current research on trauma therapies and how those treatments affect youths' school performance. The areas of school performance that effects youth are their grades, school refusal, negative classroom behaviors and social skills. This systematic review will focus on how cognitive behavioral therapy (CBT) and other similar treatments such as trauma focused cognitive behavioral therapy (TF-CBT), game based cognitive behavioral therapy (GB-CBT) and cognitive behavioral intervention for trauma in schools (CBITS) effect the grades, school refusal, negative classroom behaviors and social skills of these traumatized youth. A systematic review research design was utilized analyzing 20 studies meeting criteria and these articles were then analyzed. CBT, TF-CBT, GB-CBT and CBITS were all found to be effective when working with youth who experience traumatic symptoms and affect their school performance. However, the findings have shown to be limited and further research is needed to better address the benefits of broader use of trauma therapies in schools.

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Review

Mental illness is a global problem that affects youth and does not discriminate by culture. The statistics show that mental illness affects approximately one fifth of America's children (Centers for Disease Control and Prevention, 2015) and that there are roughly six million children in the child protective system for traumatic reasons (U.S. Department of Veteran Affairs, 2015).

Youth who've experience trauma symptoms have a wide range of events that happen within their lives. The majority of these traumatic events are related to violence, youth coming from war-torn countries, psychological or emotional abuse, car accidents and natural disasters (Boston Children's Hospital, 2011; U.S. Department of Veteran Affairs, 2015). Trauma symptoms negatively impact the quality of life for youth and they can be diagnosed with mental health disorders or emotional issues such as post traumatic stress disorder (PTSD), depression, anxiety, aggression, poor self-esteem, substance abuse or sexually inappropriate behavior. PTSD is when an individual experiences, witnesses or learns of traumatic events that happened to a friend or family (APA, 2013).

Many children have had significant mental health issues from past traumatic experiences and this can affect children's long-term school performance. The APA first put trauma as a medical diagnosis in the Diagnostic and Statistical Manual of Mental Disorders-III in 1980 under the designation of PTSD (Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009).

According to APA (2013) when youth experience trauma symptoms, they must have the four symptom clusters including: intrusive memories, avoidance, negative changes in mood, and arousal. The diagnostic criterion requires that individuals must also witness a death or be in danger of death, or have been exposed to injury or violence. This can include any type of violence including physical, emotional, psychological, verbal, cultural and sexual. To have a PTSD diagnosis, someone must have directly experienced an event, witnessed the event, found out a loved one has experienced a violent or unintended event, or had been repeatedly exposed to a violent event such as through their job or at school (APA, 2013). According to the National Institute of Mental Health (NIMH, 2009), approximately four percent of children experience PTSD symptoms. The rates of PTSD symptoms are much higher in girls (6.6 %) compared to boys (1.6 %; NIMH 2015). There are also many other factors that contribute to PTSD symptoms among youth including parental incarceration, relationships, violence, cultural differences, poverty and barriers to mental health services. All of these areas make it difficult for youth to perform well in school.

When working with children and adolescents there has been little research done with trauma symptoms and how that affects the school performance. This systematic review examines various treatments such as cognitive behavioral therapy (CBT), cognitive behavioral intervention for trauma in schools (CBITS), game-based cognitive behavioral therapy (GB-CBT) and trauma-focused cognitive behavioral therapy (TF-CBT), which improve school performance in children and adolescents. The purpose of this research study is to examine the success of trauma therapies and

how they improve school performance for youth who have experienced trauma in their lives.

This systematic review aims to recognize the different individual components of therapies that lead to more successful school performance outcomes for children and adolescents. It is important that research continues, so youth can receive the best possible way to support these to be successful in their school environments.

Literature Review

The experience of trauma in youth can be established in many different forms including violence, poverty, lack of support, and parental incarceration.   All of these areas are risk factors for youth experiencing a traumatic event that would trigger PTSD. PTSD or other trauma related mental health issues can lead to a number of internal problems such as depression and anxiety, but they are also linked with external problems such as aggression, conduct issues and oppositional defiant behavior. These external issues can then affect school performance, which is what this systematic review has investigated.

Mental Health Symptoms

Children and adolescents can experience numerous harmful mental health symptoms as a result of trauma. These include depression, anxiety and other symptoms related to PTSD. APA (2013) summarizes major depression as: having a lack of interest in doing enjoyable activities, weight loss, lack of sleep, feeling hopeless, feelings of guilt, struggling to concentrate and thoughts of death or suicide. To be diagnosed with depression, an individual must have at least five of the symptoms above. These symptoms can affect normal social, educational, and physical development. The National Alliance on Mental Illness (NAMI, 2009) reports anywhere from two to eight percent of youth are depressed within the school settings. In schools, this can lead to concentration issues, not being able to stay in school, excessive worry and failing in school (Noble, 2008).

There are gender differences for rates of depression. Girls tend to have a much higher rate of depression (16.2 %) compared to boys (5.3 %). Girls report

higher levels of depressive symptom, which leads to negative moods during weekdays at school (NIMH, 2013). However, the incidence of depression is estimated to be as much as 20 % higher over the lifetime of youth who have experienced trauma (Eder, O'Connor, Williams, Whitlock, 2009).

There are many factors that influence depressive symptoms in children and adolescents. Fite et al. (2012) report that rule-breaking behavior is not well liked by peers. The peers of these youth will often disassociate with those who break rules, which can lead to depressive symptoms, peer rejection and academic performance issues. When youth break the rules, their peers often reject them. This can lead to a lack of friendships and exacerbate their symptoms of depression. This can also lead to a lack of motivation, lack of confidence and a struggle to succeed in school (Bierman, 2004; Coie, 1990; Hawkins et al., 1985; Rubin et al., 1998).

Youth who experience trauma also suffer from symptoms of anxiety. APA (2013) summarizes anxiety disorders as having intense or excessive worry, feeling restless, feeling tired, having concentration issues, sleep issues, and muscle tension for at least a six month period of time. Anxiety can emerge as early as the age of six. About 8 % of teens from the age of 13 to 18 have an anxiety disorder (NAMI, 2009). These individuals tend to worry unnecessarily, have insomnia and need constant reassurance from others. When a youth experiences anxiety issues, they often deal with changes in behavior, personality, sleeping habits (e.g., waking up early and acting agitated), concentrating, and staying still. These can all lead to failure in school (NAMI, 2009).

Anxiety disorders in youth can manifest itself in many different forms and contribute to many issues within school settings. These include excessive worry about grades, literacy issues, truancy, late arrival times, tearful morning drop-offs at school, tantrums at school, refusal to attend school, avoiding peers and social activities, and low self-esteem (Massachusetts General Hospital, 2010). Separation anxiety is another issue, which often causes struggles with transitions and coping with stress throughout life (Fletcher et al., 2012).

For youth with anxiety disorders, this increases their issues within school, such as building prerequisite skills, interfering with their studies and their general knowledge. Anxiety can also interfere with learning, fluency and motivation that effects reading ability and leads to poor performance in math compared with peers without a chronic illness (Ercikan & Martinez, 2009; Fletcher et al, 2012). Anxiety disorders can make learning difficult and educational evaluation to rule out learning disabilities would be beneficial. According to Cochrane (2015) CBT treatment for anxiety in children found a 50 % success rate, higher than in those not receiving CBT treatment. This helps youth develop new ways of thinking about their anxiety. However, medication management is also a common form of treatment.

A PTSD diagnosis requires that individuals must experience a trauma prior to being diagnosed. This includes witnessing a death, being in danger of death, or exposed to injury or violence. This can include any type of violence including physical, emotional, psychological, verbal, cultural or sexual violence. For youth to experience PTSD, they must have the four diagnostic symptom clusters. These include: 1) intrusive symptoms; 2) avoidance; 3) negative changes in mood; and 4)

arousal. Those who experience trauma must experience one intrusive symptom, such as distressing memories from the event, nightmares, emotional distress, physical reactions, or flashbacks. Individuals also must experience avoidant behavior such as avoiding places, people or events (APA, 2013).

Youth can experience PTSD symptoms in many different ways. Finkelhor et. al (2007) conducted a study showing that 50 % or more of children in their study experienced at least two traumatic events a year. The youth in this study were between the ages of 2 and 17, all were from low-income families (under $50,000 per year) and were recent victims of violence within the last year. Of the traumatic events described, 40 % of children were assaulted, 38 % witnessed a crime, 43 % were a part of gang activity, 8 % were victims of sexual assault, and 95 % witnessed or had been a part of domestic violence.

Many of these traumatic experiences begin early in the lives of children. Finkelhor et al. (2007) report that youth are more likely to have a PTSD diagnosis than adults. This study also reports that 39 % showed that preschool children had PTSD symptoms, compared with 33 % for elementary school children, 27 % for adolescents, and 24 % for adults. Younger children will report symptoms of numbing and have other behaviors issues which lead to school problems. For example, anti-social behavior can be shown in 30 % of preschoolers and 12 % of elementary school children.

There can also be significant differences between genders. For example, 10 % of girls experience PTSD compared to 6 % of boys in their lifetimes. When both

genders experienced multiple traumatic issues, the rates of PTSD jump to 40 % for girls and 20 % for boys (Kessler et. al, 1994).

For many of the youth experiencing PTSD there can be significant behavioral issues, failure rates, and higher rates of dropouts than youth who did not experience these PTSD symptoms. American Psychological Association's Zero Tolerance Task Force (2008) reports that exposure to trauma for youth correlates with higher risk for school dropout. Youth who report traumatic symptoms were nearly 2.5 times more likely to drop out of school. Traumatic symptoms are likely to lead to punishment and exclusion from academic activities from their peers. Alegria et al. (2011) report that when these individuals had specific traumas such as being physically abused as a child (31.13 %), observing domestic violence in and outside of the home (26.01 %), being a victim of rape (25.34 %), were battered or abused (24.82 %), or being a part of a natural disaster (22.43 %), these youth had the highest level of dropout rates.

The best thing for students to do is develop coping skills, increase self-esteem and learn new ways to protect themselves. Aisenberg et al. (2001) report that youth who experience trauma have continued academic issues. However, a reduction of symptoms can help their school performance. When youth are involved with teachers, social workers and school counselors they can see a reduction in community violence and traumatic symptoms.

Violence

The United States is one of the most violent countries in the world. This is being reflected in rates of youth's exposure to violence. In a study conducted by Scarpa, (2003), the number of youth exposed to violence ranged from 76 % to 82 %

for victimization and 93 % to 96 % for witnessing violence or violent crimes.

Furthermore, in 2010, 15,576 children were injured and 2,694 killed due to gun

violence. That means that one youth is killed or injured every 30 minutes, 50 times a

day, and 351 times a week (Children's Defense Fund, 2014).

Based on a large study of 2,248 sixth, eighth and tenth graders, when youth

witness shootings or stabbings it can predict poor academic achievement (Schwab-

Stone, 1995).   In a study of 110 African American students between the ages of 11

and 13 at four different inner city schools, they were asked about violent events and

traumatic experiences. Ten out of 11 students had personally experienced violent

events in the community. All 11 of the students reported having experienced violence

or traumatic events directly related to their family, community, or at school

(Thompson & Massatt, 2005). Furthermore, Rosenthal (2000) reported that 40 % of

youth reported having been threatened in the past three years and 21 % reported being

mugged. Among high school students in Cleveland, 36 % reported being threatened

in the past year and 16 % reported being mugged.

In a study of 2,248 students in sixth, eighth and tenth grade, more than 40 %

of those students felt unsafe due to violence within their communities (Schwab-

Stone et al., 1995).   Furthermore, the Centers for Disease Control and Prevention

(2014) reported that 707,212 youth were treated for injuries that were sustained due to

violence within schools. When youth are exposed to community violence it can result

in halting maturity and an inability to appropriately adapt to their environment. The

previous study also suggests youth who grow up in urban areas have higher levels of

poverty and violence (Cooley-Strickland et al., 2009).

A study of male and female students from Baltimore, between the ages of 13 to 18 were asked to discuss their feelings on being exposed to violence in their community. Regardless of gender, between 93 % and 100 % had some exposure to violence (Gorman-Smith et al., 2004; Rosenthal, 2000; Scarpa, 2003). Students reported being concerned about witnessing violent acts, or being the next victim of violence (Gorman-Smith, Henry, & Tolan, 2004). Some of these students wouldn't go to school due to the overwhelming amount of violence that occurred within their school settings.

School is a place where students should be able to learn while being safe and not surrounded by violence. However, this continues to be a growing concern within schools. For example, there have been a number of school shootings in recent years and youth continue to be at risk for violence. The National Coalition for the Homeless, Safe Horizon (2012), reports that violent school threats have increased 158 % from 2010 to 2011. With these growing concerns, it's no surprise that students have issues with their educational performance. For example, Everstine and Everstine (1989) discuss how children who are traumatized often act out within the school setting with inappropriate behaviors and somatic complaints. Violence may also happen indirectly. For instance, in a study of 750 inner city high school students, Sheley and Wright (1995) report that 66 % of students reported knowing someone who brought a gun to school. This is a staggering number, and would make it difficult for any child or adolescent to effectively engage in school.

Violence, both in and outside of the schools, can lead to many issues for students. Thompson and Massatt (2005) report that violence can lead to many school

problems including concentration problems, being fixated with traumatic events, and physical illnesses. Of the youth in this study, nearly 59 % found it hard to concentrate and pay attention, two-thirds were avoidant and nearly 50 % reported more stomach aches, headaches, or sick feelings than before the traumatic event. Similarly, Cooley-Strickland et al. (2009) reported that violence that happens within the community and in schools can effect youth's cognitive development, lead to lower IQ scores, difficulties with reading and higher dropout rates. This can lead to many other issues within the schools including negative classroom behavior, in-school suspensions, out-of-school suspensions, and expulsions (Azen et al., 2006).

Having students assessed for high levels of violence can help social services within the school and help these providers be more successful in working with students over time. Within schools, violence rates are associated with multiple issues including students with a lack of support in their homes, high dropout rates and underachieving school performance (Cooley-Strickland et al., 2009). Youth will sometimes be moved to another school or drop out of school as an indirect result of trauma or violence in their life.

According to a study of 95 middle and high school students in the Los Angeles area, Limbos and Casteel (2008) report that when teachers were able to form relationships with students, teachers had better success with helping students with less incidents of violence, delinquency and positive academic performance. For students to be successful, teachers would benefit from collaborating with colleagues to find the best ways to work with students who are experiencing high levels of violence within their communities. Lack of funding can lead to violence within schools, high rates of

turnover among teachers, increased gang activity, and lack of leadership (Hoover &

Oliver, 1996). Furthermore, Limbos, and Casteel (2008) also reported that school

performance was positively affected when youth had support from the community

including family structure, housing quality and decreased crime rates.

Poverty

Poverty can be defined many different ways. The most common factor is a

lack of income but it can also mean a lack of resources to meet basic needs for food

and shelter. Poverty can also be defined by hunger, being physically or mentally sick,

not being able to access education or employment, and illiteracy (National Coalition

for the Homeless, 2014). Poverty usually leads to substandard housing and is linked

to homelessness, couch hopping and having no set address. Despite improvements in

employment, 4.8 million people live below the poverty rate. In America about 4 % of

children are homeless, which is over 1.6 million children a year. Homeless children

often have higher rates of medical and mental health issues than those who are housed

(National Alliance to End Homelessness, 2015). Homeless children have continued

issues getting to school. This can significantly affect their overall school

performance.

Since youth tend to be among the poorest of all age groups, there can be some

significant trauma due to living in poverty.   Cooley-Strickland et al. (2009) report

that poor urban children are among those most vulnerable to the development of

emotional and behavioral problems. Einhorn et al. (2008) conducted a study that

discussed the association between socioeconomic status, poverty-related stresses,

medical and mental health, and academic performance in a study of youth in poverty.

Their research suggests that youth poverty experiences have an effect on their overall functioning.

Since youth have considerable issues with trauma due to poverty, it can lead to issues with their school performance. A Children's Defense Fund (2014) report notes that due to poverty, almost 60 % of all fourth and eighth grade public school students could not read at their grade level. In 2010, only 78 % of public school students graduated from high school in four years. During the 2009-2010 school year, over half a million high school students (514,238) dropped out. Another troubling fact about youth who live in poverty is the lack of being college ready. The Children's Defense Fund (2014) reports that of the three-quarters of high school students who take the ACT college entrance exam, only one-quarter were ready for college-level English, math, science, and reading.

School districts aren't doing everything they can to help affected youth. Of all the states in America, only 11 have school districts required by law to offer full-day kindergarten.   Youth who live in poverty also struggle with getting the assistance they need to be successful in school. In 2007-2008, Alaska was the only state to spend more than 40 % more for each student in its poorest school districts than its richest (Children's Defense Fund, 2014).

Supports

Support for everyone starts at birth. This is when infants learn to trust, rely on their emotions, thoughts and react to situations. When children have secure attachments, they can learn a complex vocabulary, learn how to describe their feelings, learn how to communicate and come up with response strategies.   When

caregivers are unreliable, violent, or neglectful, children are likely to become distressed and learn that they can't obtain relief when needed (Van der Kolk, 2005). This can lead to other issues for children going forward in life. Bianchi et al. (2006) report disorganized infants are at risk of negative outcomes such as being withdrawn, having chaotic play and aggressive behaviors towards their peers in school.

When youth don't have supportive parenting, it can lead to attachment issues for those youth. For example, this lack of support and attachment can lead to long-term affects with how they others in the community. Bianchi et al. (2006) suggest that disruptive parenting can lead to disorganization in early childhood. These results in substantial issues within school as well as long-term effects such as conduct issues, mental health problems and poor school performance. Van der Kolk (2005) discusses how children with insecure attachment have difficulty regulating emotions and therefore experience more anxiety and anger. Furthermore, when youth are sexually abused it can cause even further serious issues. However, when parents are positively involved in the lives of children who are sexually abused, it can lead to improvements of children's behavior, ambition, school performance and other issues (Cohen, 2000; Cohen, 2006; Corcoran & Pillai, 2008; Trusty, 2002).

When youth grow up with poor relationships with parents, family members and others it can lead to many issues going forward. Siegel (1999) discusses that parents' attunement and emotional availability is important for their children's development. If parents are unavailable, insensitive and inattentive to their children it can affect their ability to problem solve and develop later in life. This can lead to continued issues long-term for children within social and school settings. For

instance, Berzin (2010) suggested that social or parental support is a strong factor in youth having academic goals in their high school years. Furthermore, a child's lack of supportive environments (homes and child care settings) affects brain development and impacts their ability to learn. However, when there are supportive services involved, youth can develop greater mathematical ability, greater thinking, attention skills, and fewer behavioral problems than children with lower quality care (Children's Defense Fund, 2014).

There are also many youths who grow up in non-traditional households. Within the United States, around six million children live in households headed by parents such as aunts, uncles and grandparents. Around 2.5 million of these children live in homes in which neither of their parents live with them (Noble, 2008). According to Financial Assistance for Grandparents (2004) many of these families have financial issues since their caregivers often have families of their own or have grandparents who are on a fixed income and have limited resources. There are differences from state to state, but there is financial assistance programming such as Temporary Assistance for Needy Families (TANF), foster care supplements, income for guardianship or kinship for children, income from adoptions and Earned Income Tax Credit. There are also Social Security benefits for children who are disabled, poor, and under 18.

During the last several years there has been a significant reduction in services outside of the school settings. Youth involved in childcare programs can enhance their academic performance by developing better work habits and relationships, compared with children who spend time without programs. However, many families

are unable to afford those services without help from cash assistance programming.

From 1996 to 2000, cash assistance receipt declined by 42 % for poor children in

single parent families (Children's Defense Fund, 2014). Many of these families

struggle to survive without cash assistance and food support programming.

      Youth get many supportive services within their schools. Some of the

services include social workers, counselors and teachers. Abdallah et al. (2013)

report that students obtain a variety of social skills, but social workers were also able

to identify students who are in need of additional assessment for past and current

traumas. School-based mental health services can employ many different models of

intervention or prevention depending on how schools implement their social service

programming. Porter et al. (2003) discuss how most schools have social workers.

However, there can be other professionals that are imbedded for supportive services

for students. Some of the mental health providers may have restrictions on their duties

and may not be able to offer services for students.   When this is the case, some

schools bring in other mental health professionals to provide services. Slade (2003)

states that when schools imbed mental health services, as opposed to exporting them

to community based clinics, there is a positive impact for the students. However,

there are many areas in which there are not school-based mental health services such

as schools in rural areas, smaller schools and suburban school who don't think its' a

problem.

      There have been studies on having group or block support for social support

for youth within school settings. This has been shown to build on educational goals

for youth and engage in elements related to academic performance and school

satisfaction. Studies also report that strong support systems can be highly influential

on student goals (Blustein et al., 2001; Lent et al., 2001; Marjoribanks, 2004).

Abdallah et al. (2013) conducted a study where an intervention group of students had

a significant reduction in posttraumatic stress, depression, traumatic grief, negative

school impact, and mental health difficulties compared to the wait-list group. The

program shows an impact in reducing PTSD (d = 0.76), depression (d = 1.24), mental

health difficulties (d = 0.90), and traumatic grief (d = 0.96), and a reduction on

impacts of trauma on school performance (d = 0.35). Students were described as

having a "positive behavior change" from their families, teachers, and friends (p.

315).

Supports for youth can also come from others outside of parents, traditional

support groups and professionals. Hoover and Oliver (1996) report that teachers and

coaches are in a key position to shape youth with positive, healthy directions through

classroom discussions and developing abstract thinking and idealism. Coaches and

teachers can offer support for youth by mentoring, mediation, counseling and peer

support. However, Slade (2003) reports that only 50 % of middle and high schools

have mental health services available to their students. Only 11 % of schools have

mental and chemical health services and physical exams available to students.

Parental Incarceration

The number of children with parents in prison is alarming. Between 1991 and

2007, the number of parents in prison increased almost 80 % (Glaze & Maruschak,

2010). Of those incarcerated mothers, almost half of the mothers gave birth while

incarcerated.   Since the average sentence for incarcerated mothers was around 36

months, many of these mothers rarely saw their children and hundreds of these mothers became separated from their children forever (Margolies et al. 2006). The youth who have incarcerated parents tend to have negative thoughts and feelings toward their parents. Shlafer and Poehlmann (2010) report that slightly more than one-third of the children (39 %) did not discuss their relationship with incarcerated parents. Thirty-one percent of children reported negative feelings about their incarcerated parent. The other children (28 %) reported having mixed feelings. Farrington et al. (2012) reported that when students of incarcerated fathers were asked, 38 % didn't know their parent was in jail. The non-incarcerated parent of the child would often lie about the whereabouts of the other parent who was in jail.

When fathers are in prison or jail, 89 % of children will live with their mothers and often times they live alone.   When mothers go to prison or jail, nearly 75 % of those mothers were the primary, and often sole provider for the child. This can lead to many issues for these children, including entering the foster care system due to a lack of the other parent involved (Margolies et al. 2006). Many of the youth who had incarcerated parents had no contact with their parents. This leads to permanent problems obtaining a bond with their incarcerated parent (Hairston, 1998).

When youth have incarcerated parents, it can also lead to relationship and emotional problems. Farrington et al. (2012) report when children have family who go to prison, it increases the incidence of anti-social behavior compared to peers. This can lead to long-term continued issues for youth within social and school settings. Murray (2007) reported that prisoners and their children are susceptible to social exclusion, including loss of social capital following imprisonment, stigma,

political exclusion, and poor future prospects. In some instances, having family

members in jail can lead to many issues for youth including isolation and being

rejected by peers. For example, when youth have family members in jail it can lead

to being bullied.   One child with his father in jail described how "they bully me, say

nasty things. I don't let them know I care, but sometimes I cry on the way home. The

teachers don't know my Dad's in prison and I don't want to tell them" (Boswell,

2002, p. 19).

Youth often have limited contact with their incarcerated parents due lack of

resources and transportation (Hairston, 1998; Murray, a 2005; b 2007). This can lead

the remaining caregivers of the youth to experience feelings of depression, loneliness,

reduced income and moving into undesirable neighborhoods (Farrington et al. 2012).

This can also lead to mental health issues for youth. Murray (2005) reported youth

have many problems during their parent's incarceration including depression,

hyperactivity, aggressive behavior, withdrawal, regression, clinging behavior, sleep

problems, eating problems, running away, truancy and poor school grades. Youth of

incarcerated parents also often have below average social skills in school, emotional

and academic characteristics compared to students not having incarcerated parents.

When youth have mental health issues, it can lead to academic and other

issues within school. Farrington et al. (2012) report that having parents who are

incarcerated results in poor educational performance for their children. This

eventually leads to higher drop-out rates for youth who had incarcerated parents. In

fact, the high school drop-out rates are almost three times higher and are five to six

times higher to become incarcerated than for their peers (Children's Defense Fund,

2014). This can also lead to long-term attachment issues, which can produce negative

behaviors later in a youth's life (Bowlby, 1980; Bowlby, Ainsworth, Boston &

Rosenbluth, 1956; Shlafer & Poehlmann, 2010). Teachers have also expressed

concerns that these students are more prone to fighting, bullying, arguing, and

defiance. Teachers are also concerned about their students relationships with peers,

lack of trusting others and neediness. Shlafer and Poehlmann (2010) conducted a

study where 32 % exhibit borderline or clinically significant externalizing problems

and 44 % of youth exhibit borderline or clinically significant internalizing problems.

Cultural Differences

Traumatized youth of varying cultures experience trauma at a higher rate than

other cultures. For example, African American students have the highest rates of

trauma at 8.7 %, followed by White students 7.4 %, then Hispanic students at 7.0 %

and Asian students, the lowest at 4.0 %. African American and Latinos have higher

rates of child maltreatment, such as domestic violence. Asians, African American

men, and Latina women have higher risk of war-related trauma than Whites (Breslau

et al. 2011). Different cultures also work through their mental health symptoms and

traumatic events in different ways.

Throughout history, people from different cultures have been found to have a

lack of culturally suitable treatment. Youth from these different cultures often have

less access to mental and medical services because of poverty, mental health issues,

underfunded schools, violent communities and high rates of students within the

juvenile system (Kennedy & Bennett, 2006; McGauhey & Starfield, 1993; Oswald &

Coutinho, 1996). When working with African American and Latino families, it is

important to take into account factors with families before utilizing traditional mental health services such as psychiatry, traditional therapy and medications (Pumariega, 2003).

Different cultural groups also access services for their youth in various ways. According to McMiller and Weisz (1996), African-Americans and Latinos are less likely than Caucasians to obtain help from agencies and professionals. African Americans and Latinos are also less likely to obtain help for their children's mental health symptoms through professionals and more likely to obtain help from family psycho education. However, Slade (2003) reports that students with different cultural backgrounds had positive results with on-site mental health services in schools.

There are many cultural differences between youth who are struggling in schools. Many of these issues stem from the lack of traditional families. According to Kids Count Data Center (2015) 35 % of American children under the age of 18 are raised by single parents. However, 67 % of African American, 52 % of American Indian and 42 % of Hispanic youth are raised in single parent homes. That number is significantly higher compared with that of the 25 % of white single parent homes (U.S. Census Bureau, 2004). This can lead to significant long-term issues for different cultures including failing grades and academic problems.

During the 2011-2012 school year, only 81 % of all students graduated with a high school diploma. The differences among cultures consisted of only 66 % of African American students graduating, 68 % for Native American students and 76 % for Latino students (National Center for Education Statistics, 2015). There are also differences in the rates of dropouts among different cultures. According to Alegria et

al. (2011), Asians have the lowest dropout rate (5.58 %). Whites are the second

lowest (8.37 %), followed by African Americans (17.19 %), Afro-Caribbean (19.02

%), where Latinos have the highest dropout rate (38.89 %). One of the main

contributing factors of dropout rates has to do with the major childhood trauma.

Nineteen point seventy-nine percent of all cultures combined drop out of school.

Some of main reasons Latino youth drop out of school is due symptoms of anxiety

from trauma and lack of cultural specific resources for mental health services

(Townsend et al. 2007).

Finally, there is significant difference in other cultures with regards to special

education programming. Although there are only 16 % African American students in

schools, 32 % end up in special education programming and Latino students have

similar numbers (Job & Zorigian, 2010).   Different areas of the country seem to tend

toward similar results. For instance, 5.5 % of students report they are

developmentally delayed. However, African American children are 2.3 times more

likely to be labeled developmentally delayed than White students. This also tended to

be true for Latino and Native American children (Oswald et al. 1999). However,

some schools have much higher discrepancies. For example, the Charlotte-

Mecklenburg school located in North Carolina, has a population consisting for 30 %

African Americans students, 11 % for Latino and 53 % for Whites within the school.

Within this school there was twice as many African American students in special

education than White students (Job & Zorigian, 2010).

Trauma Treatments

CBT is a form of psychotherapy that explores the relationships of a person's thoughts, feelings and behaviors. CBT has also been shown to be a widely successful form of treatment in working with many different diagnoses including depression, anxiety, bipolar, and schizophrenia (NAMI, 2015). There are many forms of treatment for people who have experienced trauma, but the most common, effective treatment for working with traumatized youth is CBT (Chaffin & Friedich, 2004; Wertherington et al., 2008). CBT treatment is often short-term and offers help with psycho education and affects regulation by working with youth on their internal problems and negative self-talk patterns. CBT therapists are well trained and have been treating trauma for many years. However, there have been modifications to traditional CBT interventions. Wertherington et al. (2008) found that when working with individuals and groups, CBT interventions reduce PTSD symptoms such as anxiety, depression, and external problems.

There is also CBT that is more focused on trauma called trauma-focused cognitive-behavior therapy (TF-CBT). Bender et al. (2010) report that TF-CBT works with youth by utilizing cognitive reframing, stress management and, if possible, involving parents or caregivers. This can be a more specific approach than that of traditional CBT treatment. According to the National Child Traumatic Stress Network (2012), TF-CBT can be modified in many different settings including school specific settings. TF-CBT can work with youth who have significant emotional and behavioral issues from their trauma. Through TF-CBT, youth can learn to develop trusting relationships, social skills, coping skills and to cope with various mental health symptoms (Cohen et al. 2004).

When using the TF-CBT model, the acronym 'PPRACTICE' uses: Psycho

education or information for trauma victims about trauma; Parenting skills or

behavior management; Relaxation skills; Affective modulation skills or reactions to

trauma; Cognitive coping skills or understanding connections between thoughts,

feelings, and behaviors; Trauma narrative and processing or discussing the stories of

trauma that are related to the trauma; In vivo mastery overcoming their fears;

Conjoint parent-child meetings; and Enhancing safety for future planning (Cohen et

al., 2010).

Building on TF-CBT, game-based cognitive behavioral therapy (GB-CBT)

uses play therapy and the use of games so children can express their thoughts and

feelings. The GB-CBT programming uses age appropriate games in which providers

and their peers can build stronger relationships with children and adolescents. For

instance, some of the games consist of competitions, card games, board games and

playing with others (Reddy et al. a 2001; b 2005). The GB-CBT practice model can

help youth develop social skills such as conversational skills, appropriate boundaries

and respecting personal space. This discusses how GB-CBT has been successful in

decreasing symptoms of anxiety and trauma (Cohen, 2006; Deblinger et al. , 2001;

Johnson & Young, 2007). By using this treatment framework, children can reduce

self-blame, shame, and embarrassment by using reframing techniques. Reddy (2005)

reports youth can have better relationships, build social skills, build confidence and

feel accepted within their peer group through GB-CBT.

Another form of school-based treatment is cognitive behavioral intervention

for trauma in schools (CBITS). CBITS is similar to other forms of treatments

including CBT and TF-CBT as it is geared to working with youth who struggle with PTSD, depression and anxiety (The National Child Traumatic Stress Network, 2013). CBITS has been mainly geared towards working with youth between the ages of 10 and 15. Sessions consist of both individual and group settings, which are about one-hour sessions. CBITS teaches six cognitive-behavioral techniques including education on trauma, relaxation techniques, real-life exposure, cognitive therapy, stress and trauma exposure and social problem solving (The National Child Traumatic Stress Network, 2013). CBITS have been successful in reducing symptoms such as PTSD, depression and youths' overall functioning within school settings (Jaycox, et al., 2009).

School Outcomes

Traumatized youth have been affected by various forms of trauma such as their outcome of trauma, violence, poverty, lack of supports and parental incarceration that all affect their school performance. Throughout this conceptual framework, it's important to see how those traumas affect youth's grades, school refusal, negative classroom behaviors and their social skills.

Grades.

When youth have experienced trauma, they are greatly affected in many ways in school, but often the most recognizable it their overall grades. According Children's Defense Fund (2010) report that 10% of all children suffer from mental illness serious enough to struggle within school. Other issues such as violence directly impacts youth's ability to learn due to intrusive thoughts that prevent them from paying attention, being able to study, get homework done or performing well on

tests. This exposure to violence also impacts youth's overall IQ and learning abilities. Also when youth live in poverty, the may not be prepared for the start of school and are less likely to graduate (National Coalition for the Homeless, Safe Horizon, 2012). Youth who have a parent in prison are less likely to be successful in school and are far less likely to go onto college. With all those factors, traumatized youth need all the support they can get through the treatments that are utilized in this systematic review.

School refusal.

Some students also struggle to get to school altogether due to the trauma they experience. Traumatic events such as family issues, violence in communities and within schools, poverty and parental incarceration can all lead to school refusing behaviors. Often times, youth may be dealing with many different symptoms including depression, anxiety or PTSD. School refusal can also stem from violence they experience at home, within the community or at the school itself. Excessive absences are also far more prevalent in youth who live within poverty. Youth who also don't live within a supportive environment or live with parents dealing with their own mental and chemical health issues can all lead to school refusal issues with traumatized youth. According to Don't Call Them Dropouts (2014) 79% of traumatized youth who don't go to school have at least one parent who is incarcerated. School refusal can also be from issues within school such as academic issues or learning difficulties or anxiety with being away from parents

Negative classroom behaviors.

When youth experience various forms of trauma, this can also lead to negative classroom behaviors. Some of the issues that happen within their classroom settings include acting out in class, such as verbal abuse of both students and teachers, harassment of teacher or other students, threats to harm others with physical violence, creating a hostile work environment, inappropriate demands for attention, refusing to comply with classroom directions and interfering with the teacher's presentation during class. Bianchi et al. (2006) suggests that lack of parental support can lead to substantial issues within school as well as long-term effects such as conduct issues, mental health problems and poor school performance. Some emotional issues include anger, rage, shame, opposition, unusual aggression or reckless behavior. These behaviors can lead to various forms of dismissal from class, not completing assignments and missing out on learning opportunities. If enough of these behaviors continue these negative behaviors can lead to suspensions and eventual expulsions.

Social Skills

Trauma also can lead to long-term effects with how students interact with their peers, teachers and others. When traumatized youth have social difficulties it can lead to many issues within school. When youth are traumatized it can lead to avoiding their peers, anti-social behavior, lack confidence with making friends and affect normal social development (Finkelhor et al. 2007; Massachusetts General Hospital, 2010; NAMI, 2009). Due to the trauma these youth experience, they distrust adults or other students as well. Traumatized youth can also struggle with social skills that are age appropriate. This makes it difficult for these youth to

develop their relationship skills with other students and their teachers. After a while youth tend to fall behind academically or refuse to go to school.

It is important for youth to get the best available treatment for their symptoms. The best treatment options should be based on current research, evidence-based practices and clinically adept social service workers. It's important to use those evidence-based practices to focus on improving traumatized youths' grades, school refusal, negative classroom behaviors and social skills. By choosing these theories as a framework it can also help clarify the varying effectiveness of CBT, TF-CBT, GB-CBT, and CBITS and how it impacts trauma symptoms and indirectly on school performance.

Since there is a lack of research that discusses how traumatic events affect school performance in youth, this systematic review helps identify what treatments are most helpful for youth in schools. Therapies such as CBT, DBT, TF-CBT, CBITS and GB-CBT all work to decrease symptoms and link youth with strategies to improve their school performance.

Conceptual Framework

Evidence-Based Practice

The conceptual framework of this research project is based on evidence-based practices such as cognitive behavioral therapy (CBT), psychodynamic theory, conflict theory and systems theory. These evidence-based practices are based on research studies and are time-tested in their ability to positively affect mental health and trauma. Clinical experience is also developed by continuing to work with varying kinds of clients, making clinical decisions and merging clinical research with treatment planning choices (Sackett et al., 1996). Mental health providers use their clinical experience in combination the research they conduct to deliver the best possible care for all clients. The purpose of this study is to review the current literature for CBT, GB-CBT, TF-CBT and CBTIS for trauma that directly helps school performance of traumatized youth.

Evidence-based practices were first utilized to train medical residents who were not experienced in applying these types of interventions in a clinical setting (Sackett et al., 1996). When residents had clinical research and evidence-based practices on which to base their clinical decisions, they were better able to critically assess patients' needs and provide the best care. Successful evidence-based practice requires using the available research, having clinical proficiency, and being aware of a client's needs, values, and considerations. Some researchers are under the belief that mental health providers often don't make use of current research or evidence-based practices (Mullen et al., 2008). There is sometimes a divide between what research shows as the best practice and how schools, agencies, hospitals and professionals are

functioning within those settings (Mullen et al., 2008). It is very important for social

workers and other mental health providers to integrate current research in their

practice, but also maintain clinical discussions about what was effective with their

clients.

There are many barriers to using evidence-based practice in the field of social

work. Some of the barriers consist of a lack of information about evidence-based

practices, where to access these practices or clients expressing suspicion about using

new practices (Bellamy et al., 2006). Researchers also report uncertainty regarding

the definition of evidence-based practice in social work. Some social workers

struggle with scarce access to journal articles, lack of time to keep up on the recent

research and not being aware or able to find research studies. Other social workers

think that some evidence-based practices are not effective at addressing cultural

differences and client strengths. Some social workers are apprehensive about certain

evidence-based practices, as they may be seen as intended to "control" mental health

providers while ignoring their clinical expertise and judgment (Bellamy et al., 2006).

In the end, there are many barriers in accomplishing evidence-based practice in social

services. This can, at times, affect the client's ability to obtain the best care possible.

Overall, evidence-based practices are very important for social workers and

how to work with traumatized youth within the school setting. Evidence-based

practices are also important because are effective for traumatized youth and work

within their specific diagnoses. For example, it can provide consistency with their

treatment, reduce the amount of time families have to utilize behavioral health

treatment, increases adherence for traumatized youth and maybe most importantly empower traumatized youth to get the treatment they need.

Social Science Theories

There are many theories and systematic approaches used when working with youth who struggle with school performance. Psychodynamic theory shows how issues youth face in life is often rooted in their childhood experiences. The psychodynamic theory discusses the importance of how internal and external factors play into how people cope with everyday life stresses. So it's important to note that psychoanalysis works with both the inner and external world of the individual and gives them the capacity to cope with everyday life. Robbins et al. (2012) discuss how those experiences are central in the patterning of emotions, and therefore, central to problems of living throughout life. So when youth are faced with traumatic events within their childhood, they tend to struggle in many areas throughout their life. This especially presents itself in difficulties with confidence, which directly relates to performing well in school.

Youth who experience traumatic events often have conflict within their own families. Conflicts theorists also see child abuse or family violence as a result of lack of power for children with abusive family members. Miley et al., (2012) discuss conflict theory as a sense of power being unequally divided within cultures or groups. Often times abused youth grow up in unstable homes filled with violence, poverty and single-family homes. These factors can all affect an ability to engage in school and school performance.

Systems theories are used to recognize, understand and tackle problems within social systems. A system is a set of things or parts that interact with one another and serves a common purpose or goal. These components constitute a "system", which functions or operates within a field or an environment. For example, social service providers can work with youth to improve social conditions and work within family systems to identify how it functions. Social service professionals can then identify the negative impacts of the family system and understand how they can help change those negative aspects for youth who are experiencing school performance issues. Miley et al. (2012) discuss using systems theory to work with youth at all of the micro, mezzo and macro levels within their environment to affect school performance. For instance, at the micro level, social workers can work with youth and families within the school. At the mezzo level, social workers can organize committees within schools to focus on changes for services for youth. Finally, at the Macro level, social workers can lobby legislatively for more services within school settings. Robbins et al. (2012) use the ecosystem perspective to show how family behaviors interconnect with their environment. The ecosystem perspective is helpful when working with students individually or being able to prioritize their concerns.

There can be many barriers when working with different theoretical perspectives. For instance, psychodynamic therapy processes don't work for everyone and can be interpreted in many different ways. Other critics of psychodynamic theory suggest that the model relies immensely on beliefs about the unconscious mind that are hard to prove. Criticisms of conflict theory have to do with a lack of shared values within society. Conflict theory doesn't look at social

structure and how "social patterns" can cause people in society to be have lack of power. Buschbacher (2002) reports that early interventions with youth by social service professionals can be beneficial when there are issues residing with their family system. Systems theory does not discuss the individual, but rather only the entire system or family. This is a barrier and makes it difficult for social workers to decide what areas to work on with traumatized youth and how there can be specific changes made.

It is important for youth to get the best available mental health treatment. The best treatment options should be based on current research, evidence-based practices and clinically adept social service workers. Using the conceptual framework of evidence-based practice, psychodynamic theory, conflict theory and systems theory, this research study attempts to distinguish the strengths and limitations of four therapies for youth experiencing traumatic symptoms. By using evidence-based practices as well as different theories and perspectives it can help youth become successful in their school performance. By choosing these theories as a framework it can also help clarify the varying effectiveness of CBT, GB-CBT, TF-CBT and CBITS directly on trauma symptoms and indirectly on school performance.

Methodology

A systematic review was chosen to examine the considerable amount of research and journal articles available. The purpose of this systematic review was to examine how traumatized youth's school performance was affected by specific trauma therapies. This systematic review consisted of detailed inclusion criteria, a well-defined search strategy and an unbiased way of gathering the findings.

Research Design

This systematic review was organized to examine the effectiveness of various specific trauma therapies on traumatized youth's school performance. A systematic review depends on scientific methods in order to limit errors of biased research and analyze all appropriate studies to focus on the designated question. In addition, a systematic review discusses policy, limitations, the need for future research, social work implications and procedure practices of various trauma specific treatment therapies (Petticrew & Roberts, 2005).

Due to these factors and a need to explore how traumatized youth's school performance is affected, there were many different studies of trauma therapies utilized for this systematic review. This systematic review evaluated the effectiveness of CBT, TF-CBT, GB-CBT and CBITS with the traumatized youth's school performance and how it affected their grades, school refusal, negative classroom behaviors and social skills.

Data Collection

Selection process.

The objective of the review was to distinguish how youth's school performance was affected by various trauma treatment therapies. Articles included that reviewed 1) youth who had experienced trauma or mental health symptoms associated with trauma, 2) a cognitive behavioral trauma specific intervention and 3) specifically discussed school performance. Initially inclusion criteria for school performance focused on grades, school refusal and truancy but was later expanded to negative school behaviors and social skills due to lack of available research. Additionally, the articles that were reviewed were published between the years of 1989 and 2015. Also, the studies included youth that were no older than 18 years old, due to the average age of a high school graduate. Finally, all research articles were then further selected that specifically addressed the theoretical interventions of CBT, TF-CBT, GB-CBT and CBITS.

Search strategy.

The search for research articles for the systematic review was conducted from September 2015 through April 2016. Figure 1 depicts the search strategies for obtaining journal articles. The following electronic databases were utilized: ERIC, Academic Search Premier, Social Work Abstracts, SocIndex with Full Text, PsychInfo and dissertation abstracts. The search terms that were used are shown in Table 1 including: trauma therapies, trauma, school performance, youth and mental health symptoms. All articles that were found were peer-reviewed articles, clicking the peer-reviewed tab ensured this. After research articles were found, the writer

reviewed the titles, abstracts, results and discussions to assess if the articles would be appropriate for this systematic review.

The abstracts of the 2,634 articles were reviewed to ascertain whether the theoretical frameworks of the articles were appropriate for the review. The abstract review resulted in 91 articles for further assessment. Many of the articles were duplicated and only needed to be included once. Of the 91 articles, 43 had potential to meet inclusion criteria. Twenty articles met full inclusion criteria and were included in this systematic review.

Table 1
Search Categories and Terms

Search Categories	Search Terms
Trauma therapies	Cognitive Behavioral Therapy (CBT), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), trauma-focused therapy (TF-CBT) and Game-Based Cognitive Behavioral Therapy (GB-CBT).
School performance	Failing grades, skipping class, dropping out of school, social skills and classroom behaviors.
Youth	Children, child, adolescents, youth
Mental health symptom management	PTSD, depression, anxiety

Data Abstraction and Analysis

The following information was abstracted from the research in order to determine which articles would be utilized for this systematic review. Each of the twenty articles were reviewed on several occasions and important data was abstracted during these reviews. Firstly, the articles needed to address all selection criteria as addressed in the inclusion criteria. Secondly, the articles were further reviewed and abstracted based on the criteria of school performance as defined by grades, school refusal, truancy, negative classroom behaviors and social skills. These criteria allowed for a theoretical framework defining school performance so research is able to be systematically reviewed for the effectiveness of the specific trauma therapies.

To determine what constituted trauma or traumatic event the youth must have had one or more traumatic events. Data was abstracted that referenced traumatized youth and their various forms of trauma. Youth's traumas included violence within their communities, the poverty they experienced, their lack of support and parents involved within the criminal justice system.

Finally, data was abstracted that concerned treatment therapies outcomes for traumatized youth. The trauma therapies included in this review were CBT, TF-CBT, CBITS and GB-CBT.

All of the articles abstracted had to include how traumatized youth's school performance was affected due to the use of the four trauma therapies. This narrowed down the articles for analysis to 20 articles. Once the data was abstracted it was compiled into a table in Appendix E and used for analysis.

Findings

The analysis was composed from 20 research articles that address traumatized youth's school performance as it is affected by CBT, TF-CBT, CBITS or GB-CBT therapies. The trauma-focused treatments were delivered within classroom settings, out of the classroom, in groups and individually with traumatized students. The traumatized youth were specifically selected to receive treatments of CBT, TF-CBT, CBITS and GB-CBT to affect their struggling school performances in regards to grades, school refusal, negative classroom behaviors and social skills.

Grades

One of the most measurable ways to analyze how trauma therapies affect trauma symptoms in youth is to examine their overall grades.   Eight studies within this systematic review utilized outcomes from trauma therapies to assess traumatized youth's grades. All research findings for Grades are located Appendix A.

Of the eight articles, three articles used TF-CBT as a school-based trauma treatment for youth to measure improvements in their grades. EPISCenter (2015), Saltzman, et al. (2001) and Cohen et al. (2006) all analyzed the use of TF-CBT in schools and found that it positively affected student's grades. Saltzman et al. (2001) conducted a study with 812 middle school students utilizing TF-CBT who were experiencing PTSD symptoms and struggling within school. Of the 812 students, 58 utilized group TF-CBT treatment. While using TF-CBT students were able to show a significant improvement in their GPA within the sample post-treatment and a pre-post reduction in PTSD symptoms.

Cognitive behavioral therapy

Of the eight articles, one article used traditional cognitive behavioral therapy (CBT) as a school-based treatment for youth experiencing trauma. Fischer and Ruffolo (2009) conducted a study with 9-17-year old students over a nine-week period. This school-based CBT was in a group setting and showed significant decreases in depression and negative mood. According to teachers of this study, students who participated in the CBT groups were able to complete more homework assignments and earned better grades.

Trauma focused cognitive behavioral therapy

EPISCenter (2015) utilized Trauma Focused Cognitive Behavioral Therapy (TF-CBT) therapy over a 12-18 week time period. These sessions lasted 60-90 minutes and consisted of working both with youth who had experienced trauma and their parents. Through these sessions traumatized youth improved their school performance.   Cohen et al. (2006) utilized TF-CBT treatment over a 12-18 sessions, with sessions lasting 50 to 90 minutes. These therapy sessions were conducted in numerous different settings including hospitals, schools, in-home, in a community or in a group home setting. Findings showed that youth were able concentrate better in school, thus improving their overall grades.

Game based-cognitive behavioral therapy

Of the eight articles for this systematic review there were no findings in regards to grades when utilizing GB-CBT.

Cognitive behavioral intervention for trauma in schools

Of the eight articles, three used Cognitive Behavioral Intervention for Trauma in Schools (CBITS) as a school-based treatment for youth with improvements in

grades as an outcome measure. Kataoka et al. (2011**),** Jaycox et al. (2011) and

Kataoka et al. (2011) all discussed the use of CBITS and how it positively affected

youth's school performance on a number of outcomes, including grades. Kataoka et

al. (2011**)** conducted a study of 123 middle school students who were experiencing

violence in the Los Angeles area. The CBITS framework was conducted through

random assignment with 59 of the students and the other 63 were part of the delay

group. The students who had CBITS did better in math and were more likely to have

a grade of "C" or higher.   However, there was no significant differences between the

immediate and delay groups. The study also conducted CBITS in group settings

which consisted of 10 group sessions and 1-3 individual sessions. CBITS showed

significant results in both math and language arts then with the other students in

delayed intervention group.

Additionally, Jaycox et al. (2011) conducted a study during the 2008–2009

school year, with 214 students across 30 different schools. Of the students who

participated in CBITS, there was a significant pre- to post-CBITS decline in PTSD

symptoms. During this study, those schools obtained data on school performance

grades from both fall and spring report cards. About 25% of the students

participating in CBITS improved their grades in math, reading, and writing. Other

results consisted of 62% of youth maintaining their grades and about 13% having

worse grades. Jaycox et al. (2011) reported these findings as CBITS positively

effecting grades as a measure of school performance.

Finally, Kataoka et al (2011) used CBITS treatment with 10 group sessions

and one to three individual sessions. Social workers conducted the CBITS treatment

sessions during one class period per week. Youth within group settings showed a

higher GPA in both math (2.0 vs. 1.6) and language/arts (2.2 vs. 1.9). These results

were compared with youth who had delayed interventions. However, math scores

were found statistically significant. After CBITS interventions were conducted,

youth were projected to pass math (69.5%) and language/arts (79.7%) at a much

higher rate than youth with delayed intervention (math: 54.7%; language/arts:

60.9%).

School Refusal

One of the most common forms of measuring school performance outcomes

of trauma therapies with youth is school refusal. School refusal is defined as truancy

or "dropping out" of school. Seven studies within this systematic review utilized

trauma therapies to assess traumatized youth's school refusal. All research findings

for School refusal are located Appendix B.

Cognitive behavioral therapy

Five articles used Cognitive Behavioral Therapy (CBT) as a school-based

treatment for youth who had experienced trauma with school refusal as an outcome.

Heyne (2011), Bernstein et al. (2010), Tolin et al. (2009), Brendel (2015) and Fischer

and Ruffolo (2009) all discussed the use of CBT and its effects on students' school

refusal.

Heyne (2011) conducted a study using CBT treatment with twenty students

who were refusing to go to school. All of the students met criteria for anxiety and

participated in a non-randomized trial, with parents and other school staff.   The main

goal of the study was to measure improvements of students' attendance through the

use of CBT for anxiety-based school refusal in adolescence. After a two-month

follow up, students improved their school attendance.

Bernstein et al. (2010) conducted a study of students who utilized medications

combined with CBT treatment to improve their school refusal and overall attendance.

With the use of medications such as anti-depressants, combined with CBT treatment,

there were significant effects of improving school attendance and decreasing

symptoms compared to a group with no treatment involved.

Tolin et al., (2009) conducted a study with four male youth who were

struggling with school attendance, among other aspects of school. CBT was

conducted over 15 sessions over a one-week period. CBT was shown to work well

with three out of four students increasing their attendance significantly.

Brendel (2015) conducted a study with CBT treatment and medication

management for youth dealing with anxiety issues. The findings of effects of CBT

treatment with medications and anxiety were mixed. The treatment proved successful

for youth with attendance issues compared to the control group. However, the results

of increased attendance also showed outcomes of increased in anxiety for these youth.

The Fischer and Ruffolo (2009) study conducted with a school-based, group

CBT intervention showed a positive effect on grades. Teachers in the middle school

also reported improvements in attendance with the youth who participated in school-

based CBT group sessions.

Trauma focused cognitive behavioral therapy

Of the seven articles, two used TF-CBT as a school-based trauma treatment

for youth and improvements with school refusal. Cohen et al. (2006) and EPISCenter

(2015) both discussed the use of TF-CBT in a school-based setting with youth who had experienced trauma. Both studies found that TF-CBT was effective for improving school attendance.

Game based-cognitive behavioral therapy

Of the seven articles for this systematic review there were no findings in regards to school refusal when utilizing GB-CBT.

Cognitive behavioral intervention for trauma in schools

Of the seven articles for this systematic review there were no findings in regards to school refusal when utilizing CBITS.

Negative Classroom Behaviors

Negative classroom behaviors were another outcome used to measure the effects of trauma therapies on school performance. Negative classroom behaviors were defined as externalizing behaviors in the classroom, failing to respect other students, creating excessive noise, being aggressive, restlessness, using profanity, harassing students and teachers, threats to oneself or others and being psychically aggressive. Fourteen studies within this systematic review utilized trauma therapies to treat traumatized youths as measured by their negative classroom behaviors.   All research findings for Negative Classroom Behaviors are located Appendix C.

Cognitive behavioral therapy

Of the 13 articles, four used CBT as a school-based trauma treatment for youth and improvements with negative classroom behaviors. Azen et al. (2006), Walkup et al. (2008), Fischer and Ruffolo (2009) and Bernstein et al. (2010)

discussed the use of CBT and how it affected negative classroom behaviors. All studies showed a reduction in negative classroom behaviors after CBT therapy.

Azen et al. (2006) conducted a review of 75 studies comparing behavioral parent training (BPT) and CBT. Forty-five studies with 2,745 participants were included in the CBT study. The study had an age range of youth 5 to 18 years old. CBT was shown to be effective in treating aggression, restlessness and behavior problems with youth. Walkup et al. (2008) conducted a study with 488 youth between the ages of 7 to 17 who were diagnosed with anxiety or social phobias. The youth had 14 sessions of CBT paired with a combination of medications. Youth within the study improved their insomnia, fatigue and restlessness when CBT was used along with medications.

Fischer and Ruffolo (2009) indicated that school-based CBT in a group setting showed significant decreases in depression and negative moods. Six weeks after the study was completed students still reported positive changes in their moods, but this was shown to be no longer statistically significant. There were no significant differences noted between the older, high school adolescents and the younger, middle school adolescents on depression measures. Differences based on race/ ethnicity and gender were also not significant.

Bernstein et al. (2010) conducted a study of students utilizing medications combined with CBT treatment to improve school performance. With the use of medications, combined with CBT treatment there were significant effects of improving school attendance and decreasing symptoms compared to a group with no treatment involved.

Trauma focused cognitive behavioral therapy

Five of the 13 articles used negative classroom behaviors as a measure of the effectiveness of TF-CBT as a school-based trauma treatment. EPISCenter (2015), Cohen et al. (2004), Child Welfare Information Gateway (2012), Cohen (2010) and Cohen et al. (2006) discussed the use of TF-CBT and its effects on negative classroom behaviors. EPISCenter (2015) utilized TF-CBT therapy with both traumatized youth and their parents. Through these sessions youth showed significant improvements with externalizing behaviors as well as sexualizing behaviors.

Cohen et al. (2004) conducted a study with 229 youth ages 8-14 years old that utilized separate treatments of TF-CBT and Child Centered Therapy (CCT). Their findings indicated that youth treated with TF-CBT experienced fewer intrusive thoughts and avoidance behaviors. Youth also reported being able to cope with their emotions, had a reduction in behavior problems, sexualized behavior, and trauma-related shame.

Child Welfare Information Gateway (2012) reports that TF-CBT reduced symptoms of PTSD, depression and behavioral difficulties. When compared with other interventions, TF-CBT was shown to be more effective at helping students cope with their behavior problems and trauma-related shame and help develop safety skills.

Cohen (2010) conducted a study with 124 youth aged 7-14 years old. The study consisted of eight sessions of TF-CBT. Youth within this study showed improvements in intrusive thoughts and reported being able to cope to better with their emotions. Youth had a reduction in behavioral problems including sexualized

behaviors and were able to cope better with reminders of the trauma and associated

trauma related shame. Cohen et al. (2006) had similar findings for TF-CBT

effectively reducing trauma related behaviors, symptoms and shame.

Game based-cognitive behavioral therapy

Finally, of the 13 articles, three used GB-CBT as a school-based trauma

treatment for youth and improvements with negative behaviors. Cohen (2006),

Deblinger (2001) and Johnson and Young (2007) indicated that GB-CBT was able to

effectively reduce negative classroom behaviors. Cohen (2006), Deblinger (2001)

and Johnson and Young (2007) discuss how GB-CBT has been successful in

decreasing symptoms of anxiety and trauma. By using this treatment framework,

children were able to reduce self-blame, shame, and embarrassment by using

reframing techniques.

Misurell et al. (2011) conducted a 12-week GB-CBT program with 90 minute

sessions. GB-CBT was designed to treat children who were sexually abused. The

study consisted of 48 sexually abused children from the ages of 5-10 years old. Their

findings showed that GB-CT was effective for improving internalizing and

externalizing symptoms, reducing sexually inappropriate behaviors, and improving

children's knowledge of abuse and self-protection skills.

Cognitive behavioral intervention for trauma in schools

Of the 14 articles, one used CBITS as a school-based trauma treatment for

youth and measuring effectiveness of changing negative classroom behaviors. Stein

(2003) conducted a study during the 2001-2002 academic school year with sixth

grade students in two large Los Angeles middle schools. The study utilized a CBITS

intervention, no significant differences were found between groups for symptoms of PTSD, depression, parent-reported psychosocial function, or teacher-reported classroom behaviors. Stein (2003) found that CBITS had no effect on reducing negative classroom behaviors.

Social Skills

The final measureable aspect of the effectiveness of trauma therapies for traumatized youth was improvement in their social skills within school settings. Seven articles had findings showing how trauma therapies can be effective in working with traumatized youth on their social skills.   Of the eight articles, there were no findings on social skills as an outcome for CBITS treatment for traumatized youth. All research findings for social skills are located Appendix D.

Cognitive behavioral therapy

Of the seven articles, three used CBT as a school-based trauma treatment for youth and improvements with social skills. Abdallah et al. (2013), Cohen et al. (2004) and Fischer and Ruffolo (2009) discussed the use of CBT and how that was able to effect traumatized youth social skills for the positive.

Abdallah et al. (2013) conducted a study with 11-14-year old students in Nablus, Palestine. Over 50% of the students were experiencing high levels of PTSD and living in environments of ongoing violence. Students who worked within the CBT framework improved their social skills and their overall learning capacity.

Cohen et al.(2004) conducted a study of two hundred and twenty-nine 8-14 year old youth when utilizing TF-CBT and Child Centered Therapy (CCT).   Youth

reported that when treated with CBT they were able to obtain improvements in their overall social skills at posttest than youth who received supportive therapy.

However, there was one study that was unable to find and results in CBT and social skills within schools. Fischer and Ruffolo (2009) showed no significant changes in student's relationships with their peers after a CBT intervention.

Trauma focused cognitive behavioral therapy

Of the seven articles, three articles used TF-CBT as a school-based trauma treatment for youth and for improvements with social skills. EPISCenter (2015), Cohen et al. (2006), Cohen et al. (2004) and all indicated that TF-CBT had a positive effect on social skills for youth who had experienced trauma.

EPISCenter (2015) showed that through sessions of TF-CBT traumatized youth improved their social skills by decreasing anti-social behaviors and improved communication with their parents, teachers and other students. Cohen, et al. (2006) findings showed significant results in reducing youth's mental health symptoms, improving trust and social competence in relationships, improving personal safety skills and developing better ways to cope with their trauma. Through treatment, traumatized youth were able to develop better friendships and become more successful in school. Cohen et al. (2004) also showed that TF-CBT improved traumatized youth's trust and social competence.

Game based cognitive behavioral therapy

Of the seven articles, four articles used GB-CBT as a school-based trauma treatment for youth and improvements with social skills. Cohen (2006), Deblinger (2001), Johnson and Young (2007) and Misurell et al. (2011) discussed the use of

GB-CBT and its effect on social skills with traumatized youth. Cohen (2006)

Deblinger (2001), and Johnson and Young (2007) discuss how GB-CBT has been

successful in decreasing symptoms of anxiety and trauma. Findings suggest that GB-

CBT programming has positive effects on mental health symptoms. Through those

improvement, youth were able to improve their social skills among their peers and

thus improves overall school performance.

Misurell et al. (2011) conducted a study with GB-CBT that had inconclusive

findings. Their results pointed in a positive direction for social skills and self-

perception, but the findings were not statistically significant.

Cognitive behavioral intervention for trauma in schools

Of the eleven articles for this systematic review there were no findings in

regards to social skills when utilizing CBITS.

Discussion

Through a review of the 20 articles, findings show that traumatized youth struggle with school performance as measured by their grades, school refusal, truancy, negative classroom behaviors and social skills. The systematic review of these articles was intended to analyze whether various trauma therapies applied in a school setting were effective at improving youth's school performance. The traumatized youth population for the review included student's ages of five and before the graduation age of 18 with mostly positive effects for the participants involved in their trauma therapy experience.

Eight of the articles are replicated throughout the findings as the treatment therapy was shown to affect one or more of the school performance criteria. The overall objective of this systematic review is to show how CBT, TF-CBT, GB-CBT and CBITS treatments are effective in affecting traumatized youth and their school performance.

Through this systematic review the findings show that trauma therapies are effective for traumatized youth and their school performance. However, the review indicates that some of the therapies are more effective than others. This systematic review's findings show that CBT treatment is the most effective treatment for traumatized youth's school performance (Chaffin & Friedich, 2004; NAMI, 2015; Wertherington et al., 2008). CBT also has the most available articles with relevant findings which could have contributed to it being the found the most effective. CBT treatment is effective across all four categories including grades, school refusal, negative classroom behaviors and social skills.

Nine of the ten research articles showed positive outcomes while using CBT treatment. For example, Fischer and Ruffolo (2009) utilized school-based CBT within group settings. This study showed significant findings of improvements in traumatized youth completing homework and thus improving grades, truancy, positive changes in their moods, and improvements in social skills with peers. However, Brendel et al. (2015) reported mixed findings with school attendance. The findings of this study found CBT treatment to only be successful when the treatment was used in combination with medication management.

Finally, the available research on CBT had the only article to utilize a different cultural group as its population. Abdallah et al. (2013) conducted a study of Palestinian students who were suffering from trauma within school performance. Over 50% of the students were experiencing high levels of PTSD and living in environments of ongoing violence. Students who worked within the CBT framework improved their social skills and their overall learning capacity.

TF-CBT is also effective at improving school performance and the research shows that it improves school performance in all four subcategories of grades, school refusal, negative classroom behaviors and social skills. However, there isn't as much supportive research on the topic of traumatized youth and their school performance as CBT. Of the six articles reviewed that used TF-CBT, all six showed positive findings in grades, school refusal, negative classroom behaviors and social skills. There were no articles that showed negative or insignificant findings. Cohen et al. (2006) found that TF-CBT was successful all four categories of grades, school refusal, negative

classroom behaviors and social skills when working with traumatized youth in school settings.

By the standards of this review CBITS treatment is shown to be less effective than CBT and TF-CBT since the analysis shows it did not improve school performance across all the subcategories. CBITS is only shown to be an effective treatment for working with traumatized youth and improving their grades. Three out of the four research articles found that CBITS was effective at improving grades in students experiencing trauma. Kataoka et al. (2011) found CBITS had significant results in both math and language arts grades. However, one research article showed how CBITS is an ineffective treatment for traumatized youth and negative classroom behaviors. Stein (2003) conducted a study that utilized CBITS treatment, which showed no significant differences between groups or teacher-reported classroom behaviors.

Finally, this review indicates that GB-CBT is effective when working with traumatized youth and improving their negative classroom behaviors and social skills. GB-CBT research showed no improvement in the grades or school refusal measures of school performance. The GB-CBT findings did not show any evidence of being effective at changing the concrete, academic measures of school performance. Three out of the four articles that addressed GB-CBT showed that the treatment effectively improved youth's negative classroom behaviors and social skills. For example, Cohen (2006), Deblinger (2001), and Johnson and Young (2007) indicated that GB-CBT was able to effectively reduce negative classroom behaviors. However, while GB-CBT is an effective treatment it is not shown to be statistically significant when

discussing social skills. Misurell (2011) reported that the results pointed in a positive

direction for social skills and self-perception, these findings were not statistically

significant.

Of the studies in this systematic review, CBT, TF-CBT, CBITS and GB-CBT

all address the issue of trauma for youth in many different ways. However, another

goal for these trauma therapies is to provide social workers, teachers and other

supportive school staff with the tools to work with students who have experienced

trauma on improving their school performance. This can also be helpful for parents

to be involved with these youth to be successful. Findings suggest that parents can be

just as important to their youth's improvements through their ambition, school

performance and other issues (Cohen, 2000; Cohen, 2006; Corcoran & Pillai, 2008;

Trusty, 2002).

Policy Implications

Policy is a complicated issue for social workers in school settings, especially

for the issue of trauma and its effects on trauma. Many times advocating for policy

changes can be a difficult process that involves many levels of administration, school

board meetings and other staff to effectively make change happen. It also can involve

working with other school staff that may not be as well versed on the topic of trauma

and its effects. However, one area that everyone can agree on in schools is failing

grades of students. Throughout this systematic review there has been evidence that

students who have been affected by trauma can have negatively affected school

performance (Cohen, 2000; Corcoran & Pillai, 2008; Johnson & Young, 2007). One

policy change social workers within schools can implement is to inform others by

presenting evidence and solutions to staff. This can help to educate staff members on the cause of trauma and how it can affect youth's school performance. This can also help all staff get on the same page and work with students to be successful.

Social workers can also take the integrated approach of working as a team with other staff to help these students when they are in need. Social workers can work with teachers, administrators, students' peers and other staff to help students when they are experiencing symptoms of trauma and support them as needed. Through this, social workers can teach others how to work most effectively with students who may be experiencing those traumatic symptoms in the moment. This can also provide the school some structure on how to best work with these students. When everyone in a youth's world is on the same page, it can help set a strong future framework for managing their trauma. Youth will have up and down days with trauma, but when everyone works together, youth can feel supported and hopefully be successful in school.

Schools can also build relationships with outside institutions to provide better mental health support for their children. The State of America's Children (2004) report that provided incentives to states and communities to encourage the use of family and community engagement strategies, such as family support programs, family group decision making, family to-family and other organizations that recognize the importance of asking parents what they need to protect their children. This can include non-profit organizations, cultural institutions, preschool environments and other community-based organizations to open opportunities and support youth with traumatic symptoms. Even furthering partnerships with

universities can help students work towards being prepared for college. All of these partnerships with other services can provide students with resources for their overall health, mental health, housing, and supportive services for parents to enhance their ability to learn and be successful in school.

Finally, social workers can advocate at the macro level by doing community organizing around policy changes within schools. For example, there are schools in the community that have on-site mental health services. Slade (2003) reported that on-site mental health services greatly benefits students both medically and with mental health symptoms. For example, many schools within the Minneapolis school district have implemented on-site mental health services with great success.   NAMI (2012) reports that since 2008 more than 8,400 students have accessed their onsite mental health services within the Minneapolis School System, which has reduced barriers to learning and less time spent out of class. Social workers can also organize meetings with the school board as well to get these services implemented within the schools. Through this, students can also obtain more supportive services that may not be available to them outside of school settings. However, many schools don't offer these services within school settings and these are ones that do are.

Limitations

There were a number of limitations of the findings of this systematic review. This includes the amount of research that was gathered on this specific systematic review, duplication of authors on represented sample, other factors that affect school performance and variety of CBT frameworks.

With the specific search terms for this systematic review, 43 articles were gathered and only twenty articles were included in the systematic review. Although there were significant findings, it would be beneficial for a review if there were a larger representative sample of articles. The numbers of authors on the studies are limited and authors on the twenty articles are often duplicated. Because of this, there are a limited variety of different author's research findings.

Not all of the available research on traumatized youth who have school performance issues measures its outcomes through the subcategories of grades, school refusal, negative classroom behaviors and social skills. Many times the youth who are struggling in school are also dealing with other issues outside of their schools' settings. For example, many youth also struggle with mental health issues and living in extreme poverty. The studies that were conducted in the systematic review were not conducted on them because of those issues. Mental health and poverty can also affect the other aspects of school performance issues such as negative behaviors and social skills. This can make it more difficult for CBT, TF-CBT, CBITS and GB-CBT to be effective.

Secondly, there are numerous factors tied together such as mental health symptoms, violence, poverty, lack of support, parental incarceration, differences in cultures and the trauma treatments themselves all affect school performance. Some of these factors can't be separated from school performance, so it's hard to obtain clear information on what trauma therapies are effective on a traumatized youth's school performance. Some of the articles will only address certain aspects of the

trauma, so it's difficult for all of trauma therapies to address the overall focus of the study.

Thirdly, when utilizing CBT therapies there were times where the treatment of traumatized youth was used with medications. Since medications and CBT therapies were paired together it is hard to distinguish if the CBT therapy or the medications had the most effective role in the success of the treatment. Also medications can be effective on their own without CBT therapies being a part of the treatment for traumatized youth. Some of the articles discussed the aspects of medications and CBT therapies, so it's difficult to see what was more effective.

The final limitation is the variety of interventions that were utilized within the CBT framework. Since the interventions were all based around the CBT framework, it is difficult to get a clear sense of which framework was most effective. For example, CBT is shown to be more effective in working with school performance in regards to school refusal issues. However, all CBT frameworks with the exceptions of GB-CBT are effective in working with traumatized youth in regards to their overall grades.

Implications for Future Research

Most of the studies conducted focused on the effectiveness of CBT, TF-CBT, CBITS and GB-CBT in regards to improving symptoms. Studies geared towards interventions with school performance such as academics, failing grades, skipping class, dropping out and not being able to even attend school would be beneficial to work effectively with students who struggle with trauma. Therefore, the areas for

research involving traumatized youth and the future implications of school performance.

During this systematic review a lack of new research on the topic of CBT, TF-CBT, CBITS and GB-CBT in schools. Most of these studies were not conducted within the last five years and it would beneficial to expand on future research of the treatment therapies. With the research that was conducted, the same researchers conducted much of the research. Having research done by different researchers would bring different perspectives to the subject.

Additionally, it would also be beneficial to discuss culturally specific effects. In the literature there was discussion of cultures outside of the United States such as Latino youth and refugee children. However, the differences affecting youth within the school system in the United States was vague. It would beneficial for social work researchers to go into more specific traumatic events of different cultures and how it affects those youths' school performance. Having research done on different cultures would benefit traumatized youth, social workers, teachers and other school staff on how to work with those culturally specific trauma issues.

Thirdly, when working with youth in school, no experience for youth dealing with trauma is the same. Although it would difficult, having CBT, TF-CBT, CBITS and GB-CBT focused on specific age groups would benefit to have a focus of how to work with elementary, middle school and high school aged students. As students begin to age, they obviously go through many changes, in many different ways. Those youths will also go through traumatic events at different times in their lives. So, it would be important to know how to work with that age-specific trauma during

that period in their lives. Most if not all students are not the same areas of trauma

their years of development. It would be beneficial to alter those treatments as needed.

As discussed before, when utilizing CBT therapies there were times when the

treatment of traumatized youth also utilized with medications. Since medications and

CBT therapies were paired together it would be beneficial to have comparison studies

between medications and CBT therapies. Some of the articles discussed the aspects

of medications and CBT therapies, so it's difficult to see what was more effective.

Since medications are often a stand-alone treatment it would beneficial for future

research to have pre and posttests with CBT therapies paired with medications.

The final future implication consists of students who were a danger to

themselves or others. Many times youth who experience trauma also experience

these symptoms and thoughts of suicidal ideation. However, the reviewed articles did

not address these issues. Sometimes students who are dealing with such intensive

trauma are also unable to function in all of the areas that were discussed in this

review. For future research it would be beneficial to explore these symptoms and

how treatments can be developed to be more effective in helping students be

successful in school.

Social Work Implications

The findings of this systematic review have several implications for future

social work practice with youth who experience trauma and its effects on school

performance. Social workers are often the biggest supports for traumatized youth.

Youth can experience a wide range of trauma including violence, poverty, lack of

support or neglect or parents that aren't available due to being incarcerated. Since

social workers utilize a wide range of trauma therapies, it is their duty to use the most effective treatments with when working with traumatized youth who have school performance issues. With this systematic review, it would be important for social workers to learn about how CBT, TF-CBT, CBITS and GB-CBT treatments are effective in working with school performance.

The main implication for social workers is to continue the study and research of CBT, TF-CBT, CBITS and GB-CBT in regards to traumatized youth's school performance. These treatments can be helpful in reducing mental health symptoms and also be adapted to work effectively with many different settings, including school settings.

Another implication for this systematic review involves CBT, TF-CBT, CBITS and GB-CBT in regards to working with different cultures that experience trauma and how that affects their school performance. Social workers work towards being culturally competent, but studies that were utilized within the systematic review had limited knowledge of working with various cultures. Often times, treatments are unable to adapt to different cultures. Many times what may work for one culture may not work for another. It would beneficial for social workers to learn to work within these cultures and adapt the treatments.

Next, it's important for social workers to develop different treatment focuses. There are many different forms of trauma treatments. However, CBT interventions and the various forms such as TF-CBT, CBITS and GB-CBT can be effective ways to treat trauma. Further training on the topics of CBT, TF-CBT, CBITS and GB-CBT would be beneficial to the overall findings of treating traumatized youth who have

school performance issues. As stated before, these treatments can be effective in working with certain aspects of school performance issues.   Further exploring the effectiveness of specific trauma therapies and how they impact certain areas of school performance would be helpful for all parties involved, including teachers, students and the school system.

The final implication of this study is to give a detailed review of how traumatized youth have school performance issues and how these trauma therapies can positively affect them. Social workers can work with a huge number of individuals and other school providers. It is important for school social workers to inform and educate in a wide range of environments, which benefit youth's school performance by utilizing these trauma therapies.

Conclusion

Systematic reviews are used in order determine how well interventions work, with what population and how those interventions work best in treating those symptoms and current issues researched. This systematic review of trauma-based therapies set out to review cognitive-based interventions for traumatized youth and how that affected their school performance. The data that was included was that of CBT, TF-CBT, CBITS and GB-CBT trauma treatments and their effects on youths' school performance as measured by grades, school refusal, negative classroom behaviors and social skills. The findings revealed that these trauma interventions were effective both in treating trauma symptoms and in improving school performance. However, there is a need for further and more current research to compile more data on the effectiveness of these trauma therapies.

Through this systematic review, and the future research recommended throughout this paper, trauma-focused programming may be improved when the effective evidence-based programs becoming further utilized across the board in school settings. It would also benefit students, families, social workers, teachers and school providers for there to be continued future research that works on obtaining different authorial perspectives, cultural and age specific interventions, and specifically addressing students who struggle with harmful symptoms. Social workers can contribute by being culturally competent, developing different treatment focuses and educating others.

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Appendix A

Trauma Therapies Grades

Author (s)	Title	Interventions	Findings
Saltzman et al., (2001)	Trauma- and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment protocol.	TF-CBT	While using TF-CBT students were able to show a significant improvement in GPA within the sample post-treatment and a pre-post reduction in PTSD symptoms and there was correlation with post-test improvement these students overall GPA.
EPISCenter (2015),	Trauma Focused Cognitive Behavioral Therapy.	TF-CBT	Through these sessions traumatized youth

			improved the school performance.
Cohen, Mannarino and Deblinger (2006)	Treating trauma and traumatic grief in children and adolescents.	TF-CBT	Through TF-CBT, traumatized youth were able concentrate better in school and thus improving their overall grades
Kataoka et al., (2011)	Effects on School Outcomes in Low-Income Minority Youth: Preliminary Findings from a Community-Partnered Study of a School Trauma Intervention.	CBITS	CBITS showed significant results in both math and language arts, than the other students in delayed intervention group.
Jaycox, et al. (2011)	Going to Scale: Experiences Implementing a School-Based Trauma Intervention.	CBITS	About 25% of the students participating in CBITS improved their grades in

			math, reading, and writing. Other results consisted of 62% youth maintaining their grades and about 13% having worse grades.
Kataoka et al (2011)	Responding to Students with PTSD in Schools.	CBITS	After CBITS interventions were conducted, youth were projected to pass math (69.5%) and language/arts (79.7%) at a much higher rate than youth with delayed intervention (math: 54.7%; language/arts: 60.9%).
Fischer and	Using an evidence –	CBT	Teachers reported

Ruffolo (2009)	based CBT group intervention model for adolescents with depressive symptoms: lessons learned from a school-based adaptation.	that those students participating in the CBT groups completed homework assignments more and earned better grades.

Appendix B

Trauma Therapies School Refusal

Author (s)	Title	interventions	Findings
Bernstein et. al,(2010),	Impiramine Puls Cognitive-Behavioral Therapy in the Treatment of School Refusal.	CBT	With the use of medications, combined with CBT treatment there were significant effects of improving school attendance and decreasing symptoms compared to a group with no treatment involved.
Brendel (2015),	Psychosocial Interventions for School Refusal with Primary and Secondary Students: A systematic review.	CBT	The treatment proved successful for youth with attendance issues compared to the control group. However, the

			results of increased attendance also increased anxiety for these youth.
Fischer and Ruffolo (2009),	Using an evidence –based CBT group intervention model for adolescents with depressive symptoms: lessons learned from a school-based adaptation.	CBT	Teachers in the middle school reported improvements in attendance while the adolescents who participate in school-based CBT group sessions
Heyne (2011)	School refusal and anxiety in adolescence: Non-randomized trial of a developmentally sensitive cognitive behavioral therapy.	CBT	After a 2 month follow up, students improved their school attendance.
Tolin et al., (2009)	Intensive (daily) behavior therapy for school refusal:	CBT	CBT was shown to work well with three out of four

	A multiple baseline case series.		students increasing their attendance significantly.
Cohen, Mannarino and Deblinger (2006)	Treating trauma and traumatic grief in children and adolescents.	TF-CBT	Findings showed significant results in reducing symptoms and improving overall attendance.
EPISCenter (2015)	Trauma Focused Cognitive Behavioral Therapy.	TF-CBT	Through these sessions traumatized youth improved their school attendance.

Appendix C

Trauma Therapies Negative Classroom behaviors

Author(S)	Title	Interventions	Findings
Cohen, Mannarino and Deblinger (2006).	Treating trauma and traumatic grief in children and adolescents.	GB-CBT	GB-CBT and how that was able to effect traumatized youth negative classroom behaviors for the positive.
Deblinger, Stauffer, and Steer (2001).	Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexual abused and their non-offending mothers.	GB-CBT	By using this treatment framework, children can reduce self-blame, shame, and embarrassment by using reframing techniques.
Johnson and Young (2007)	Handbook of cognitive-behavioral group	GB-CBT	The GB-CBT framework works to build stronger

	therapy with children and adolescents		social skill through practicing conversations, learning about boundaries and respecting the personal space of others.
Child Welfare (2012).	Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma.	TF-CBT	TF-CBT has more ability to help students cope with their behavior problems, trauma-related shame, develop safety skills and are be more prepared for future trauma reminders.
Cohen (2010),	Community treatment for PTSD in children exposed	TF-CBT	Youth had a reduction in behavioral

	to intimate partner violence: A randomized controlled trial.		problems, cope with reminders and associated emotions, sexualized behavior and trauma related shame.
Cohen, Mannarino and Deblinger (2006),	Treating trauma and traumatic grief in children and adolescents.	TF-CBT	
Cohen, Deblinger, Mannarino and Steer (2004)	A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms.	TF-CBT	Youth were also able to cope with their emotions , had a reduction in behavior problems, sexualized behavior, and trauma-related shame.
EPISCenter (2015)	Trauma Focused Cognitive Behavioral	TF-CBT	Through these sessions with traumatized youth

	Therapy.		had significant improvements with their externalizing behaviors. These behaviors also included improvements in sexualized behaviors.
Stein (2003)	A mental health intervention for school children exposed to violence: A randomized controlled trial	CBITS	The study utilized CBITS intervention, no significant differences were found between groups for symptoms of PTSD, depression, parent-reported psychosocial function, or teacher-reported classroom

			behaviors.
Azen, Davies, McCart and Priester, (2006)	Differential Effectiveness of Behavioral Parent-Training and Cognitive-Behavioral Therapy for Antisocial Youth: A Meta-Analysis.	CBT	CBT was shown to be effective in treating aggression, restlessness and behavior problems with youth.
Fischer and Ruffolo (2009),	Using an evidence –based CBT group intervention model for adolescents with depressive symptoms: lessons learned from a school-based adaptation.	CBT	At the 6-week follow-up measurement, the adolescents still reported positive changes and improved mood but the difference was no longer significant.
Bernstein et. al,(2010)	Cognitive behavioral therapy, sertraline, or a	CBT	Over the course of treatment, there was sleeplessness

	combination in childhood anxiety.		within class and restlessness associated with CBT than with medications.
Walkup, et al. (2008)	Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety.	CBT	Youth within the study improved their insomnia, fatigue, restlessness when CBT with medications.

Appendix D

Trauma Therapies Social Skills

Author(s)	Title	Intervention	Findings
Azen, Davies, McCart and Priester, (2006)	Differential Effectiveness of Behavioral Parent-Training and Cognitive-Behavioral Therapy for Antisocial Youth: A Meta-Analysis.	CBT	This is due to youth developing more abstract cognitive skills such as self-reflection.
Abdallah, Barron, Smith, (2013).	Randomized Control Trial of a CBT Trauma Recovery Program in Palestinian Schools.	CBT	58% of the students were experiencing higher levels of PTSD and situations of ongoing violence. Students who worked within the CBT framework had improved perception of

			learning capacity.
Cohen, Deblinger, Mannarino and Steer (2004)	A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms.	CBT	Youth reported that youth treated with CBT obtained improvements in their knowledge of body safety skills at posttest than youth who received supportive therapy.
Fischer and Ruffolo (2009)	Using an evidence –based CBT group intervention model for adolescents with depressive symptoms: lessons learned from a school-based adaptation.	CBT	At the 6-week follow-up measurement, the adolescents still reported positive changes and improved mood but the difference was no longer significant.
Cohen, Mannarino and Deblinger E. (2006).	Treating trauma and traumatic grief in children and	GB-CBT	The GB-CBT framework works to build stronger

	adolescents.		social skill through practicing conversations, learning about boundaries and respecting the personal space of others.
Johnson andYoung (2007)	Cognitive-behavioral group treatment for child sexual abuse.	GB-CBT	Findings suggest that GB-CBT programming has positive effects on mental health symptoms and thus improves overall school performance. When conducted there was a drastic improvement in
Misurell et. Al (2011)	Game-based cognitive-behavioral therapy	GB-CBT	Youth who utilized GB-CBT was effective for

(GB-CBT) group program for children who experienced sexual abuse: a preliminary investigation.

improving internalizing and externalizing symptoms, reducing sexually inappropriate behaviors, and improving children's knowledge of abuse and self-protection skills. Although results pointed in a positive direction for social skills and self-perception, these findings were not statistically significant. Clinical significance was also evaluated to assess the clinical utility of treatment

			effects.
Cohen, Mannarino, and Deblinger (2006)	Treating trauma and traumatic grief in children and adolescents.	TF-CBT	significant results in reducing symptoms, improving their trust and social competence in others, improving personal safety skills and developed better ways to cope with their trauma. Through, this traumatized youth were able to develop better friendships and become more successful in school.
Deblinger, Stauffer, & Steer	Comparative efficacies of	GB-CBT	The GB-CBT framework works

(2001).	supportive and cognitive behavioral group therapies for young children who have been sexual abused and their non-offending mothers		to build stronger social skill through practicing conversations, learning about boundaries and respecting the personal space of others.
Cohen, Deblinger, Mannarino and Steer (2004)	A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms.	TF-CBT	TF-CBT also improved their trust and social competence. Youth were also better prepared to cope with future traumatic traumatic reminders.
EPISCenter (2015)	Trauma Focused Cognitive Behavioral Therapy.	TF-CBT	Through these sessions traumatized youth improved their social skills by

| | decreasing their anti social behaviors, improved communication with their parents, teachers and other students |

Appendix E

Trauma Therapies Abstracted

Author(s)	Title	Intervention	Findings
National Child Traumatic Stress Network (2012)	Mental health by the Numbers.	TF-CBT	TF-CBT emphasizes rapport building and having practical expectations of youth.
Wetherington HR, Hahn RA, Fuqua-Whitley DS, Sipe TA, Crosby AE, Johnson RL (2008)	The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents.	CBT	individual and groups by decreasing symptoms among youth exposed to trauma compared to play therapy, art therapy traditional therapy
Morsette, Schuldberg, Van	Culturally informed cognitive behavioral	CBITS TF-CBT	Symptoms significantly

den Pol, Swaney, & Stolle (2009)	interventions for trauma symptoms: Group therapy in rural American Indian reservation schools		improved from at a ten month follow-up in both groups, decreasing from 22.82 to 12.00 for the TF-CBT group (p < .01) and from 21.98 to 15.81 for the CBITS group (p < .001). Both treatments showed a significant reduction in PTSD symptoms.
Schultz, Barnes-Proby, Chandra, Jaycox, Maher and Pecora, (2010).	Toolkit for Adapting Cognitive Behavioral Intervention for Trauma in Schools (CBITS) or Supporting Students	CBITS	CBITS has been effective in working with youth in school in reducing

	Exposed to Trauma (SSET) for Implementation with Youth in Foster Care		symptoms of depression, psychosocial dysfunction and post traumatic symptoms
Bender, K., Ferguson, K., Thompson, S., Komlo, C., Pollio, D. (2010)	Factors associated with the trauma and Posttraumatic Stress Disorder among homeless youth in three U.S. cities: The importance of transience.	CBT	TF-CBT treatment consists of exposure techniques, cognitive processing, reframing, stress management, and parental treatment are effective TF-CBT treatment techniques for traumatized youth
National Alliance of Mental Illness (2009)	Mental health by the Numbers.	DBT	developing coping skills or techniques to manage their

	mental health
	symptoms.