# Teachers' Perspectives on Providing Support to Children After Trauma: A Qualitative Study

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A considerable number of children are exposed to extreme stressors such as the sudden loss of a loved one, serious traffic accidents, violence, and disaster. In order to facilitate school psychologists' assistance of teachers working with traumatized children, this study aimed to explore elementary school teachers' perspectives. Using a qualitative design, the study explored the perspectives of a purposively varied sample of 21 elementary school teachers (ages 22–55 years; with 0.5–30 years of teaching experience; 5 men). The teachers participated in semistructured interviews, which were transcribed and analyzed in line with the method of "summative analysis" by F. Rapport. Even though some teachers expressed confidence in working with children after traumatic exposure and many referred to a supportive atmosphere within the school, the most prominent themes in the participants' narratives reflected uncertainty about, or a struggle with, providing optimal support to children. They searched for a clear role definition as well as a good balance in answering conflicting needs of the exposed children and classmates, wished for better knowledge and skills, and experienced difficulties related to the emotional burden of their work. The findings suggest a need for further research into this understudied topic. In addition, the identified themes can be used by school psychologists to systematically explore individual teachers' strengths and difficulties and to provide them with tailored advice and training.

*Keywords:* children, posttraumatic stress, social support, teachers, trauma

When it comes to schoolchildren's mental health, teachers rely in large part on school psychologists (Reinke, Stormont, Herman, Puri, & Goel, 2011). In order to successfully advise teachers regarding mental health issues in the classroom, school psychologists need an understanding of teachers' perspectives and information needs. This article aims to contribute to this understanding by exploring teachers' views on the topic of child traumatic stress.

Traumatic events—such as serious traffic accidents, violence, the sudden loss of a loved one, and disaster—are rather prevalent in childhood. In an epidemiological study in the United States, 54% of the 9- to 13-year-olds had been exposed to at least one traumatic event as defined by the *Diagnostic and Statistcal Manual of Mental Disorders* (4th ed., text rev.; *DSM–IV–TR*; American Psychiatric Association, 2000; Copeland, Keeler, Angold, & Costello, 2007). In European peace-time population studies, from 14% to over 70% of children and adolescents reported exposure (Alisic, Van der Schoot, Van Ginkel, & Kleber, 2008; Elklit, 2002).

The consequences of traumatic exposure can be serious and long lasting. Most children experience distress in the first few weeks after the event; they may feel scared, experience concentration difficulties, try to avoid reminders of what happened, lose interest in social activities, or show regressive behavior (Kaminer, Seedat, & Stein, 2005; Winston et al., 2002). These

symptoms interfere with children's ability to learn (Ko et al., 2008) and may pose challenges to teachers. Between 10% and 30% of the exposed children develop chronic psychological problems, including posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000; Kramer & Landolt, 2011), affecting their development and well-being in academic, social, emotional, and physical domains (Fairbank & Fairbank, 2009; Pynoos et al., 2009; Seng, Graham-Bermann, Clark, McCarthy, & Ronis, 2005).

Teachers can facilitate children's recovery from trauma (Baum, Rotter, Reidler, & Brom, 2009). For example, they may provide "coping assistance," including emotional processing, distraction, and the reinstitution of familiar roles and routines (Prinstein, La Greca, Vernberg, & Silverman, 1996). Moreover, several teacher-provided classroom interventions have been found to successfully reduce children's psychological reactions to trauma (e.g., Berger, Pat-Horenczyk, & Gelkopf, 2007; Wolmer, Hamiel, Barchas, Slone, & Laor, 2011). Furthermore, spending a large amount of time with children each week enables teachers to identify posttraumatic behavior change and potential obstacles in recovery. Finally, when necessary, teachers can link children and their families to mental health care (Farmer, Burns, Phillips, Angold, & Costello, 2003).

To help teachers provide children with optimal support after trauma, it is essential for school psychologists to know how teachers perceive their role, because teachers' opinions and experiences influence children's outcomes (Kochenderfer-Ladd & Pelletier, 2008; Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007). A better understanding of their views will enable mental health professionals to provide teachers with the appropriate resources.

Systematic research on teachers' perspectives regarding child trauma is virtually nonexistent. Although a number of studies have examined teacher-provided interventions to reduce posttraumatic stress (Rolfsnes & Idsoe, 2011), teachers' views on the topic have been underresearched (cf. Williams et al., 2007). Even though a few studies have explored other perspectives on traumatic stress, including those of parents (e.g., DeVoe & Smith, 2002) and children (e.g., Urman, Funk, & Elliott, 2001),

teachers have unique experiences that cannot be explained by these accounts.

The aim of the present study is to gain an understanding of teachers' perspectives on day-to-day support of children in elementary schools after a variety of traumatic events. To explore the topic in-depth, a qualitative design with semistructured interviews was adopted.

## Method

### Participants

Participants were "purposively sampled" (Boeije, 2010) to maximize the diversity in perspectives. Diversity was sought in gender, levels of teaching experience, school background (e.g., religious, nonreligious, Montessori method), and school neighborhood (e.g., inner-city, village). Teachers were contacted via school principals and received a letter explaining the purpose of the study (mentioning the future development of tailored information materials) and the informed consent procedure, followed by a phone call to answer any questions. The study was approved by the Medical Ethics Committee of the University Medical Centre Utrecht in The Netherlands. Sixteen out of 27 principals (59%) agreed to invite teachers, and all teachers who were subsequently asked to participate consented. The main reason for school principals to not invite teachers was the heavy workload of their staff.

Twenty-one teachers from 13 schools participated (the teachers from 3 schools were not able to be interviewed within the study period), with saturation of information after 17 interviews (cf. Boeije, 2010; no new themes emerged from participants' narratives in subsequent interviews). The mean age of the teachers was 35.5 years (range $22-55$ years; $SD = 11.69$). Five of them (24%) were men. Amount of teaching experience was less than 3 years for six teachers (29%), 3 to 10 years for another six teachers (29%), and more than 10 years for nine teachers (43%) ($M = 9.9$ years; range 0.5–30 years; $SD = 9.76$). All teachers had interacted with one or more children who had been exposed to a traumatic event as defined by the *DSM–IV–TR* A1 criterion (American Psychiatric Association, 2000).

## Interviews

The semistructured interviews were conducted by trained, final-year Bachelor's degree students in pedagogy. The topics in the interview guide (see Table 1) related to teachers' experiences with traumatized children, their strategies and feelings when working with these children and their families, exchanges with colleagues, and information needs. An expert on counseling of elementary schoolchildren reviewed the interview guide, and the use of it was trained in role plays. Interviewers worked in couples (one primary interviewer and an observer/secondary interviewer) to enhance reliability and fidelity of the procedure. In addition, the author supervised the interviewers by listening to their audiotapes and providing feedback on formulation of questions and coverage of topics. The interviews lasted 31 min on average (ranging from 22 to 59 min).

## Analysis

Interviews were transcribed verbatim, with names being substituted with functional codes. The analytical procedure was based on the "summative analysis" approach proposed by Rapport (Rapport, 2010; Rapport et al., 2010), which allows for maximization of individual contributions, while minimizing individual subjectivity. Each of the four interviewers independently summarized each of the 21 interviews in exactly 20 rows of text (typed, Times New Roman, 12 points) and made an overall summary in exactly 25 rows of text (same format). This format forced the interviewers to make a selection within the narrative and to describe

Table 1
*Topic Guide for Semistructured Interviews With Teachers*

| Type | Question |
|------|----------|
| General | |
| D. | Which grade do you teach? |
| D. | How long have you worked with this group? |
| D. | How many years have you worked as a primary school teacher? |
| D. | What is your age? |
| Experience and strategies | |
| I. | What is your experience with regard to children and trauma? |
| F. | Can you give an example? What did you do? How did you feel in this situation? How did the child react? How did other children in the class react? How did parents react? |
| I. | About which themes would you like to have more knowledge or skills, if any? |
| F. | Could you elaborate on that? Would that be the same for your colleagues? |
| School protocols | |
| I. | Does your school have a protocol with regard to trauma? |
| F. | What does it look like? What do you think of it? What are the effects when using it for the child/ the class/parents? |
| I. | What are your habits of guiding families to mental health care? |
| F. | Which organizations do you refer to? How do you do that? |
| Colleagues | |
| I. | How do you exchange about the topic of children and trauma with colleagues? |
| F. | How often does that occur? How do you experience it? |
| I. | How do you support each other? |
| F. | What do you think of this support? To what extent does it answer your wishes? |
| Needs | |
| I. | To what extent would you want to have more information than you have now? |
| F. | What information should it be? In what form should it be provided? |
| I. | Which kind of situations would make you nervous? |
| F. | What kind of support would you like to have in those situations? |

*Note.* Each interview included the first four questions about demographics (starting with D), and interviewers filled out the gender of the participants. Subsequently, each topic (e.g., *Experience and strategies*) was discussed with mostly open-ended introductory questions (examples starting with I) and follow-up questions dependent on the participants' response (examples starting with F).

themes in a condensed fashion. As a form of "member checking" (i.e., systematically obtaining informants' feedback; Onwuegbuzie & Leech, 2007), the summaries were sent to each teacher to be commented on. The teachers agreed with the summaries. The author subsequently coded the summaries line-byline using MAXQDA 2007 (VERBI, 2007), a software package for qualitative analysis. Finally, two sessions with the interviewers were devoted to discussing the code tree made of the themes until consensus was reached.

## Results

The teachers' current and former pupils had been confronted with a range of traumatic experiences, including the loss of a parent, serious accidents, maltreatment, domestic violence, war, fire, and burglary. The exposed children showed a wide spectrum of behavioral and emotional reactions in the classroom, varying from withdrawing to acting out, with only a few children being "talkative" about their experiences. Classmates often reacted in an understanding and flexible manner when something serious had happened to a child.

Even though some teachers expressed confidence in working with children after traumatic exposure and many referred to a supportive atmosphere with the school, the most prominent themes in the participants' narratives reflected uncertainty about, or a struggle with, providing optimal support to children. The core themes, described in more detail below, related to (a) the role of a teacher, (b) finding a balance in answering different needs, (c) a need for more professional knowledge and know-how, and (d) the emotional burden of working with children after trauma.

### Role of a Teacher

Several teachers struggled with their role and wondered at what point their tasks as a teacher ended and at what point those of a social worker or psychologist started. They had the impression that teaching was moving away from teaching children academic skills toward playing a major role in children's social and emotional development:

> Children are confronted with more and more adverse events these days, and with more extreme ones. And

that's what you have to deal with in the school system. It influences the behavior of a child in your classroom. I think teachers' task was more like proper teaching in earlier days, but that we're slowly growing into a caregiver's role.

Although some teachers felt that this was an important and logical trend, others wanted to stick to teaching academic skills. They stated that tasks should be divided and described more clearly, in order to have every professional (teacher, psychologist, etc.) stick to their specific expertise. For example, one teacher said,

> I feel that in education, a teacher needs to watch out not to get too much of social work on his or her plate. Because our primary task is to teach, after all . . . in that respect I think that the boundaries in education are still very vague.

### Finding a Balance in Answering Different Needs

The question of teachers' role definition was posed on both general and abstract levels. On a more practical level, teachers experienced difficulties in negotiating a good balance with respect to conflicting demands. They identified three potentially conflicting sets of needs among their pupils that were present in day-to-day school life.

**A child's needs versus the group's needs.** The teachers found it difficult to support a child who had been confronted with a severe stressor, while looking after the rest of the class at the same time. Several teachers provided examples of children who were overwhelmed by emotions during lessons and demanded extra attention, while the rest of the class had to take care of themselves. For example,

> The first week that [this boy] was in my class, he did not want to do anything. He could only sit and cry and he wouldn't let me go away. I really had to hold him and hold his pencil; in those conditions he would write down some work. But most of the time he was just sitting and crying (. . .), so that is a lot of compromising between "I want to give full attention to the kid because he needs it," and "I just have to teach the class." So it's difficult.

Another teacher explained that not only excessive crying and acting-out behavior (e.g., screaming and throwing things) caused this difficulty in balancing demands but also withdrawn behavior, because it required extra effort and attention to involve a withdrawn child in lessons.

**Focus on trauma versus focus on normal life.** Finding a good trade-off between looking after a child and preventing this attention-giving from becoming too "heavy" was a challenge. The teachers did not want to focus too much on the traumatic experience and overlook other experiences or accomplishments of the child, because they felt that normal life should go on. For example, one teacher tried to find a healthy balance but had difficulty communicating with the child and parents about whether it was a good approach:

> I was like "this family has already enough to worry about," so I didn't want to ask them how they were doing. I just hoped that they would inform the school when there were changes.

Another participant recounted an instance in which, with hindsight, the focus had been too much on the traumatic event: A girl who had lost her brother had been obliged to regularly go to the school counselor during 2 years to talk about the loss and was continuously referred to as "the sister of," which had made it difficult for her to come to terms with the loss.

Even though several participants stressed the importance of taking up normal routines and focusing on aspects of life other than the trauma, they did not want to play down the experience of the child either and tried to involve the class in an appropriate way as well:

> But one also wants to involve classmates because they have a child in the classroom "with a story" and you want to explain it . . . you want to have them think about what it means, although it shouldn't become too heavy of course, children should not have sleepless nights because of it.

**Giving extra attention versus creating an outcast position.** Teachers wanted to "be there" for a child, but felt this should not put the child in a special position that made him or her an outcast or interfere with general behavior rules in class. Several children had told their teachers directly or indirectly that they did not want to be "a special case." For example, a child with sleeping problems due to intrusive thoughts did not want to sleep a little longer in the morning and come to school when he was ready, as his teachers suggested. Even mingling in during the morning break was too unusual in his view, and he continued coming to school at normal times despite the fatigue. On the other hand, some children sought new boundaries af-

ter a traumatic experience. One teacher recalled a child who had prior conduct problems:

> I wanted to stick to normal rules with this child. He was a boy with some behavior problems so I had to correct him now and then. But I also wanted to be there for him. He lost his mother, so that's terribly sad . . . I asked myself regularly how to find that balance.

Although the participants were able to describe these conflicting demands, many did not feel sufficiently competent to solve the issues.

## A Need for Professional Knowledge and Know-How

The majority of the teachers expressed feeling a lack of competence regarding how they should act when a child has been exposed to trauma. Although different forms of coping assistance came up in the interviews (the teachers touched on emotional processing and normalizing, and incidentally on providing distraction), the narratives were dominated by doubts. In addition, they were often unaware of any protocols or guidelines within their school. A young teacher said,

> One of the children has lost his dad last year. It's hard for me to deal with . . . in this case, I wasn't even there when the worst things happened. I mean: Funeral, should I go? Who goes? What to do with the rest of the class? I now only have to deal with the aftermath but that's already difficult for me, let alone if I had to handle all those really tough issues.

A few experienced teachers indicated that they had learned to deal with these issues over the years but recognized the difficulties for inexperienced colleagues. They identified a need to include trauma-focused courses within teachers' training. Learning through being thrown into the deep end was "not the best way" to acquire the necessary skills. Overall, teachers would like to have more information materials about trauma recovery, either on the Internet or in a booklet. In addition to a general need for more knowledge and skills, the participants' questions could be categorized in the following three broad areas.

**How to talk about the traumatic event?** One of the topics the teachers were unsure about was to what extent they should discuss the experience with the child, the class, and parents, and how to do this:

> I would like to know which topics one could talk about with children after specific stressful events. You know,

I'd like to have some kind of tips and tricks for if I want to chat about it with a child, but also for when I want to discuss it with parents or other adults.

Several teachers explained that they discussed the experience with a child on the child's initiative, but were unsure whether they should do nothing when the child did not start a conversation. For example, a teacher was reading a book about a girl with cancer with the class and did not dare to ask the pupil who had lost his father because of cancer whether this was difficult for him, even though she pondered over his possible feelings and thoughts.

A related question that came up was how to create a safe atmosphere in the classroom to discuss emotions. Although many participants stressed the importance of openness about feelings, only a few felt confident in expressing them.

**When is specialized care necessary?** The teachers' narratives showed uncertainty about when they should decide that a child needs specialized mental health care. They had questions about which stress reactions are part of normal recovery trajectories, which duration of symptoms and behavior problems was normal, and in which cases additional care would be necessary. Especially with children who were "difficult to read" and children for whom it was unclear whether traumatic exposure played a part in their behavior problems (e.g., with suspicions of child abuse or maltreatment), participants talked about the difficulty in choosing the best approach:

Of course, a child shows certain behavior, but I find it really difficult to check whether the behavior wouldn't exist if the event had not happened. That's hard sometimes, also to know whether the traumatic event is the cause of the behavior or whether other circumstances play a role.

Most of the teachers were able to identify an internal advisor such as a school psychologist to ask for guidance and indicated that they would contact them when in doubt. However, not in all cases had they done so. For example, with a child who had undoubtedly been hit by his father, the involved teachers had waited longer than necessary to inform the responsible colleague.

**Where to refer?** In addition to the question of when to refer to additional care, several teachers admitted that they did not know where they could find information about mental health care possibilities for a child and his or her family. Again, the internal advisor was seen as the first person to go to, although teachers felt that they should have basic knowledge of the "map of available services" in their region.

A teacher who had two children in his class who had been exposed to a traumatic event put his questions about the last two described areas (when is specialized care necessary and where to refer) this way:

It leaves you with "Yes, what to do now actually? What to do about it? Is something really wrong with these boys? Or do they just work through it their way? And what should you keep an eye on? And when would it be necessary to get help? And if so, where to get it?" I don't know.

## The Emotional Burden of Working With Traumatized Children

Finally, it was a challenge for teachers to find a balance between being committed to the well-being of a child and keeping enough distance in order to avoid too strong an emotional involvement. The following three themes came up in teachers' narratives.

**Taking problems home.** The participants indicated that traumatic exposure and traumatic stress among their pupils were part of the most demanding aspects of their work. It was difficult not to "take the problems home." A few teachers were emotional while telling about the children's backgrounds, and several teachers indicated that being confronted with a child who lost a loved one was the thing that they feared the most. One teacher, who was relatively inexperienced, explained that she dreaded seeing the child in severe emotional pain in the classroom. She felt she would get very sad herself and would not know what to do about it.

An important source for the burden was feeling unable to help, either because of unfruitful contacts with parents or because of a lack of knowledge or skills:

I keep it with me, you know, it touches you anyway. It's about kids and sometimes complete families. It makes you think: if I could just take them home in my arms. Because you want them to have a much better life . . . I take that with me. It makes me think "terrible, horrible that this happens." . . . It's that feeling of powerlessness and sometimes of not knowing which steps to take exactly.

Some experienced teachers pointed out that they had improved their way of managing feel-

ings over time, even though that did not prevent them from feeling sad when a child was victimized.

**Earlier personal experiences.** A few teachers referred to being reminded of their own history of trauma as an emotional experience. One teacher said that the experience of a pupil reactivated memories of a loss that she had faced, which overwhelmed her and made her less available to the child than she wanted to be. Although the acute memories of their own histories made it more difficult for teachers to be aware of, and act upon, the children's needs, they had also provided teachers with the motivation to develop classroom materials for children. For example, one teacher had written a protocol for supporting children after loss, because of the pitfalls she had encountered in a personal experience.

**Support by colleagues.** Although teachers expressed many doubts and questions relating to optimal support for children, the supportive, open atmosphere within their team was regularly mentioned as a helpful factor:

> I know I can ask my colleagues for help at any moment, our culture is such that it is easy to do so. And then I go to someone who I want to share my story with. The team is quite close, so that's helpful. I think that the most important thing is that we know we can count on each other, but [a traumatic experience of a child] does touch me anyway.

They felt that they could vent emotions with colleagues and ask them for advice. Several participants brought up that colleagues would stand in for them if they felt overwhelmed, although examples were also given of situations in which a participant had been requested to "jump in and solve the issue" while not feeling confident.

## Discussion

This study uncovers a largely understudied topic: teachers' perspectives on supporting children who have been exposed to trauma. Although many children are victimized (Copeland et al., 2007) and teachers can play an important role in children's recovery (Rolfsnes & Idsoe, 2011), research examining teachers' views is virtually nonexistent. In this study, elementary school teachers' perspectives were explored in a qualitative design with semistructured interviews. Even though teachers identified helpful factors such as support by colleagues, the main finding was that they struggled with providing support to children after traumatic exposure. They searched for a clear role definition as well as a good balance in answering conflicting needs of the exposed children and classmates, wished for better knowledge and skills, and experienced difficulties related to the emotional burden of their work.

One theme that emerged regarded the role of a teacher. Where do we need to put the boundary between the tasks of a teacher and those of a mental health care provider? Ko et al. (2008) pointed out that trauma makes schools face the dilemma of how to balance a mission of education with the fact that many pupils need help in dealing with traumatic stress to be able to engage in learning. This study shows that the dilemma not only exists at the school level but also at the individual teacher's level. A number of teachers in this study described providing support after traumatic exposure as a voluntary, or extrarole behavior, which they preferred to leave to mental health care professionals. Somech and Oplatka (2009) reported that the extent to which teachers perceived handling school violence as one of their in-role tasks, and not as an extrarole behavior, presented a significant favorable influence on actual school violence. Likewise, when schools and teachers explicitly consider posttrauma support (e.g., signaling serious coping problems and informing about mental health care possibilities) as a part of their duty, which was expressed by several teachers in this study, this will probably exert a positive influence on child well-being.

However, even if teachers view their role as including psychosocial support of children who have been exposed to trauma, they are confronted with daily challenges when putting this view into practice. Although the teachers in this study were able to clearly describe the contrasting demands in their work, the knowledge and skills necessary to deal with these demands were experienced as insufficient. Because some quantitative evidence shows that teachers' attitudes toward taking up psychosocial tasks are mediated by their feelings of competency (Kos, Richdale, & Hay, 2006), not only the extent to which this lack of competence can be generalized to larger groups of teachers but also the relation with attitudes toward providing support deserves further research.

Further research is also requested with regard to the emotional burden experienced by teachers. In other groups of professionals, such as first responders and mental health care providers, the risks of compassion fatigue or secondary trauma have been described (e.g., Beaton, Murphy, Johnson, & Nemuth, 2004; Boscarino, Figley, & Adams, 2004). When teachers experience secondary trauma, both their own health and the support they can give to children are at risk. Scheeringa and Zeanah (2001) described the construct of "relational PTSD," in which the symptoms of a parent exacerbate the stress reactions in children, for example, when a parent is unavailable for a child because of his or her own emotions. Although the associations are probably weaker in the teacher–child relationship, this pattern could endanger teachers' functioning and pupils' outcomes.

This study adds to the literature by its focus on a seriously underresearched topic and the use of an innovative method for qualitative analysis. However, several limitations should be kept in mind. First, because the study focused on teachers' views, it is not possible to draw firm conclusions about behavior. It would be valuable to measure behavior in the classroom to know what teachers actually do. Second, even though maximum diversity of participants was sought, this study relied on teachers' willingness to participate. The views of teachers who are not interested in the topics of traumatic stress and psychosocial support may be underrepresented. Third, because of the novelty of the topic, the findings require replication in large samples, which may allow identification of the characteristics (e.g., small amount of experience) of the teachers struggling the most with the topic and development of target programs to assist them.

Even though replication through quantitative studies is necessary, the findings provide direct input into school psychologists' practice. It appears of importance to help teachers feel confident in their approach of a child after a traumatic event. This could be facilitated by having a clear policy within schools on the role of teachers and what is expected of them (cf. Ko et al., 2008). In addition, the identified themes and subthemes can be used by school psychologists to systematically explore individual teachers' strengths and difficulties and subsequently provide them with tailored advice and training. In particular, training efforts may include (a) how to assist coping in day-to-day school life, (b) how to recognize signs of successful recovery and of a need for more help, (c) where to refer students and their families when specialized trauma services are necessary, and (d) how to take care of oneself in stressful situations.

## References

Alisic, E., van der Schoot, T. A., Van Ginkel, J. R., & Kleber, R. J. (2008). Looking beyond posttraumatic stress disorder in children: Posttraumatic stress reactions, posttraumatic growth, and quality of life in a general population sample. *Journal of Clinical Psychiatry, 69,* 1455–1461. doi:10.4088/JCP.v69n0913

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Baum, N. L., Rotter, B., Reidler, E., & Brom, D. (2009). Building resilience in schools in the wake of Hurricane Katrina. *Journal of Child and Adolescent Trauma, 2,* 62–70. doi:10.1080/19361520802694323

Beaton, R. D., Murphy, S., Johnson, L. C., & Nemuth, M. (2004). Secondary traumatic stress response in fire fighters in the aftermath of 9/11/2001. *Traumatology, 10,* 7–16. doi:10.1177/153476560401000102

Berger, R., Pat-Horenczyk, R., & Gelkopf, M. (2007). School-based intervention for prevention and treatment of elementary-students' terror-related distress in Israel: A quasi-randomized controlled trial. *Journal of Traumatic Stress, 20,* 541–551. doi:10.1002/jts.20225

Boeije, H. R. (2010). *Analysis in qualitative research.* London, UK: Sage.

Boscarino, J. A., Figley, C. R., & Adams, R. E. (2004). Compassion fatigue following the September 11 terrorist attacks: A study of secondary trauma among New York City social workers. *International Journal of Emergency Mental Health, 6,* 57–66.

Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry, 64,* 577–584. doi:10.1001/archpsyc.64.5.577

DeVoe, E. R., & Smith, E. L. (2002). The impact of domestic violence on urban preschool children: Battered mothers' perspectives. *Journal of Interpersonal Violence, 17,* 1075–1101. doi:10.1177/088626002236661

Elklit, A. (2002). Victimization and PTSD in a Danish national youth probability sample. *Journal of the American Academy of Child and Adolescent*

*Psychiatry, 41,* 174–181. doi:10.1097/00004583-200202000-00011

Fairbank, J. A., & Fairbank, D. W. (2009). Epidemiology of child traumatic stress. *Current Psychiatry Reports, 11,* 289–295. doi:10.1007/s11920-009-0042-9

Farmer, E. M. Z., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services, 54,* 60–66. doi:10.1176/appi.ps.54.1.60

Kaminer, D., Seedat, S., & Stein, D. J. (2005). Posttraumatic stress disorder in children. *World Psychiatry, 4,* 121–125.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., . . . Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice, 39,* 396–404. doi:10.1037/0735-7028.39.4.396

Kochenderfer-Ladd, B., & Pelletier, M. E. (2008). Teachers' views and beliefs about bullying: Influences on classroom management strategies and students' coping with peer victimization. *Journal of School Psychology, 46,* 431–453. DOI doi:10.1016/j.jsp.2007.07.005

Kos, J. M., Richdale, A. L., & Hay, D. A. (2006). Children with attention deficit hyperactivity disorder and their teachers: A review of the literature. *International Journal of Disability, Development and Education, 53,* 147–160. DOI doi:10.1080/10349120600716125

Kramer, D., & Landolt, M. (2011). Characteristics and efficacy of early psychological interventions in children and adolescents after single trauma: A meta-analysis. *European Journal of Psychotraumatology, 2.* doi:10.3402/ejpt.v2i0.7858

Onwuegbuzie, A. J., & Leech, N. L. (2007). Validity and qualitative research: An oxymoron? *Quality & Quantity, 41,* 233–249. DOI doi:10.1007/s11135-006-9000-3

Prinstein, M. J., La Greca, A. M., Vernberg, E. M., & Silverman, W. K. (1996). Children's coping assistance: How parents, teachers, and friends help children cope after a natural disaster. *Journal of Clinical Child Psychology, 25,* 463–475. doi:10.1207/s15374424jccp2504_11

Pynoos, R. S., Steinberg, A. M., Layne, C. M., Briggs, E. C., Ostrowski, S. A., & Fairbank, J. A. (2009). *DSM–V* PTSD diagnostic criteria for children and adolescents: A developmental perspective and recommendations. *Journal of Traumatic Stress, 22,* 391–398. doi:10.1002/jts.20450

Rapport, F. (2010). Summative analysis: A qualitative method for social science and health research. *International Journal of Qualitative Methods, 9,* 270–290.

Rapport, F., Jerzembek, G., Seagrove, A., Hutchings, H., Russell, I., Cheung, W., & Williams, J. G. (2010). Evaluating innovations in the delivery and organization of endoscopy services in England and Wales. *Qualitative Health Research, 20,* 922–930. doi:10.1177/1049732309354282

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26,* 1–13. doi:10.1037/a0022714

Rolfsnes, E. S., & Idsoe, T. (2011). School-based intervention programs for PTSD symptoms: A review and meta-analysis. *Journal of Traumatic Stress, 24,* 155–165. doi:10.1002/jts.20622

Scheeringa, M. S., & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress, 14,* 799–815. doi:10.1023/A:1013002507972

Seng, J. S., Graham-Bermann, S. A., Clark, M. K., McCarthy, A. M., & Ronis, D. L. (2005). Posttraumatic stress disorder and physical comorbidity among female children and adolescents: Results from service-use data. *Pediatrics, 116,* e767–e776. doi:10.1542/peds.2005-0608

Somech, A., & Oplatka, I. (2009). Coping with school violence through the lens of teachers' role breadth: The impact of participative management and job autonomy. *Educational Administration Quarterly, 45,* 424–449. doi:10.1177/0013161X09334278

Urman, M. L., Funk, J. B., & Elliott, R. (2001). Children's experiences of traumatic events: The negotiation of normalcy and difference. *Clinical Child Psychology and Psychiatry, 6,* 403–424. doi:10.1177/1359104501006003009

VERBI. (2007). MAXQDA [Computer software]. Marburg, Germany: Author.

Williams, J. H., Horvath, V. E., Wei, H., Van Dorn, R. A., & Jonson-Reid, M. (2007). Teachers' perspectives of children's mental health service needs in urban elementary schools. *Children and Schools, 29,* 95–107. doi:10.1093/cs/29.2.95

Winston, F. K., Kassam-Adams, N., Vivarelli-O'Neill, Ford, J., Newman, E., Baxt, C., . . . Cnaan, A. (2002). Acute stress disorder symptoms in children and their parents after pediatric traffic injury. *Pediatrics, 109,* e90. doi:10.1542/peds.109.6.e90

Wolmer, L., Hamiel, D., Barchas, J. D., Slone, M., & Laor, N. (2011). Teacher-delivered resilience-focused intervention in schools with traumatized children following the second Lebanon War. *Journal of Traumatic Stress, 24,* 309–316. doi:10.1002/jts.20638