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Building Resilience Intervention (BRI) with teachers in Bedouin communities: From evidence informed to evidence based

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ABSTRACT

The Building Resilience Intervention (BRI), a program developed in the wake of terrorism and war in Israel, provides teachers with resilience-building skills that enable them to support students suffering from post-traumatic distress. Teachers in the Bedouin city of Rahat were evaluated both before and after the BRI workshop intervention for post-traumatic distress levels, functional impairment, flexibility, emotional regulation, general resilience measures and workshop impact. Results showed significant increases among teachers in areas such as positive refocusing and reappraisal, and increased willingness to discuss traumatic material with their students. Incorporating resilience training in teacher education is discussed.

1. Introduction

1.1. Teachers' roles in 21st century schools are both complex and challenging

The subjects of instruction may differ greatly across cultures ranging from training in crafts, vocation, the arts, religion, philosophy, history, science, civics or technology. In most societies, in addition to teaching, educators are expected to create a social climate in the classroom that is conducive to learning, develop individual relationships with all students, initiate contact with parents, grade papers, prepare assignments, and report to administrators and principals. Is it any wonder that there is a considerable literature documenting teaching as a high stress profession leading to burnout that can significantly impede optimal functioning and be a catalyst to early retirement (Howard & Johnson, 2004; Tang, Au, Schwarzer, & Schmitz, 2001)? Similar to other human service occupations such as social work and nursing, which also report high rates of burnout, teaching requires a significant level of emotional investment on the part of the teacher who is involved in relationships with students and colleagues (Flook, Golberg, Pinger, Bonus, & Davidson, 2013; Roeser, Skinner, Beers, & Jennings, 2012). Additional factors that add to teachers' stress levels may be heavy workloads, large classes, poor student behavior, inadequate salaries and a feeling of general lack of appreciation (Collie, Shapka, & Perry, 2012; Howard & Johnson, 2004; Unterbrink et al., 2007). The potential for high stress in teaching makes the case that teachers must be equipped with both the knowledge and tools to better understand their own stress and be able to effectively cope with these difficulties (Baum, 2005; Baum et al., 2013).

But, aside from focusing on their own stress levels, teachers are also expected to help students who are, or have, undergone stress, crisis or trauma. Reaching out to students in times of need and being a ready ear to listen to problems that students face are part of an educators' job description. The teacher may in fact, in addition to all of his or her other roles, be the gateway to a child's mental health. It has been noted that schools are “children's most important entry point to mental health care” (Alisic, Bus, Dulack, Pennings, & Splinter, 2012), with teachers expected to identify and screen children for potential learning and emotional problems. As teachers spend significant amounts of time with their students, they are also uniquely qualified to note behavioral changes and posttraumatic stress symptoms in their young charges (Wolmer, Hamiel, Barchas, Slone, & Laor, 2011; Wolmer, Laor, Dedeoglu, Siev, & Yazgan, 2005) and are trusted and familiar figures in their students' lives (Wolmer, Laor, & Yazgan, 2003). Teachers are often the ones called upon to alert parents to a child's disability or distress and serve as the conduit to mental health evaluation and referral (Jaycox, Morse, Tanielian, & Stein, 2006).

Additional points of entry into mental health on the part of teachers,

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is often – by default – when they serve as first-responders in times of acute trauma (Pfefferbaum et al., 2004). An example of this might be the World Trade Center bombings on September 11th, 2001. This traumatic event occurred as school was in session with four elementary schools and three high schools in a six block radius from the twin towers (Greene, Barrios, Blair, & Kolbe, 2004). Teachers were called upon to deal with the emergency at hand ensuring the safety of their students, while dealing with the fear, uncertainty, and massive confusion that was engendered by this event of epic proportions. There was clearly a difference between schools in the immediate vicinity of the twin towers and those thousands of miles away, however all teachers were on the front line and were expected to act in a professional and effective manner while themselves being witnesses or participant in this event.

Whether it is as a result of a large-scale trauma (e.g., natural disasters, acts of terrorism) or an individual loss (e.g., the loss of a parent or sibling), teachers must be able to cope with their own reactions to stressors, while being able to provide emotional support and care to their students (Baum et al., 2013; Pfefferbaum et al., 2004). Unfortunately, teachers often report feeling unprepared to deal with these exigencies.

In a sample of elementary school teachers' in the Netherlands, 50–63% of respondents indicated that they felt it difficult to know when children needed to be referred to mental health care providers and how to best support children following trauma (Alisic et al., 2012). One in five teachers in their sample expressed a high degree of difficulty in dealing with day-to-day trauma encountered in their schools. The authors' stress that teachers do not need to become therapists, but should be equipped to recognize the symptoms of, and feel confident dealing with, traumatic stress (Alisic et al., 2012). Are teachers in fact trained to deal with day-to-day stressors as well as extreme traumatic events?

1.2. School based interventions for promoting mental health

Teachers have direct access to large populations of children, who are most vulnerable in the wake of exposure to trauma and violence and are at high risk to develop post-traumatic stress disorder (PTSD) (Pat Horenczyk et al., 2009). Many school based programs have thus capitalized on teachers' access to children in need, while other have not involved teachers but rather based their interventions on mental health professionals placed in the school system.

The latter can be seen in two basic forms: interventions that focus on individual treatment for specific children (e.g., Chemtob, Nakashima, & Hamada, 2002) and group interventions for children within school settings (e.g., Dean et al., 2008; Layne et al., 2008; Morsette et al., 2009; Wong et al., 2007).

Alternative programs have focused on training teachers to implement skills based programs in the classroom during school hours. Mental health professionals train teachers to introduce structured units of study and activity into the classroom that are directly related to traumatic exposure and reduction of posttraumatic symptoms. Each of these interventions has a slightly different focus with some choosing to offer teachers training centered around traumatic exposure following natural disasters (Gelkopf, Ryan, Cotton, & Berger, 2008; Wolmer et al., 2005), war (Baum et al., 2013; Cox et al., 2007; Gupta & Zimmer, 2008; Layne et al., 2008; Pat-Horenczyk et al., 2011; Tol et al., 2008; Tol, Komproe, Jordans, Susanty, & de Jong, 2011) terrorism (Berger, Pat-Horenczyk, & Gelkopf, 2007; Gelkopf & Berger, 2009), and other trainings centered on general resilience building techniques (Gillham et al., 2007; Jaycox et al., 2006; Wolmer et al., 2011; Wong et al., 2008) and violence reduction (Wong et al., 2007). Reduction of post-traumatic stress symptoms, somatic complaints, and anxiety levels in students have been reported in several controlled studies where teachers have been trained and then implemented programs in the classroom (Baum et al., 2013; Berger et al., 2007; Berger, Gelkopf, & Heineberg, 2012; Gelkopf et al., 2008; Gelkopf & Berger, 2009; Tol et al., 2008; Tol et al., 2011). These studies provide significant support for the training of teachers to expand the manner and form that schools address the challenge of traumatic exposure, particularly in the case of large scale exposure such as war, terrorism and natural disaster.

Among the advantages of school-based interventions is the fact that these programs are accessible to all children in an non-stigmatic setting, in addition to being cost effective (Berger et al., 2012; Gelkopf & Berger, 2009). Furthermore, after receiving training teachers may be empowered in both their personal and professional lives and the effects of the program can have a lasting impact on the school and community for years to come (Baum et al., 2013). The school is no longer dependent on outside professionals to intervene during times of crisis.

The current study implemented the "Building Resilience Intervention" (BRI) (Baum, 2005; Baum et al., 2013; Baum, Rotter, Reidler, & Brom, 2009), a model that endeavors to impart resilience-building tools to teachers for both personal and classroom use. The model's brief teacher training is conducted over the course of 12 h, in four 3-h meetings, and is led by mental health professionals with a background in trauma and resilience. Workshop facilitators are also trained in the manualized, BRI protocol (Baum, 2002).

The BRI model has four underlying objectives, which are referred to as the four "S's." 1) Self awareness and regulation; 2) Support for feelings; 3) Strengths and personal resources for coping; and 4) Significance, meaning and hope (Baum et al., 2009). Each of these objectives is the focus of one of the workshop sessions, with teachers being provided with both psycho-educational resources and training as well as an opportunity to process their own personal traumatic material, stress and feelings of helplessness. The goal of the BRI in a school-based intervention is to empower teacher participants with tools, support and coping strategies for the day-to-day stresses of their chosen profession, in addition to any additional stresses related to traumatic events in their classrooms, schools or communities.

The focus on expanding and building personal resilience skills in teachers makes the BRI model stand out from other school-based interventions. While there is no one definition for the term resilience, for the purpose of this article, resilience is defined as the ability to establish and maintain a healthy and stable pattern of adjustment following an aversive event (Bonanno, 2012; Ungar, 2013). With this definition in mind, the concept of strengthening a teacher's own resilience is a cornerstone of the BRI. The hypothesis of the intervention is that when the focus of a training workshop is on teachers and the way they themselves – rather than their students – cope with trauma, teachers will be able to positively impact their students.

While previous studies have examined the impact of teacher training on students (for example Baum et al., 2013) the current study focuses on the impact of this program on the teachers themselves. Examining what changes, if any, occur in teachers after the intervention, will give us further understanding of the process involved in building resilience system wide in school settings.

What constitutes a resilient teacher? A resilient teacher is one who can weather the storms and challenges that teaching presents. Ideally, a teacher is someone who can create a nurturing environment while responding to his or her students' emotional needs (Jennings, 2011). This might require characteristics such as emotional regulation, flexibility, and a sense of inner strength and an armory of coping skills. In addition a working knowledge of the breadth of human response to stress and trauma would certainly aid a teacher in responding to student distress. Jennings (2011) states that few teachers receive such necessary training.

1.3. The Bedouin community

As part of the larger evaluation project BRI workshops were conducted in three schools in Rahat. This study took place as part of a larger five-year evaluation study in the Bedouin community of Rahat, which was funded by the Center for Disease Control (CDC, Atlanta) to