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Trauma Training in Educational Settings: Developing a Universal Approach Training Manual

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TRAUMA TRAINING IN EDUCATIONAL SETTINGS: DEVELOPING A UNIVERSAL APPROACH TRAINING MANUAL

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Dissertation Approval

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Abstract

Children who have experienced trauma(s) may display a wide variety of symptoms, including withdrawal, behavioral challenges, difficulty with focus, learning disabilities, and social/emotional delays (Cole et al., 2005). Each of these challenges can present a barrier to learning. Therefore, in order to provide the highest quality support in the school setting, teachers and other school staff need to be educated and trained on the topic of trauma. Further, they need strategies and tools regarding how to best work with all of their students, including those who have, or may have, experienced trauma. The current study examined the available research, as well as a pilot program, in order to develop the *Trauma-Informed Practices in Schools (TIPS)* program manual for educators. Outcomes of the study included a program manual and supplemental materials needed to implement the program. Initial comments from reviewers, future directives, and limitations are also discussed.

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Chapter 1: Introduction

Trauma-informed schools are an important research topic for many reasons. One of the main reasons is that studies show that children are being exposed to trauma at much higher rates than previously believed (Rossen & Cowan, 2013). The Adverse Childhood Experiences (ACE) study found that of 17,000 adults surveyed, 50% reported having been exposed to at least one type of childhood adversity (Felitti et al., 1998). In addition, the number of children and adolescents in the United States who have been exposed to traumatic events has increased significantly over the past few years. This statistic cannot be ignored because, unfortunately, that number is not likely to decrease anytime soon (Jaycox, Morse, Tanielian, & Stein, 2006). Another reason that trauma-informed schools are an important topic is *trauma* is a broad term that can refer to any experience that disrupts a child's sense of safety and security. Some examples of potentially traumatic experiences include separation from a parent, death of a loved one, serious illness (mental or physical), natural disasters, abuse (witnessed or experienced), neglect, exposure to criminal activity, homelessness, and bullying. Trauma can be caused by one event or by repeated exposure to situations that overwhelm the child's ability to cope (Walker & Weaver, 2007). Finally, thoroughly researching trauma and trauma-informed schools could lead to more effective interventions. The minimal research currently available indicates that positive student outcomes are related to trauma-sensitive practices in schools. Positive changes related to a trauma-sensitive environment include increased test scores, decreased school dropout, decreased office referrals related to behavior, and a more positive school climate (Oehlberg, 2008).

Research has shown that children who experience trauma(s) may experience long-term physiological, behavioral, and educational consequences (The National Child Traumatic Stress Network, n.d.). When children experience trauma at a young age, the world can feel like a dangerous place, and their brains may become hardwired in a state of "fight or flight." Being in a state of fight or flight can cause an individual to feel the need to be hyperalert and ready to move at all times (Cole et al., 2005); therefore, the majority of their cognitive energy is spent ensuring their own sense of safety. Owing to this state of hyperarousal, evidence shows that concentration, organization, memory, and language abilities are diminished in children who have been exposed to trauma (Cole et al., 2005). Furthermore, when children experience trauma, they are at higher risk of engaging in behaviors that may be perceived as insubordinate, oppositional, irrational, or disorderly. Teaching educators how to recognize signs of trauma is important so they do not misunderstand the reasons that underlie some children's academic, social, emotional, and behavioral difficulties. In fact, preliminary studies have shown that school-based implementation of trauma-informed practices has resulted in decreased suspensions and office referrals (Smith, as cited in Overstreet & Chafouleas, 2016, p. 4).

Finally, children who have a history of trauma are more likely to experience learning difficulties, as well as challenges related to social, emotional, and behavioral functioning in the school setting. In general, children who have experienced trauma have been found to have lower IQ scores, lower overall GPA, increased peer rejection, increased school absence, and decreased graduation rates as compared to children who have not experienced trauma (Kataoka, Langley, Wong, Baweja, & Stein, 2012). If teachers are educated regarding the signs of trauma, they may be better equipped to

intervene with students who are demonstrating challenges. Furthermore, teachers may also potentially prevent retraumatization resulting from exposure to triggers. Therefore, with the emerging literature that focuses on the definition, rates, and impact of trauma, the lack of research that specifically explores evidence-based interventions, particularly in the school setting, is surprising.

Chapter 2: Review of the Literature

Introduction

A review of the current literature on the specific topic of trauma-informed/trauma-sensitive schools has revealed it to be fairly limited; however, this area of research seems to be gaining momentum. Even though the research regarding trauma-informed schools is not abundant at this time, the research is abundant on childhood trauma and the impact it may have on an individual's functioning in a variety of settings, including school. The research shows that trauma may be the root cause of a number of learning and behavioral issues (Cole et al., 2005); yet, the research is lacking on how schools and teachers can support these children and adolescents or how school staff can play a role in decreasing the negative outcomes associated with trauma. Owing to the significant amount of time that children and adolescents spend in school, the school setting is an ideal place for intervention. Therefore, additional research is clearly needed in this area.

Trauma can be defined as

> …experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being (Substance Abuse and Mental Health Services Administration, 2014, p. xix).

Childhood trauma can include any event that disrupts a child's sense of safety and overwhelms his or her ability to cope and can include violence, homelessness, bullying,

and neglect, as well as a number of other events or circumstances (Gerrity & Folcarelli 2008). Further, the rate at which youth in the United States are being exposed to traumatic events has been described as a "public health problem" (Mendelson, Tandon, O'Brennan, Leaf, & Ialongo, 2015, p. 142) that is highly correlated with a variety of short- and long-term negative outcomes.

Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) study was one of the first to address the relationships between exposure to adverse events in childhood and high-risk behaviors and disease (Felitti et al., 1998). The researchers in this study gathered information through questionnaires that were mailed to adults in the San Diego area of California. Greater than 9,000 individuals returned surveys, and after some exclusions, greater than 8,000 surveys were analyzed for the study. The respondents ranged in age from 19 to 92 years, approximately 52% were women, and 79% were white. Almost half of the respondents were college educated (43%), and all participants were covered by private health insurance.

Each individual who received a survey had completed a standard medical evaluation between August 1995 and March 1996 (with the exclusion of December). The surveys were mailed 1 week after the participant's examination. The survey addressed adverse childhood experiences in the areas of abuse (i.e., sexual, physical, psychological) and household dysfunction (i.e., substance abuse, mental illness, mother treated violently, and criminal behavior in household). The results of the study indicated a strong relationship between childhood exposure to abuse and/or household dysfunction and risk

factors for disease and early death, such as substance abuse, depression, suicide attempts, smoking, and promiscuity (Felitti et al., 1998).

Since the publication of the ACE study, a number of states, social-service agencies, and pediatricians have conducted their own ACE surveys, which have generally resulted in similar findings (Hochman & Stevens, 2017). For example, the city of Philadelphia in Pennsylvania conducted a version of the ACE study in order to explore whether living in an urban setting brings additional stressors not covered in the original study (Cronholm et al., 2015). Philadelphia used the framework of the ACE study to create the Philadelphia ACE Task Force (PATF). PATF was originally created with the goal of integrating ACE screenings into pediatric primary care but eventually expanded to focus more broadly on a community-based approach to addressing adverse childhood experiences through a variety of sectors in the city and the entire Philadelphia region (Pachter, Lieberman, Bloom, & Fein, 2017). The PATF has successfully conducted research regarding ACE in an urban setting and identified the presence and impact of "expanded ACE" in addition to the "conventional ACE" that were studied in the original study (Cronholm et al., 2015). The expanded ACE that were identified included racism, witnessing violence, living in an unsafe neighborhood, experiencing bullying, and having a history of living in foster care (Cronholm et al., 2015). Cronholm et al. (2015) found that approximately one half of their respondents experienced one to three of conventional ACE and one fifth experienced four or more. In regard to expanded ACE, the study revealed that approximately half of the respondents experienced one to two and approximately 13% experienced three or more. Further, almost one half of the participants in this study reported experiencing both types of ACE, and almost 14%

experienced only expanded ACE, meaning they would have gone unrecognized in the original ACE study.

Neurobiological Impact of Trauma

Research indicates that trauma can have a biological impact on brain development and may negatively affect neurobiological systems that are crucial for academic achievement. Carrion and Wong (2012) reviewed previous studies and conducted a longitudinal study using magnetic resonance imaging (MRI) to investigate the changes in brain structures. The participants in these studies ranged in age from 8 to 17 years, and most studies compared children who demonstrated symptoms of posttraumatic stress disorder (PTSD) with a control group. Carrion and Wong (2012) found that trauma significantly impacted the hippocampus and the prefrontal cortex, which are brain structures that are critical to learning and memory. Furthermore, the hippocampus, which is crucial for learning, memory (specifically declarative memory), control of stress responses, and fear conditioning, has been found to be smaller in individuals who have experienced trauma compared to those who have not (Sherin & Nemeroff, 2011). According to Carrion and Wong (2012), increased cortisol levels in children who have been exposed to trauma are predictive of the decreased hippocampal volume. They also found that children with a history of trauma demonstrated decreased hippocampal activity during a memory task and performed worse than "healthy" children on memory retrieval tasks.

The prefrontal cortex, which plays a significant role in executive skills, such as shifting and forming associations between stimuli and response (Carrion & Wong, 2012), is also negatively impacted by trauma. Specifically, like the hippocampus, the frontal

cortex has been found to be smaller in individuals who have experienced trauma as compared to those who have not (Sherin & Nemeroff, 2011). Owing to the impact of trauma on the prefrontal cortex, studies have found that individuals with trauma history often have difficulty sustaining attention, suppressing intrusive thoughts, and decreasing fear responses (Carrion & Wong, 2012). Each of these deficits may make learning and completing academic tasks difficult.

Other areas of the brain, such as the amygdala, which is related to emotion regulation and emotional expression, are also known to be impacted by trauma (Cook-Cottone, 2004). The amygdala has been found to be hyperactive in individuals who have experienced trauma, thereby promoting a state of hypervigilance and decreasing an individual's ability to discriminate between a threat and nonthreat (Sherin & Nemeroff, 2011). Related to these deficits, trauma can cause a consistent state of flight or fight, during which an individual is constantly on alert and may perceive benign situations as threatening. According to Walkley and Cox (2013), children and adolescents who have experienced trauma may be easily overstimulated, causing additional challenges related to emotion regulation. Children and adolescents who are exposed to trauma may demonstrate general cognitive impairment and delays in physical development related to biological disruptions to development (Walkley & Cox, 2013).

Brain Plasticity

When discussing changes that occur in the brain as a result of trauma, one must note that the connections in the brain can essentially rewire themselves, with the right interventions (Hosier, 2013). Research has shown that in certain conditions the brain can correct the neural pathways that are "faulty," thereby decreasing the damage (behavioral

and emotional) that was caused originally (Hosier, 2013). Evidence shows that damaged neural circuits resulting from childhood trauma can be corrected and that individuals' brains, and consequently their behaviors, can be reshaped even into adulthood (Hosier, 2013). These findings mean that the adults who work in school systems are in a prime position to actually change the brain development of students and, by doing so, offer them the possibility of a healthier, more successful future.

In her book, *Reaching and Teaching Children Exposed to Trauma*, Dr. Barbara Sorrels (2015) discussed the "fear and hope connection." Dr. Sorrels referenced a study conducted by Dr. Karyn Purvis and Dr. David Cross in 2007 that examined adopted children with behavioral challenges related to abuse and/or neglect. The study, which eventually became known as "The Hope Connection," started as a 3-week day camp. The researchers began to notice a significant change in the behavior of the children, and as a result, they began to look at the neurochemical profiles of the children before, during, and after the camp (Sorrels, 2015). What Purvis and Cross found was that prior to entering the camp, most of the children had neurochemistry profiles that were similar to those of adults diagnosed with PTSD (Sorrels, 2015). The researchers referred to PTSD in children as "the neurochemistry of fear." However, as the children spent time in an environment that was emotionally and physically safe, rich in sensory input, and filled with opportunities for positive attachment, their observable behavior began to change significantly (Sorrels, 2015). Further, a statistical correlation existed between the changes in brain chemistry and the children's observed behavior (Sorrels, 2015).

By the end of the 3-week camp, the brain chemistry of the children who participated began to approach typical levels, and the children began to display positive

behavioral changes (Sorrels, 2015). Even more significant, the children's behavior improved in areas that had been thought of as the most resistant to "developmental catch-up" (i.e., attachment, self-regulation, and prosocial behavior; Purvis, Cross, Federici, Johnson, & McKenzie, 2007). This study was one of the first to show that the brain could change as a result of environmental changes (Sorrels, 2015).

Resilience

Appropriate intervention may support and/or increase an individual's resiliency. Resilience, as defined by the American Psychological Association (2018), is the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress, such as family and relationship problems. According to Herrman et al. (2011), the several sources of resilience include personal factors, biological factors, and environmental-systemic factors. Herrman et al. (2011) also discussed the impact of the interaction between personal, genetic, and environmental factors. Similar to resilience, certain resources, skills, strengths, and coping skills, known as protective factors, can be drawn upon by individuals when faced with adversity. The school may be the next closest system of support that is available for children who experience adversity within their homes (Sporleder & Forbes, 2016).

Educational Impact of Trauma

Academic Performance

Experiencing trauma can disrupt a variety of developmental skills that impact the ability to learn. Among other competences, academic skills require the ability to pay attention, organize one's thoughts and environment, comprehend language, communicate expressively, and produce work (Cole et al., 2005). Experiencing trauma has the

potential to impact all of the skills necessary for learning. The symptoms of childhood trauma that may be evident at school can look similar to other educational or psychiatric disabilities. These similarities can make distinguishing these symptoms from others difficult for teachers and other school staff (Rossen & Cowan, 2013).

Language development and executive functions (i.e., focus and attention) are two areas that may be affected (Cole et al., 2005). Trauma may impact a child's language development because it can interfere with the ability to process verbal information, as well as the ability to use expressive communication (Cole et al., 2005). Traumatized children also demonstrate more difficulty organizing materials, one of the prerequisites for academic success (Cole et al., 2005). For example, children who have had adverse childhood experiences related to household dysfunction demonstrate difficulty with sequential organization of materials and memories. Difficulty with sequential organization may decrease a child's ability to learn new information sequentially and may therefore cause difficulty with organizing and processing information that they need to retrieve and apply at a later time (Cole et al., 2005).

In regard to executive functions, studies have shown that trauma symptoms in the classroom can manifest in ways that decrease a child's ability to focus and attend to instruction (Cole et al., 2005). A child may display symptoms of inattention that are related to trauma in a variety of ways. One example may be a child who completely dissociates from the environment, whereas another child may be too focused on determining the mood of the adults in the environment (Cole et al., 2005). When children cannot focus, keeping up with academic lessons and completing assigned work may be difficult (Cole et al., 2005).

Behavioral Domain

Children who are exposed to trauma may behave negatively or act out in an attempt to gain attention or as a way of acting out their personal pain (Cole et al., 2005). Children who have experienced trauma may adopt coping strategies, such as social withdrawal, aggressive behaviors, or self-medication (i.e., substance abuse), as a way of avoiding retraumatization or dealing with their pain (Cole et al., 2005). Additionally, as a result of hyperarousal, children who have experienced trauma may react in a way that is disproportionate to the situation. These children may also demonstrate physical or verbal aggression toward teachers and peers resulting from increased impulsivity and reactivity. A child's behavior may be linked to an inability to take another person's perspective, disruptions in language development, decreased ability to interpret social cues, difficulty with emotional regulation, and/or decreased ability to problem solve, all of which are linked to childhood trauma (Cole et al., 2005).

Social Skills

Positive relationships with peers and adults are an invaluable protective factor for children. However, children who have experienced trauma may have difficulty connecting to others (Cole et al., 2005). Their traumatic stress and negative relationships with others outside of school can negatively impact the way they respond to and interact with adults and peers in the school setting (Cole et al., 2005). Children who have experienced trauma may be distrustful of adults or concerned with the overall safety of the school setting. All children can benefit from positive adult relationships, but traumatized children in particular must form positive, meaningful relationships with adults (Cole et al., 2005).

In regard to peer relationships, children who have experienced trauma may have delayed social skills and may not know how to interact with peers in an age-appropriate manner (Cole et al., 2005). Because these children may be impulsive, aggressive, or withdrawn, their peers may not want to interact with them, or they may even be frightened of them (Cole et al., 2005). Furthermore, traumatized children may have a difficult time reading social cues, and they may not have the language skills needed to appropriately communicate with their peers (Cole et al., 2005), making forming and maintaining relationships difficult.

Trauma-Sensitive Practices

Although not much research has been done specific to creating trauma-sensitive schools, trauma-informed care practices have been studied with different populations and in a variety of other settings, including residential treatment facilities, outpatient facilities, and foster care settings. These practices have primarily been published as guidelines regarding the implementation of organizational change. Several longitudinal studies have found that system-wide training in trauma-informed care resulted in long-term improvements regarding trauma-informed knowledge and attitudes (Lang, Campbell, Shanley, Crusto, & Connell, 2016), as well as in more positive long-term outcomes for those serviced as compared to control groups (Morrissey et al., 2005). The sanctuary model and the Missouri model are organization-wide approaches that have been implemented in a variety of settings. More recently, the Lakeside Global Institute has developed and implemented trainings on trauma-informed care for organizations.

Sanctuary Model

The sanctuary model was originally developed in the 1980s in an adult inpatient psychiatric treatment facility (Bloom, 2017). The model came about when the treatment team realized that many of their patients had experienced some form of childhood trauma (Bloom, 2017). The sanctuary model is a method based on trauma theory and is intended to create or change the culture of an organization (Bloom & Sreedhar, 2008). Furthermore, the sanctuary model set out to promote the recovery and healing of adults who had survived childhood trauma (Bloom, 1995) and to decrease the instances of retraumatization (Bloom, 2017). Organizations that implement the sanctuary model encourage staff members to engage in ongoing, open dialogue regarding the strengths, needs, and conflicts that occur within the organization (Bloom & Sreedhar, 2008).

Since its creation, the sanctuary model has been used in a variety of settings with children, adolescents, adults, families, and communities (Bloom, 2017). The sanctuary model is now considered a research-based approach to treatment that is in line with best practices (Bloom, 2017). Organizations that have adopted this model report significant environmental changes, as well as changes in outcomes for the populations they serve (Bloom & Sreedhar, 2008). Organizations that use the sanctuary model report a decrease in use of restraints and in critical incidents, a decrease in staff turnover, fewer staff injuries, improved collaboration, improved academic performance, and improved treatment and placement outcomes (Banks & Vargas, 2009; Bloom & Sreehar, 2008).

Missouri Model

The Missouri Model: A Developmental Framework for Trauma Informed, published in 2014, has been adapted by other states, such as Wisconsin, and is meant to

help organizations increase awareness of trauma (MO Department of Mental Health and Partners, 2014). The Missouri model, similar to the sanctuary model, is not a program but a guideline that helps organizations to develop a common language regarding trauma, increase organizational effectiveness, and ensure they do no harm by increasing education and awareness about trauma (MO Department of Mental Health and Partners, 2014).

The Missouri model provides a framework that organizations can use to determine where they are in the process of becoming trauma informed. The chart includes four sections: Trauma Aware, Trauma Sensitive, Trauma Responsive, and Trauma Informed. Each section contains related key tasks and definitions, processes, indicators, and resources. The Missouri model explains what an organization in each stage looks like. For example, in the trauma aware stage, an organization should be aware of the prevalence of trauma and the effect trauma may have on their clientele, as well as on their staff (MO Department of Mental Health and Partners, 2014). In the trauma sensitive stage, organizations start to explore basic principles related to trauma-informed care, build agreement around the principles, and prepare for change (MO Department of Mental Health and Partners, 2014). In the third stage, trauma responsive, organizations have started to make widespread changes that incorporate the role of trauma (MO Department of Mental Health and Partners, 2014). Finally, when an organization is trauma informed, the organization has created an environment in which trauma-responsive practices are highly accepted as the norm (MO Department of Mental Health and Partners, 2014).

Lakeside Global Institute

The Lakeside Global Institute was created with the goal of providing comprehensive, trauma-informed training to organizations that provide support to children and adults who have been impacted by trauma. The Lakeside Institute for Family Professionals (IFP) was established in 2003 with the purpose of providing ongoing professional development to individuals in relevant fields throughout the greater Philadelphia area (Lakeside Global Institute, n.d.). Peer-reviewed research regarding the impact of IFP training was not readily available at the time this literature review was completed, but its creation and implementation are important indicators of the need surrounding trauma-informed organizations.

Limitations of Conducting Research on Trauma-Informed Care

Research methods for studying trauma-informed care have included qualitative, quantitative, and mixed methodologies. Many of the studies reviewed used self-report and surveys as data collection methods. At least one of the quantitative studies reviewed (Mendelson et al., 2015) specifically stated that gathering qualitative data as well might have been helpful in order to gain a more indepth understanding of the student perspectives. Specifically, the Mendelson et al. (2015) study discovered that the quantitative data gathered from the teachers regarding student outcomes were not consistent with the student reports. Therefore, the researchers realized after the fact that qualitative data (specifically interviews with the students about their perspectives) regarding the experience and the intervention would have been helpful. Common themes throughout many of the studies reviewed were small sample size and inclusion of

participants who met specific criteria, such as living in impoverished areas or residential facilities.

Interventions in School Settings

Dr. Sandra Bloom, one of the creators of the sanctuary model, noted that the paradigm shifts that took place in the inpatient setting are relevant for any setting that serves as a place for people to "live, learn, and function" (Bloom, 1995, p. 1).The school is such a setting. In regard to trauma-specific interventions that can be implemented in the school setting, current research on specific programs includes Multimodality Trauma Treatment (MMTT) and The University of California Trauma Grief Component Treatment Program (TGCT). However, these programs focus on providing services and education directly to the students.

The MMTT focuses on peer modeling of effective coping skills and uses tools, such as storybooks, narrative exposure, and cognitive games, in order to decrease trauma symptoms related to a variety of incidents, such as fire, natural disaster, and accidents (Amaya-Jackson et al., 2003). The target population is children and adolescents ranging from 9 to 18 years of age, and MMTT is implemented in an average of 14 group sessions with six to eight group members (The National Child Traumatic Stress Network, 2008b). The key components of the MMTT intervention include psychoeducation, anxiety management, cognitive training, anger coping, grief management, group narrative exposure, and relapse prevention, and MMTT includes an individual component in addition to group processing (The National Child Traumatic Stress Network, 2008b).

However, one should note that MMTT is targeted for children who have experienced a single traumatic incident (The National Child Traumatic Stress Network,

2008b). Furthermore, MMTT is not suitable for children with PTSD related to chronic abuse because the program is strictly school based and does not incorporate family sessions, which are necessary to address interpersonal victimization. Controlled studies conducted in elementary-, middle-, and high-school settings demonstrate a significant reduction in PTSD, depression, anxiety, and anger symptoms following MMTT implementation (Amaya-Jackson et al., 2003).

The TGCT is a school-based prevention program (Wolmer, Hamiel, & Laor, 2011) that primarily addresses trauma related to community violence and loss or death (The National Child Traumatic Stress Network, 2008a). The target population is children and adolescents ranging from 12 to 20 years of age, and the program focuses on individual differences in responses to traumatic events (The National Child Traumatic Stress Network, 2008a). The TGCT teaches adaptive coping skills and aims to foster resilience in the participating students. The goal is to teach the students the skills needed to cope with a traumatic event before the event occurs. The curriculum is woven into the classrooms and implemented by teachers. An extensive protocol must be followed, and the TGCT includes 16 to 20 group psychotherapy sessions. Results of the Wolmer et al.(2011) study indicated significantly fewer symptoms of posttraumatic stress, depression, and anxiety in those who received the intervention as compared to those on a waiting list.

As stated by Bloom (1995), becoming trauma sensitive takes more than a step-by-step program; a complete paradigm shift among all members of the organization is required, and education is the first step. Staff must be educated in and buy into trauma-informed practices because all schools educate children who have been impacted by

trauma, even though the teachers/staff do not always know who these students are (McInerney & McKlindon, 2014).

States, regions, and individual districts across the United States have begun promoting and implementing trauma-sensitive practices (Overstreet & Chafouleas, 2016), which typically involve increasing awareness and education. For example, Washington State and Massachusetts have developed trauma-informed frameworks that promote trauma-informed practices. Washington State has brought a significant amount of attention to trauma-informed care through a published handbook titled, *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success* that provides facts and statistics related to childhood trauma. The goal of the handbook is to help readers learn about the interwoven issues that are critical for academic success (Wolpow, Johnson, Hertel, & Kincaid, 2016). The handbook also addresses information regarding self-care and six principles for interactions with children who have experienced trauma (McInerney & McKlindon, 2014).

With all that teachers and school staff are required to do within the scope of their daily work, many teachers feel overworked and underappreciated (Wolpow et al., 2016). Further, educators do not always make time for themselves, or they have not been taught how to take time for self-care (Wolpow et al., 2016). However, self-care is necessary in order to monitor and prevent secondary trauma, fatigue, and burnout among those who care for traumatized youth. Wolpow et al. (2016) address burnout and self-care in their handbook by providing an explanation of self-care and its importance, suggestions for activities related to self-care, and a template for creating a self-care action plan.

Wolpow et al. (2016) also present six principles for compassionate instruction and discipline in classrooms, and a curriculum that addresses strategies for compassion and discipline is based on research and addresses three domains. The authors describe the six principles as "how we teach" and the three domains as "what we teach." The overall goal is to incorporate the six principles into the content of each domain, so the principles become a part of the overall school system. The six principles are as follow:

> (1) always empower, never disempower, (2) provide unconditional positive regard, (3) maintain high expectations, (4) check assumptions, observe, and question, (5) be a relationship coach, and (6) provide guided opportunities for helpful participation (Wolpow et al., 2016, p. 68).

The three domains are as follow:

> (1) safety, connection, and assurance, (2) improving emotional and behavioral self-regulation, and (3) competencies of personal agency, social skills, and academic skills (Wolpow et al., 2016, p. 69).

The authors note that the principles and domains are overarching themes that can be beneficial when working with all students, not just those who have experienced trauma. The handbook also provides strategies for implementation and real-life examples.

Furthermore, some states, such as Illinois, Wisconsin, and Missouri, have posted information and resources related to trauma on state and/or school websites. For example, the Wisconsin Department of Public Education and the Missouri Department of Elementary and Secondary Education websites have an entire section devoted to trauma-sensitive schools initiatives. Additionally, in Pennsylvania, the sanctuary model has been implemented in public schools, as well as in residential treatment facilities (McInerney &

McKlindon, 2014). For example, the Pace School in Pittsburgh is one of a limited number of programs that are certified sanctuary programs, meaning that they have demonstrated an ongoing commitment to open communication, nonviolence, social/emotional learning, growth, and change (Pennsylvania Office of Mental Health and Substance Abuse Services, 2016). Schools like the Pace School (as cited in McInerney & McKlindon, 2014) have reported that after implementing the sanctuary model, the schools saw an increase in student attendance and an increase in the number of students who met or exceeded academic benchmarks.

Summary of Literature Review and Relationship to School-Based Interventions

Experiencing trauma impacts a child's brain development, as well as his or her ability to learn and demonstrate expected behaviors in the school setting. Although access to expensive tests, such as an MRI, in the school setting is not likely, some symptoms can be observed without the use of intrusive or expensive tests. Following a traumatic event, children and adolescents may present with specific behavioral issues and social/emotional challenges, such as school avoidance; peer rejection/withdrawal; substance abuse; violence; somatic complaints, such as frequent headaches or stomachaches; and school dropout (Cook-Cottone, 2004). Additionally, individuals who have experienced trauma have been found to have decreased IQ scores, decreased high-school graduation rates, reading difficulties, attention and concentration challenges, and increased instances of comorbid mental-health challenges, as compared to peers who have not experienced trauma (Kataoka et al., 2012). One must also consider that as these children become adults, they are at increased risk for significant health issues, such as depression and substance abuse, as well as for adoption of high-risk behaviors, such as

promiscuity and smoking. One should also note that individuals who have experienced trauma are at greater risk of attempting suicide than are those who have not experienced trauma (Felitti et al., 1998).

Overall, as indicated by Maslow's hierarchy of needs, when children do not feel safe or are in a constantly heightened physiological state, they are less likely to learn (Duplechain, Reigner, & Packard, 2008). Therefore, school systems need to take into consideration the overall impact that trauma can have on a child's functioning, not only academically, but also emotionally, socially, and behaviorally. This information is important to school professionals because all aspects of a child's functioning impact the child's ability to perform and succeed in the school setting and beyond. Because of the amount of time that children spend in school, schools are in an ideal position to act as a resilience factor, as well as a safe place for intervention and treatment that may not be available elsewhere. Unfortunately, because research on this topic is just emerging, not many replicable, research-based interventions can be implemented in the school setting. Therefore, more research must be conducted in order to create forward progress in an area that has the potential to impact a significant number of individuals.

Current Study

Research Questions

The current study aimed to examine the research on childhood trauma, the impact trauma has on children specifically in the school setting, and training programs for trauma-sensitive practices. The author sought to determine if this information could be combined into a school-based program to develop a training sequence for school staff

that addresses trauma-sensitive practices in schools. The following research questions were addressed:

(1) What would a training program that is geared toward educators and addresses childhood trauma and trauma-sensitive practices look like?

(2) What anecdotal feedback would administrators/counselors/school staff share when asked to review the program?

Hypothesis

Combining research in childhood trauma, trauma-sensitive practices, educator training, and school staff feedback will result in a comprehensive training manual for educator training within a school setting.

Chapter 3: Method

Overview

The current study aims to develop a training program and manual designed to create trauma-informed school environments. Methodology includes a review of the existing literature and programs, as well as a review of a pilot program implemented during the 2016-2017 school year, leading to the development of a Trauma-Informed Practices in Schools (TIPS) training sequence manual with supporting materials. The program manual includes education regarding the prevalence and impact of trauma, suggestions for sensitive policies and procedures regarding school-based trauma, education and suggestions for staff self-care, and universal strategies that can be used by school staff and integrated into the overall school climate.

Pilot Program

The current study reviewed the literature and feedback from volunteer program manual reviewers. Additionally, the current study included information, such as demographics, strengths, and needs, from a pilot program that was implemented in a suburban public school district in southeastern Pennsylvania during the 2016-2017 school year. Information from the pilot program is presented in the following section.

The pilot program was developed and implemented by this author, an employee of the school district in which it was piloted, and a colleague, as part of job responsibilities. Participants in the pilot program included district paraprofessionals and special-areas teachers (i.e., art, music, and gym) from five public schools (three elementary schools, one middle school, and one high school). The demographics of this school district are approximately 86% Caucasian, 6% African American, and 5% Asian.

The average household income is $168,979, and a majority of the adults living within the district are college educated.

The pilot program that was reviewed consisted of an initial presentation to administrators, followed by four staff presentations. The presentation to administration took place during the summer, before school was in session (August 11, 2016). During this presentation, administrators were presented with facts and statistics regarding childhood trauma and the research regarding the educational impact that it may have. That information is presented in depth in Chapters 1 and 2. In addition, trauma-informed practices were specifically connected to the school district mission, and the authors stressed that trauma training was important to the specific goals of the district. Although the pilot program was initially intended for teachers from one of the elementary-school buildings, administration decided to send paraprofessionals and special-areas staff from the whole district in lieu of sending teachers. The administration believed that with a new reading curriculum being rolled out at the start of the new school year teachers would be overwhelmed with too much new information to learn.

Each of the four staff presentations was approximately 2 hours long and was presented during professional development days throughout the school year. The first session was offered on October 3, 2016, with the following three taking place on November 8, 2016, February 17, 2017, and May 16, 2017. Each of the four presentations built on the information presented in the previous session(s). The sequence was created with a logical progression and was based on available research.

During the pilot program, participants were introduced to statistics and research related to childhood trauma, watched the documentary film *Paper Tigers*, were presented

with strategies that could be incorporated into their daily work, and received information and strategies for self-care. The specific objectives of the pilot program were to prepare school staff to support traumatized students by building empathy, creating a trauma-sensitive school climate, and teaching strategies for managing student behaviors with a trauma-sensitive approach.

Hindsight review of the pilot program led to the recognition of strengths, as well as of needs. Specifically, the developers of the pilot program determined that the pilot program may have been more effective had it been presented to smaller groups of participants. (During the pilot program, the number of participants in each phase ranged from approximately 56 to 172 participants). The large group size decreased the possibility of discussion and interaction between presenters and participants. Additionally, program developers discovered that attendance varied greatly because many of the participants missed at least one of the sessions, likely taking personal or sick time on those days. Further, program developers determined that the length of time for each session should be flexible based on the goals of the presentation. Finally, program developers was determined that a more effective way of collecting quantitative data regarding the effectiveness of the program was needed. Surveys were handed out to each participant after each session; however, via district input some participants noted that the surveys were too long. When reviewing the surveys, program developers also noted that some participants did not fully complete their survey, and some did not hand in a survey at all. All of this information was considered and used when creating the current program manual.

Measures and Materials

As the purpose of this study is program development, measures are not included. Materials used included a comprehensive review of the research literature as described in Chapter 2, and a review of the pilot program that was previously described. Additionally, stakeholders in the field of education provided initial reviews to begin the process of expert validity. Several strategies were used in order to ask individuals to provide reviews. First, a variety of school psychologists from across the United States were presented with the opportunity to sign up to review the program manual at the National Association of School Psychologists (NASP) conference in Chicago, IL, during a conference session on trauma-informed schools. Those who volunteered by providing their e-mail addresses were sent an e-mail that included the program manual, as well as a Google form created specifically for program manual feedback. Finally, the author of the program manual personally contacted additional reviewers.. They were asked to provide feedback via e-mail and received the same copy of the program manual and Google form. In all, approximately 32 professionals, mostly working in the field of education, were e-mailed and asked to provide feedback. As of April 28, 2018, there were eight responses.

Procedure

A comprehensive literature review was conducted in order to understand the current research in childhood trauma and trauma-informed practices. This information, along with information regarding the creation and implementation of a pilot program and the author's original ideas, was gathered into a comprehensive manual designed to provide the basis for program development and implementation. Supporting handouts and materials were also reproduced and/or designed and are included within the manual.

The manual is included in its entirety in Appendix A. The manual was made available to individuals who volunteered by providing their e-mail addresses to the author as well as to personal contacts of the author. Most reviewers were school district employees, with the exception of one who was working as a trauma initiatives manager in Southeastern Pennsylvania. Reviewer comments are included in Appendix B.

Chapter 4: Results

This chapter provides the results of the program design. The program manual is included in its entirety in Appendix A of this document. The purpose of this study was to use the available research and a review of a pilot program to create a program manual for trauma-informed trainings for staff in schools. Owing to the lack of currently available programs, the current study addresses an area of need in the field.

Program Overview

The outcome of this project resulted in an 89-page manual. The manual is intended to provide a starting point and general framework for schools to introduce and implement a trauma-informed approach to education. The manual is purposely written in such a way that allows schools to make modifications as needed in order to make the training sequence work in their specific setting. For example, no specific requirements are offered for the length of time for each training nor is a set amount of time prescribed between trainings. Further, recommendations for supplemental materials include materials that range in cost from free to several hundred dollars so that schools have options regardless of budgetary limitations. Creating the manual in this way gives schools the flexibility to modify the presented information to fit within the school/district time constraints and financial budget. The manual offers a variety of suggestions and resources that can be used to communicate the most important information to school staff.

The manual is divided into 10 chapters, which were carefully and purposely developed based on research. Chapter 1 provides an overview of the manual, including an introduction to the purpose of the manual and how to use the manual. Chapter 2

provides a review of the literature and a clear argument in favor of trauma-informed care in schools. Chapters 1 and 2 have also been discussed in detail in the introductory and literature review sections of this study. The reader should refer to those sections for further information.

In Chapter 3, the reader is introduced to the barriers that may be encountered when implementing the program, as well as given suggestions and strategies for staff training. Chapters 4through 7 provide details regarding the information that needs to be presented during each of the four training phases. A review of the literature and existing trauma-informed frameworks uncovered four major themes and thus four phases (i.e., trauma awareness, trauma sensitivity, trauma responsive, and trauma informed), with each one building on the one previous. Information from Chapters 4, 5, 6, and 7 are described here in more detail because they are essential to the program.

Chapter 4: Trauma Awareness

Chapter 4 is the beginning of the explanation of the training phases. The main objective of the first phase of training is to make participants trauma aware. More specifically, during this phase participants are presented with the definition of trauma, are provided with trauma-related statistics regarding the prevalence of childhood trauma, and are encouraged to think about and recognize the impact of trauma on their students. During this phase, participants are presented with the "What," "Why," and "How" (i.e.,**What:** What is childhood trauma? What is the impact on development? **Why:** Why is this training important, and why does school staff need to know the information? **How:** How can we make a difference?).

Chapter 5: Trauma Sensitivity

The second objective of the training sequence is to increase trauma sensitivity of school staff. The expectation is that participants have begun applying their knowledge about trauma-informed care in their daily work. Phase 2 provides further knowledge and additional skills that support adult-student relationships. Further, this phase encourages staff and administration to review school policies in order to determine where trauma-sensitive language/changes could be made. Specific recommendations regarding discipline strategies are provided, as are general strategies related to building relationships.

Chapter 6: Trauma Responsive

The third overarching objective of the training sequence is becoming trauma responsive and teaching self-care. Being trauma responsive means putting knowledge and skills regarding trauma-informed care into practice and integrating the trauma-informed strategies into all aspects of the school culture. Chapter 6 includes specific strategies for self-care, as well as for staff and student empowerment.

Chapter 7: Trauma Informed

At the end of the training sequence, the school environment and school staff should feel more confident in their abilities to respond to children who have experienced trauma. Chapter 7 makes clear that Phase 4 is not necessarily the *end* of training, but rather is an ongoing maintenance phase. Chapter 7 suggests that participants should share input and experiences during this phase. Further, participants should be encouraged and challenged to continue to deepen their understanding of trauma, as well as to increase

their personal investment in the implementation of the strategies that are provided throughout the phases.

Chapter 8 of the manual includes manual reviews from interested stakeholders, as well as suggestions for how to continue growing and improving as a trauma-informed school/district well into the future. Chapter 9 includes a reference list of resources used in the creation of this program, and Chapter 10 includes three appendices, which provide recommended supplemental resources, including links to videos and books. The program manual, in its entirety, is included as Appendix A of this study.

Program Feedback

The *Trauma-Informed Practices in School (TIPS)* manual was made available to interested individuals for review. Voluntary respondents included an assistant principal, four school psychologists, a school counselor, a social worker, and a social worker currently working as a trauma initiative impact manager. Feedback from these stakeholders is included as Appendix B of this study. Several respondents reported that the manual was "jargon free and easy to read" and "user friendly." Respondents also indicated that the take-away strategies were helpful, the manual was easy to follow, and the facts and data would be helpful when communicating with staff and administrators.

One should note that one respondent had questions regarding the target audience. An opening message that provides more details to the facilitator of the training may be helpful with regard to who ideally should implement the program and provide more specific support for doing so. In order to address this need, future manual editions could contain an additional appendix that includes an introduction letter to the individual who will be implementing the program. Finally, that same reviewer also had questions

regarding the focus of the manual, specifically if it was meant to be a Tier 1 intervention and, if so, asked, “What about Tier 2/Tier 3 levels?” Including information on Tiers 2 and 3 might be an important factor to consider in future editions of the program manual.

Chapter 5: Discussion

The purpose of this study was to design a program manual for school staff training in the area of trauma-informed practices. Research on the significant impact of childhood trauma on the cognitive, academic, social, emotional, and behavioral development of children is becoming more widely available; however, to date, no training manuals providing specifics for training school staff could be found. Development of such a program was the primary goal of this study.

The following research questions were examined: "What would a training program that is geared toward educators and addresses childhood trauma and trauma-sensitive practices look like?" and "What anecdotal feedback would administrators/counselors/school staff share when asked to review the program?" The program design resulted in an 89-page manual that is intended to provide a framework for introducing trauma-informed care and strategies into the school system. Following the design of the program, the manual was shared with interested stakeholders for review.

The major finding of this study was that the current research could be reviewed and combined to create a comprehensive manual for universal trauma-informed training of educators. The overall result was an 89-page manual that initial readers felt to be comprehensive, easy to read, and jargon free. The outline of the program included suggestions for implementation, ongoing use of the program, a reproducible toolkit, and additional resources for the readers. Further, based on initial reviewer comments, the program is reasonable to implement and would be recommended for implementation if it were widely available. Initial reviewer comments are described in the following section.

Reviewer comments: The initial reviewers of this manual included an assistant principal, four school psychologists, a school counselor, a school social worker, and a social worker currently working as a trauma initiatives manager in southeastern Pennsylvania. In general, the feedback was positive, specifically indicating that the manual was user friendly, jargon free, and provided useful take-away strategies. Comments from reviewers indicate that this training sequence provides a useful and cohesive system for educating and training school staff on the topic of trauma and encouraging trauma-informed practices within schools.

Needs identified by reviewers included concerns regarding time constraints for trainings and administrator buy-in. With regard to the time required for training, this manual is meant to address that by being flexible and allowing schools/districts to choose how they break up the trainings. Administrator buy-in is a bit more difficult to address; however, a great deal of the data and factual information presented in the manual may be helpful when trying to get administration on board.

Implication of Findings and Future Work

This study resulted in a manual that is based on current research that indicates not only the need for such a program because of the number of youth who are exposed to trauma, but also the considerable impact that this program may have on future outcomes of children. The significant need for this program is based on research, such as the ACE study by Felitti et al. (1998). The study by Felitti et al. (1998) indicated that approximately 50% of children experience at least one adverse experience during childhood and that the more adverse experiences, the higher the risk for disease and early death, including substance abuse, depression, and suicide attempts. The ACE study has

been replicated, and the findings have been similar (Hochman & Stevens, 2017). Additional research has shown that childhood trauma can have a biological impact on brain development and that the affected neurobiological systems include areas necessary for academic achievement. More specifically, trauma may significantly impact the hippocampus, which is crucial for learning and memory, and the prefrontal cortex, which is important for executive skills, such as shifting and forming associations (Carrion & Wong, 2012). Additionally, research indicates that brain areas related to emotion regulation and emotional expression are also impacted by trauma (Cook-Cottone, 2004). Not only does research show that trauma can have an impact on the physical brain structure, but also additional research has indicated that children who have experienced traumatic events are at higher risk for academic, behavioral, and social/emotional deficits (Cole et al., 2005).

While the research is clear that adverse childhood experiences can contribute to negative, long-term outcomes, consistent and appropriate interventions clearly may mitigate or reverse damage. More specifically, research has shown that neural circuits that have been damaged as a result of childhood trauma can be corrected and that individuals' brains (and behaviors) can be reshaped, even into adulthood (Hosier, 2013). Furthermore, one study was found that children who had a neurological profile indicative of PTSD demonstrated changes in behavior and brain chemistry following intervention that were more typical (Sorrels, 2015). Owing to the significant amount of time that children and adolescents spend in the school setting, the school setting clearly may be the most effective place for intervention.

Research on the impact of trauma, as well as the research on the impact of interventions, combined with the lack of available research on school-based educator training, led to the determination that a program manual was needed. The manual is purposefully written in a way that allows for flexible implementation as a result of the recognition of the differences that exist within school systems. Given the lack of current programs/trainings for school staff on the topic of trauma, this training sequence provides a good starting place for school settings. However, future research and evaluation are needed in this area.

Initial review of the manual provided a foundation for gaining support for the program. The next logical step would be to implement the program as described. Initial program implementation would likely need to focus on changes within the participants, student outcomes, and program evaluation in order to determine the strengths of the program, as well as possible future changes.

Initial reviews also indicated areas that future work should consider. First, future research might include research specific to tiers of support and differences in service delivery and strategies for each tier. Future work also may be needed to address specific needs of children across different age levels (i.e., preschool, elementary school, middle school, and high school).

Finally, owing to an increasing amount of available research and observed interest in this area, future work may incorporate updated data from current research, as well as reviews and incorporation of any programs that may be developed in the near future. Furthermore, as the impacts of childhood trauma continue to become clearer, future work may include incorporating this training sequence into teacher training or course

requirements and/or provide a way for school staff to fulfill specific professional-development requirements.

Limitations of the Current Study

The major limitation to the current study is the lack of implementation-based data. Although initial reviews from stakeholders provide promising interest in and validity for the general use of the program, program effectiveness is not considered proven until implemented as intended and outcomes are appropriately measured. Owing to the design of the current study, outcome data were not available; these data would be the most significant measure of the actual effectiveness of the program.

Further, the differences in presentation and needs of children impacted by trauma and district demographics may affect the overall generalizability of the program. As noted previously, the pilot program that the current program manual is based on was implemented in a predominantly Caucasian public-school district where the average household income is higher than the national average and most residents are college educated. In order to address possible generalizability issues, the program was designed with flexibility in mind and created as a general framework so as to accommodate the uniqueness of districts, as opposed to being presented with strict step-by-step implementation instructions. However, in order to determine generalizability, the program needs to be implemented in areas with variable demographics. Additionally, in order to address some of the possible implementation issues, future work may require more specific instructions and recommendations for initiating and implementing the program.

Comments from stakeholders also identified limitations to the study. One such example is from one of the eight respondents who, after reading the manual, was unclear about who the target audience was and for what level of intervention this manual should be used. A future version of this program may aim to be clearer regarding those areas. One way to do so may be to include an additional appendix with a letter to the program facilitator that outlines facilitator responsibilities and a welcome letter to the participants. Finally, to address the second question regarding level of support, future editions of the program manual may aim to include information specific to Tier 2 and Tier 3 supports.

Summary and Conclusions

A significant amount of the current research focuses on the adverse impact that childhood trauma can have on the development of children, as opposed to how to intervene, specifically in the school setting. The current study used research on childhood trauma in conjunction with interventions that have been used in other treatments settings to design a program that can be used to assist in service delivery. In addition, the program was meant to increase school staff awareness of and sensitivity to students who have experienced trauma. Furthermore, the program was meant to support the needs of all learners by increasing the quality of services and supports offered to school-aged children.

The 89-page *Trauma-Informed Practices in Schools (TIPS)* manual was the result of the current study. It includes information for school staff to implement this type of training sequence in their schools. The overall framework of the program is based on research on the impact of childhood trauma on the development and functioning of school-aged children.

The current project achieved its primary objectives, which were to use current research to create a program manual and to gather comments from voluntary program reviewers. The results of this study demonstrated that one could design a training sequence meant to train school staff on trauma-informed care practices. The overall strength of this manual is its user friendly format and its addressing of childhood trauma, which because of the rates at which youth in the United States are being exposed to trauma has been referred to as a "public health problem" (Mendelson et al., 2015). Further, the program manual addresses an issue that appears to be largely ignored, or at least understudied, in the context of the school environment, until more recently. Comments from initial manual reviewers indicated overall support for the program. Issues to be addressed, such as limitations of time for training, administrator buy-in, and future directives for research, were also identified by initial reviews.

The impact of childhood trauma, including cognitive, academic, social, emotional, behavioral, and physical health deficits, has become clearer as a result of more recent research and growing interest. Childhood trauma is a widespread issue that touches the lives of approximately half of all children (Felitti et al., 1998) and does not discriminate based on such variables as race, socioeconomic status, or gender. This program incorporates current trends and best practices to assist school districts in providing high-quality services to students across all domains.

References

Amaya-Jackson, L., Reynolds, V., Murray, M. C., McCarthy, G., Nelson, A., Cherney, M. S., . . . March, J. S. (2003). Cognitive-behavioral treatment for pediatric posttraumatic stress disorder: Protocol and application in school and community settings. *Cognitive and Behavioral Practice*, *10*(3), 204-213.

American Psychological Association. (2018). The road to resilience. Retrieved from http://www.apa.org/helpcenter/road-resilience.aspx

Banks, J., & Vargas, L.A. (2009). Sanctuary in schools: Preliminary child and organizational outcomes. *Center for Learning and Innovation Research Brief.* Retrieved from http://sanctuaryweb.com/Portals/0/Bloom%20Pubs/Related%20Authors/2009%20Banks%20and%20Vargas%20Sanctuary%20in%20Schools.pdf

Bloom, S. (1995). Creating sanctuary in the school. *Journal for a Just and Caring Education, 1*(4): 403-433.

Bloom, S. (2017). The sanctuary model: Through the lens of moral safety. In Gold, S. N. (Ed). *APA handbook of trauma psychology: Trauma practice* (pp. 499-513). Washington, DC: American Psychological Association.

Bloom, S. L., & Sreedhar, S. Y. (2008). The sanctuary model of trauma-informed organizational change. *Reclaiming Children and Youth*, *17*(3), 48-53.

Carrion, V. G., & Wong, S. S. (2012). Can traumatic stress alter the brain? Understanding the implications of early trauma on brain development and learning. *Journal of Adolescent Health, 51*(2), S23-S28. doi:10.1016/j.jadohealth.2012.04.010

Cole, S. F., O'Brien, J. G., Gadd, M. G., Ristuccia, J., Wallace, D. L. & Gregory, M. (2005). Helping traumatized children learn: A report and policy agenda. Massachusetts Advocates for Children. Retrieved from https://traumasensitiveschools.org/

Cook-Cottone, C. (2004). Childhood posttraumatic stress disorder: Diagnosis, treatment, and school reintegration. *School Psychology Review, 33*(1), 127-139.

Cronholm, P. F., Forke, C. M., Wade, R., Bair-Meritt, M. H., Davis, M., Harkins-Schwarz, M., … Fein, J. A. (2015). Adverse childhood experiences: Expanding the concept of adversity. *American Journal of Preventive Medicine, 49*(3), 354-361.

Duplechain, R., Reigner, R., & Packard, A. (2008). Striking differences: The impact of moderate and high trauma on reading achievement. *Reading Psychology, 29,* 117-136.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., …Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine,14*(4), 245-258. doi:10.1016/S0749-3797(98)00017-8

Gerrity, E., & Folcarelli, C. (2008). Child traumatic stress: What every policymaker should know. Durham, NC: National Center for Child Traumatic Stress.

Herrman, H., Stewart, D. E., Diaz-Granados, N., Berger, E. L., Jackson, B., & Yuen, T. (2011). What is resilience? *The Canadian Journal of Psychiatry, 56*(5), 258-265.

Hochman, A., & Stevens, J. (2017). Mechanisms by which adverse childhood experiences influence health and well-being throughout the lifespan. *Community Resilience Cookbook*. Retrieved from http://communityresiliencecookbook.org/your-body-brain/

Hosier, D. (2013). Recovery: How the brain can rewire itself (neuroplasticity). *Childhood Trauma Recovery*. Retrieved from http://childhoodtraumarecovery.com/

Jaycox, L. H., Morse, L. K., Tanielian, T., & Stein, B. D. (2006). *How schools can help students recover from traumatic experiences: A tool kit for supporting long-term recovery.* Retrieved from http://www.rand.org/content/dam/rand/pubs/technical_reports/2006/RAND_TR413.pdf

Kataoka, S., Langley, A., Wong, M., Baweja, S., & Stein, B. (2012). Responding to students with PTSD in schools. *Child and Adolescent Psychiatric Clinics of North America, 21*(1), 119-124. http://doi.org/10.1016/j.chc.2011.08.009

Lakeside Global Institute. (n.d.). Retrieved from https://lakesidelink.com/training/

Lang, J. M., Campbell, K., Shanley, P., Crusto, C. A., & Connell, C. M. (2016). Building capacity for trauma-informed care in the child welfare system: Initial results of a statewide implementation. *Child Maltreatment, 21*(2), 113-124. doi:10.1177/1077559516635273

McInerney, M., & McKlindon, A. (2014). Unlocking the door to learning: Trauma-informed classrooms & transformational schools. *Education Law Center. Web. Unlocking the Door to Learning: Trauma–Informed http://www. elc-pa. org/wp-content/uploads/2015/06/Trauma-Informed-in-Schools-Classrooms-FINAL-December2014-2. pdf*.

Mendelson, T., Tandon, S. D., O'Brennan, L., Leaf, P. J., & Ialongo, N. S. (2015). Brief report: Moving prevention into schools: The impact of a trauma-informed school-based intervention. *Journal of Adolescence, 43*, 142-147. doi:10.1016/j.adolescence.2015.05.017

MO Department of Mental Health and Partners (2014). Missouri Model: A Developmental Framework for Trauma Informed. Retrieved from https://dmh.mo.gov/trauma/MO%20Model%20Working%20Document%20february%202015.pdf

Morrissey, J. P., Jackson, E. W., Ellis, A. R., Hortensia, A., Brown, V. B., & Najavits, L. M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services*, (10), 1213-1222. doi:10.1176/appi.ps.56.10.1213

The National Child Traumatic Stress Network. (n.d.). Impact of complex trauma. Retrieved from http://www.nctsn.org/trauma-types/complex-trauma/effects-of-complex-trauma

The National Child Traumatic Stress Network (2008a). TGCT: General information. Trauma informed interventions. Retrieved from http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/TGCT_General.pdf

The National Child Traumatic Stress Network (2008b). MMTT: General information. Trauma informed interventions. Retrieved from http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/MMTT_General.pdf

Oehlberg, B. (2008). Why schools need to be trauma-informed. *Trauma and Loss: Research and Interventions, 8*(2), 1-4. Retrieved from https://www.starr.org

Overstreet, S., & Chafouleas, S. M. (2016). Trauma-informed schools: Introduction to the special issue. *School Mental Health, 8(1)*, 1-6. doi: 10.1007/s12310-016-9184

Pachter, L. M., Lieberman, L., Bloom, S. L., & Fein, J. A. (2017). Developing a community-wide initiative to address childhood adversity and toxic stress: A case study of the Philadelphia ACE Task Force. *Academic Pediatrics 17*(7), S130-S135.

Pennsylvania Office of Mental Health and Substance Abuse Services (2016). Pennsylvania recovery and resiliency. Retrieved from http://parecovery.org/.

Purvis, K. B., Cross, D. R., Federici, R., Johnson, D., & McKenzie, L. B. (2007). The hope connection: A therapeutic summer day camp for adopted and at-risk children with special socio-emotional needs. *Adoption & Fostering*, *31*(4), 38-48.

Rossen, E., & Cowan, K. (2013). The role of schools in supporting traumatized students. *Principal's Research Review, 8*(6), 1-7.

Sherin, J. E., & Nemeroff, C. B. (2011). Post-traumatic stress disorder: The neurobiological impact of psychological trauma. *Dialogues in Clinical Neuroscience, 13*(3), 263-278.

Sorrels, B. (2015). *Reaching and teaching children exposed to trauma*. Lewisville, NC: Gryphon.

Sporleder, J., & Forbes, H.T. (2016). *The trauma-informed school.* Boulder, CO: Beyond Consequences Institute.

Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services: Treatment improvement protocol (TIP) Series 57.* HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Walker, J. S., & Weaver, A. (2007). Traumatic stress and the child welfare system. *Focal Point*, 21(3).

Walkley, M., & Cox, T. L. (2013). Building trauma-informed schools and communities. *Children and Schools, 35*(2), 123-126. doi:10.1093/cs/cdt007

Wolmer, L., Hamiel, D., & Laor, N. (2011). Preventing children's posttraumatic stress after disaster with teacher-based intervention: A controlled study. *Journal of the American Academy of Child & Adolescent Psychiatry, 50*, 348.e2. doi:10.1016/j.jaac.2011.01.002

Wolpow, R., Johnson, M. M., Hertel, R., & Kincaid, S. O. (2016). The heart of learning and teaching: Compassion, resiliency, and academic Success. Olympia, WA: Office of Superintendent of Public Instruction. Retrieved from http://www.k12.wa.us/compassionateschools/pubdocs/TheHeartofLearningandTeaching.pdf.

Appendix A

Trauma-Informed Practices in Schools (TIPS):

A Program Manual and Toolkit for Educators

Developed by Kerri A. Flatau, Ed.S., NCSP

Trauma-Informed Practices in Schools (TIPS)
Program Manual and Toolkit

Table of Contents

Chapter 1: Introduction

Children are being exposed to trauma at much higher rates than previously believed (Rossen & Cowan, 2013). The Adverse Childhood Experiences (ACE) study found that of 17,000 adults surveyed, 50% reported having been exposed to at least one type of childhood adversity (Felitti et al., 1998). In addition, the number of children and adolescents in the United States who have been exposed to traumatic events has increased significantly over the past few years. This statistic cannot be ignored because, unfortunately, that number is not likely to decrease anytime soon (Jaycox, Morse, Tanielian, & Stein, 2006).

Trauma can have severe, long-lasting effects on an individual. However, with careful and purposeful interventions, the impact can be reversed or at least minimized (Rossen & Hull, 2013; Sorrels, 2015). As a result, teachers and school staff need to be trained on this topic. The minimal research currently available indicates positive student outcomes related to trauma-sensitive practices in schools (Crosby, 2015). Positive changes related to a trauma-sensitive environment include increased test scores, decreased school dropout, decreased office referrals related to behavior, and a more positive school climate (Oehlberg, 2008).

The staff members in trauma-sensitive schools are expected to share an understanding that traumatic experiences are more common than some might imagine. They understand how these experiences can impact learning, behavior, and overall development and the absolute need for a school-wide approach to be implemented to address this issue. Trauma-sensitive school environments increase students' feelings of safety (emotionally and physically) and prioritize positive relationships.

Purpose of This Manual

School systems need to take into consideration the overall impact that trauma can have on a child's functioning, not only academically, but also emotionally, socially, and behaviorally. This information is important to school professionals because all aspects of a child's functioning impact the child's ability to perform and succeed in the school setting and beyond. Because of the amount of time that children spend in school, schools are in an ideal position to act as a resilience factor and a safe place for intervention and treatment that may not be available elsewhere.

The purpose of this manual is to provide a resource and training sequence that schools can use as part of their daily operation to meet the individual needs of all students. This manual aims to provide a starting point for schools to use as a means of becoming trauma informed. The information and strategies presented in this manual are intended to implement school-wide changes in attitude and practice, while also ensuring that the needs of all students are met. The design of this manual is flexible in order to allow opportunities for schools to make changes specific to the needs of their students.

How to Use This Manual

The intention of this manual is to provide a starting point and a general framework for schools to introduce and implement a trauma-informed approach to education. This *Trauma-Informed Practices in Schools (TIPS)* manual was designed to assist schools in delivering interventions that address the academic, behavioral, social, and emotional needs of students. The TIPS program that will be introduced throughout this manual promotes a cultural shift and an overall climate change that aim to reach all students, not just those impacted by trauma.

Following this introductory chapter, manual content begins in Chapter 2. In Chapter 2, you will find the definition of trauma used for the purpose of the TIPS training sequence, a review of the ACE study, statistics regarding the prevalence of childhood trauma, and specific information regarding the educational impact of trauma. The chapter also explains why trauma-informed schools are so important and how implementing even small changes in the school environment can lead to big changes in brain development, behavior, academic and social achievement, and overall future success.

The author of this manual recognizes that trauma is a broad term that encompasses a wide variety of causes and presentations. Creating a trauma-informed environment requires a shift in mindset for some individuals, top-down commitment to ongoing professional development, and an emphasis on self-care. The author does not intend to suggest that school staff can be trained once with this manual and then be considered "trauma informed." This program is meant to be a starting point that leads to ongoing training, discussion, change, and commitment to educating all children in a way that maximizes their success in every domain.

Chapter 2: The Need for Change

Research Implications

Research has shown that children who experience trauma(s) may experience long-term physiological, behavioral, and educational consequences (The National Child Traumatic Stress Network, n.d.). When children experience trauma at a young age, the world can feel like a dangerous place, and their brains may become hardwired in a state of "fight or flight." Being in a state of fight or flight can cause an individual to feel the need to be hyperalert and ready to move at all times (Cole et al., 2005); therefore, the majority of their cognitive energy is spent ensuring their own sense of safety. Owing to this state of hyperarousal, evidence shows that concentration, organization, memory, and language abilities are diminished in children who have been exposed to trauma (Cole et al., 2005). Furthermore, when children experience trauma, they are at higher risk of engaging in behaviors that may be perceived as insubordinate, oppositional, irrational, or disorderly. Teaching educators how to recognize signs of trauma is important so they do not misunderstand the reasons that underlie some children's academic, social, emotional, and behavioral difficulties. In fact, preliminary studies have shown that school-based implementation of trauma-informed practices have resulted in decreased suspensions and office referrals (Smith, as cited in Overstreet & Chafouleas, 2016) and increased academic success (Crosby, 2015; Oehlberg, 2008).

Additionally, children who have a history of trauma are more likely to experience learning difficulties, as well as challenges related to social, emotional, and behavioral functioning in the school setting (Cole et al., 2005) than children who do not have a history of trauma. In general, children who have experienced trauma have been found to

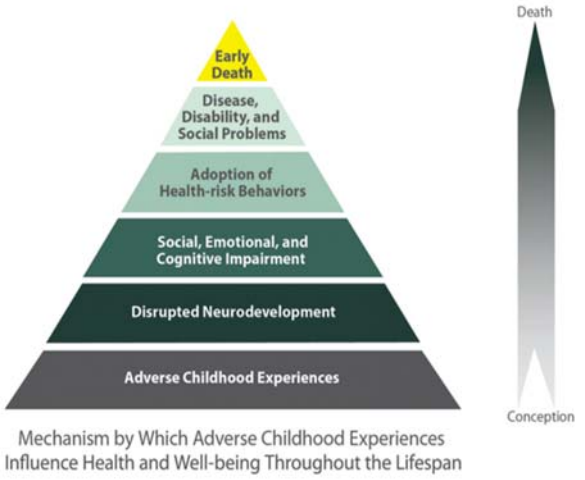
have lower IQ scores, lower overall GPA, increased peer rejection, increased school absence, and decreased graduation rates as compared to children who have not experienced trauma (Kataoka, Langley, Wong, Baweja, & Stein, 2012). If teachers are educated regarding the signs of trauma, they may be better equipped to intervene with students who are demonstrating challenges. Furthermore, teachers may also potentially prevent retraumatization resulting from exposure to triggers. Therefore, with the emerging literature that focuses on the definition, rates, and impact of trauma, the lack of research that specifically explores evidence-based, trauma-focused interventions, particularly in the school setting, is surprising.

Adverse Childhood Experiences (ACE) Study:

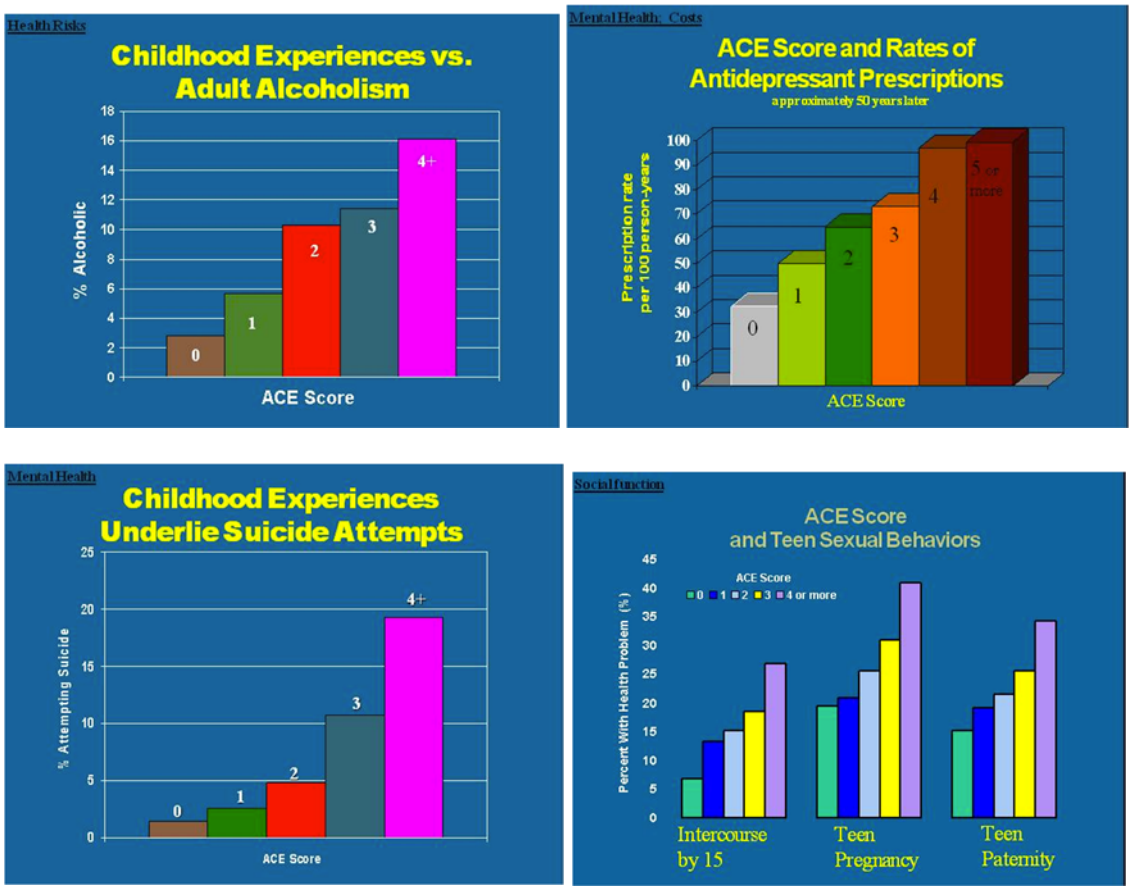
A discussion of childhood trauma and the impact it has on a child's functioning is nearly impossible without presenting information from the ACE study. The information and results from this study are eye opening, and thus, school board members and members of administration must be made aware of this study and its implications. As is often the case, in order to create significant, widespread change, the individuals who are in a position to make organizational decisions need to be on board.

The ACE study was one of the first studies to address the relationships between exposure to adverse events in childhood and high-risk behaviors and disease (Felitti et al., 1998). The researchers in this study gathered information through questionnaires that were mailed to adults in the San Diego area of California. The respondents ranged in age from 19 to 92 years, approximately 52% were women, and 79% were white. Almost half of the respondents were college educated (43%), and all participants were covered by private health insurance.

Each individual who received a survey had completed a standard medical evaluation between August 1995 and March 1996 (with the exclusion of December). The surveys were mailed out 1 week after their examination. The survey addressed adverse childhood experiences in the areas of abuse (i.e., sexual, physical, psychological) and household dysfunction (i.e., substance abuse, mental illness, mother treated violently, and criminal behavior in household). The results of the study indicated a strong relationship between childhood exposure to abuse and/or household dysfunction and risk factors for disease and early death, such as substance abuse, depression, suicide attempts, smoking, and promiscuity (Felitti et al., 1998). More specifically, as compared to individuals with an ACE score of 0, individuals who reported ACE scores of 4 or more were twice as likely to smoke, 5 times more likely to have used illicit drugs, 7 times more likely to abuse alcohol, and 12 times more likely to attempt suicide (Centers for Disease Control and Prevention, n.d.; Stevens, n.d.). Further, health concerns, such as smoking and drug/alcohol use, as well as use of antidepressants, suicidality, and teen pregnancy, increased in a step-wise fashion as the ACE score increased (Felitti & Anda, 2010).



(Image retrieved from Centers for Disease Control and Prevention https://www.cdc.gov/violenceprevention/acestudy/ACE_graphics.ht



(Images from Felitti & Anda, 2010)

Philadelphia Expanded ACE Study

Since the publication of the ACE study, a number of states, social service agencies, pediatricians have conducted their own ACE surveys, which have generally resulted in similar findings (Hochman & Stevens, 2017). For example, the city of Philadelphia in Pennsylvania conducted a version of the ACE study in order to explore whether living in a more urban setting would bring additional stressors that were not covered in the original study (Cronholm et al., 2015). Philadelphia used the framework of the ACE study to create the Philadelphia ACE Task Force (PATF). PATF was originally created with the goal of integrating ACE screenings into pediatric primary care, but eventually expanded to focus more broadly on a community-based approach to

addressing ACE through a variety of sectors in the city and the entire Philadelphia region (Pachter, Lieberman, Bloom, & Fein, 2017). The PATF has successfully conducted research regarding ACE in an urban setting and identified the presence and impact of "expanded ACE" in addition to the "conventional ACE" that were studied in the original study (Cronholm et al., 2015). The expanded ACE that were identified included racism, witnessing violence, living in an unsafe neighborhood, experiencing bullying, and having a history of living in foster care (Cronholm et al., 2015). Cronholm et al. (2015) found that approximately one half of their respondents experienced one to three of the conventional ACE and one fifth experienced four or more. In regard to expanded ACE, the study revealed that approximately half of the respondents experienced one to two and about 13% experienced three or more. Further, almost one half of the participants in this study reported experiencing both types of ACE, and almost 14% experienced only expanded ACE, meaning they would have gone unrecognized in the original ACE study.

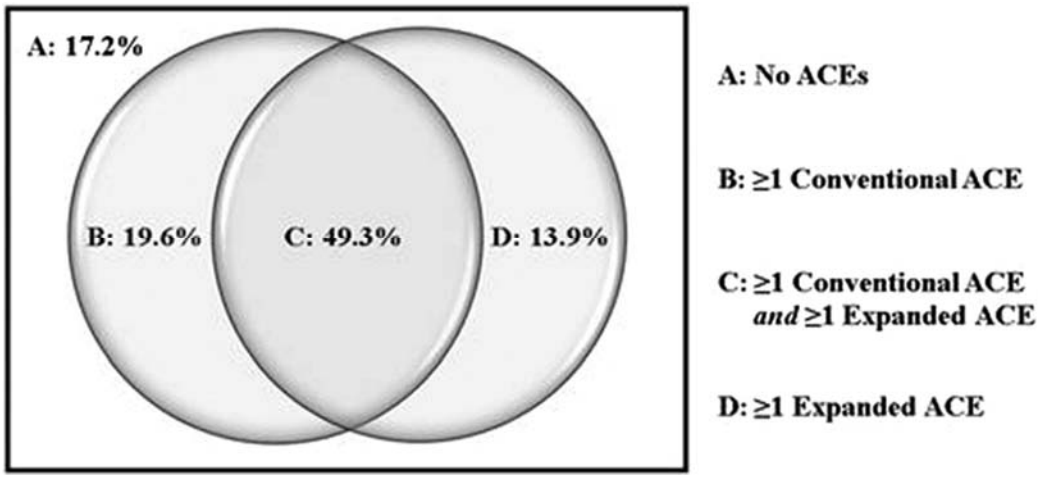


Image from Cronholm et al., 2015

This study suggests that ACE are not confined to the home setting, but occur at the community level as well. As pointed out by Cronholm et al. (2015), research such as

theirs is necessary in order to accurately classify ACE among subgroups and in various contexts. Furthermore, such research can help drive prevention efforts and interventions in a way that specifically meets the needs of the population served.

Prevalence of Childhood Trauma and Related Statistics

The following statistics are taken directly from The National Child Traumatic Stress Network website and can be found at http://www.nctsn.org/resources/topics/facts-and-figures

- In a nationally representative survey of 12- to 17-year-old youth, 8 percent reported a lifetime prevalence of sexual assault, 17 percent reported physical assault, and 39 percent reported witnessing violence.
Kilpatrick ,D. G., & Saunders, B. E. (1997). Prevalence and Consequences of Child Victimization: Results from the National Survey of Adolescents. National Crime Victims Research and Treatment Center, Medical University of South Carolina.

- A longitudinal general population study of children and adolescents (9-16 years old) in western North Carolina found that one quarter had experienced at least one potentially traumatic event in their lifetime, 6 percent within the past three months.
Costello, E. J., Erkanli, A., Fairbank, J. A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress*, *15*(2), 99-112.

- In a continuation of the North Carolina study, more than 68% of children and adolescents had experienced a potentially traumatic event by the age of 16. Full-blown PTSD was rare, occurring in less than one half of one percent of children studied. Other impairments---including school problems, emotional difficulties, and physical problems---occurred in more than 20% of children who had been traumatized. In those who had experienced more than one traumatic event, the rate was nearly 50%.
Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry, 64*(5), 577-584.

- Among 536 elementary and middle school children surveyed in an inner city community, 30 percent had witnessed a stabbing and 26 percent had witnessed a shooting.
Bell, C.C., & Jenkins E. J. (1993). Community violence and children on Chicago's Southside. *Psychiatry*, *56*(1), 46-54.

- Among middle and junior high school students (n=2248) in an urban school system, 41 percent reported witnessing a stabbing or shooting in the past year.
Schwab-Stone, M. E., Ayers, T. S., Kasprow, W., & Voyce, C. (1995). No safe haven: A study of violence exposure in an urban community. *Journal of the American Academy of Child and Adolescent Psychiatry*, *34,* 1343-1352.

- Relatively high rates of exposure in the past year, varying by location and size of the

high school, were reported by high school students (n=3735) surveyed in six schools in two states. Among males, 3 to 33 percent reported being shot or shot at, and 6 to 16 percent reported being attacked with a knife. Among females, there were lower reported rates of victimization except for sexual abuse and assault.

Singer, M. I., Anglin, T. M., Song, L. Y., & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma, *Journal of the American Medical Association*, *273,* 477-482.

Educational Impact of Trauma

Academic Performance

Experiencing trauma can disrupt a variety of developmental skills that impact the ability to learn. Among other things, academic skills require the ability to pay attention, organize one's thoughts and environment, comprehend language, communicate expressively, and produce work (Cole et al., 2005). Experiencing trauma has the potential to impact all of the skills that are necessary for learning. The symptoms of childhood trauma that may be evident at school can look similar to other educational or psychiatric disabilities. These similarities can make distinguishing one from the other difficult for teachers and other school staff (Rossen & Cowan, 2013).

Language development and executive functions (i.e., focus and attention) are two areas that may be affected. Trauma may impact a child's language development because it can interfere with the ability to process verbal information, as well as the ability to use expressive communication (Cole et al., 2005). Traumatized children also demonstrate more difficulty organizing materials, which is one of the prerequisites for academic success (Cole et al., 2005). For example, children who have had ACE related to household dysfunction demonstrate difficulty with sequential organization of materials and memories. Difficulty with sequential organization may decrease a child's ability to learn new information sequentially and may therefore cause difficulty with organizing

and processing information that they need to retrieve and apply at a later time (Cole et al., 2005).

In regard to executive functions, studies have shown that trauma symptoms in the classroom can manifest in ways that decrease a child's ability to focus and attend to instruction (Cole et al., 2005). A child may display symptoms of inattention that are related to trauma in a variety of ways. One example may be a child who completely dissociates from the environment, whereas another may be too focused on determining the mood of the adults in the environment. When children cannot focus, keeping up with academic lessons and completing assigned work are difficult (Cole et al., 2005).

Behavioral Domain

Children who are exposed to trauma may behave negatively or act out in an attempt to gain attention or as a way of acting out their personal pain (Cole et al., 2005). Children who have experienced trauma may adopt coping strategies, such as social withdrawal, aggressive behaviors, or self-medication (i.e., substance abuse), as a way of avoiding retraumatization or to deal with their pain. Additionally, owing to hyperarousal, children who have experienced trauma may react in a way that is disproportionate to the situation. These children may also demonstrate physical or verbal aggression toward teachers and peers as a result of increased impulsivity and reactivity (Cole et al., 2005). A child's behavior may be linked to his or her inability to take another person's perspective, disruptions in language development, decreased ability to interpret social cues, difficulty with emotional regulation, and/or decreased ability to problem solve, all of which are linked to childhood trauma (Cole et al., 2005).

Social Skills

Positive relationships with peers and adults are an invaluable protective factor for children. However, children who have experienced trauma may have a difficult time connecting to others (Cole et al., 2005). Their traumatic stress and negative relationships with others outside of school can negatively impact the way they respond to and interact with adults and peers in the school setting (Cole et al., 2005). Children who have experienced trauma may be distrustful of adults or concerned with the overall safety of the school setting. All children can benefit from positive adult relationships, but the formation of such relationships is especially important for traumatized children (Cole et al., 2005).

In regard to peer relationships, children who have experienced trauma may have delayed social skills and may not know how to interact with peers in an age-appropriate manner (Cole et al., 2005). Because these children may be impulsive, aggressive, or withdrawn, their peers may not want to interact with them, or they may even be frightened of them (Cole et al., 2005). Furthermore, traumatized children may have a difficult time reading social cues, and they may not have the language skills needed to appropriately communicate with their peers (Cole et al., 2005); consequently forming and maintaining relationships is difficult

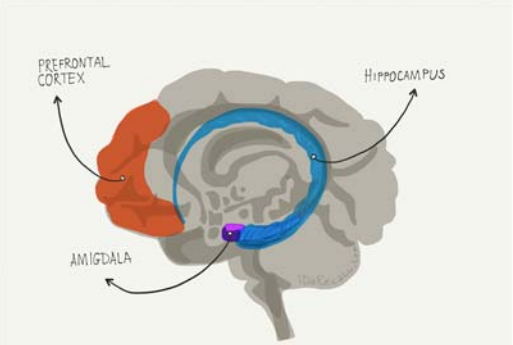


Image from http://idorecall.com/blog/the-neuroscience-of-learning-and-memory/

Neurobiological Impact of Trauma

Research indicates that trauma can have a biological impact on brain development and may negatively affect neurobiological systems that are crucial for academic achievement. Research has shown that trauma

may significantly impact the hippocampus and the prefrontal cortex, which are brain structures critical to learning and memory (Carrion & Wong, 2012). Furthermore, the hippocampus, which is crucial for learning, memory, control of stress responses, and fear conditioning, has been found to be smaller in individuals who have experienced trauma as compared to those who have not (Sherin & Nemeroff, 2011). According to Carrion and Wong (2012), children with a history of trauma demonstrated decreased hippocampal activity during a memory task and performed worse than "healthy" children on memory retrieval tasks.

The prefrontal cortex, which plays a significant role in executive skills, such as shifting and forming associations between stimuli and response (Carrion & Wong, 2012), is also negatively impacted by trauma. Specifically, like the hippocampus, the frontal cortex has been found to be smaller in individuals who have experienced trauma as compared to those who have not (Sherin & Nemeroff, 2011). Owing to the impact of trauma on the prefrontal cortex, studies have found that individuals with trauma history often have difficulty sustaining attention, suppressing intrusive thoughts, and decreasing fear responses (Carrion & Wong, 2012). Each of these deficits may make learning and completing academic tasks difficult.

Other areas of the brain, such as the amygdala, which is related to emotion regulation and emotional expression, are also known to be impacted by trauma (Cook-Cottone, 2004). The amygdala has been found to be hyperactive in individuals who have experienced trauma, thereby promoting a state of hypervigilance and decreasing the individual's ability to discriminate between a threat and nonthreat (Sherin & Nemeroff, 2011). Related to these deficits, trauma can cause a consistent state of flight or fight

during which the individual is constantly on alert and may perceive benign situations as threatening. Examples of flight, fight, and freeze responses follow (from Trauma Informed Care: A Toolkit for Educators-included as Appendix B):

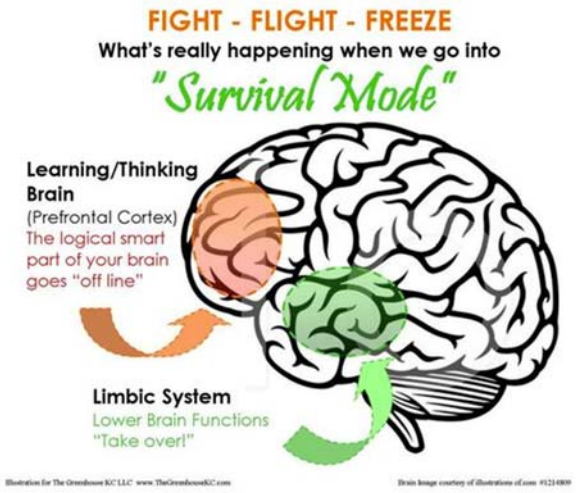


Image used with permission from http://www.thegreenhousekc.com/se.html

Flight responses:

- Withdrawal
- Eloping from the classroom
- Skipping class
- Daydreaming
- Appearing to sleep
- Hiding or wandering
- Easily overwhelmed

Fight responses:

- Acting out
- Aggression
- Being silly
- Defiance
- Hyperactivity
- Arguing/screaming/yelling

Freeze responses:

- Exhibiting numbness
- Refusing or unable to answer
- Refusing to attempt to get needs met
- Blank stare
- Appearing unable to move or act

According to Walkley and Cox (2013), children and adolescents who have experienced trauma may be easily overstimulated, causing additional challenges related to emotion regulation. Children and adolescents who are exposed to trauma may demonstrate general cognitive impairment and delays in physical development related to biological disruptions to development (Walkley & Cox, 2013).

Neuroplasticity

When discussing changes that occur in the brain as a result of trauma, one must note that with the right interventions, the connections in the brain can essentially rewire themselves. Research has shown that in certain conditions, the brain can correct the neural pathways that are "faulty," thereby decreasing the damage (behavioral and emotional) caused originally (Hosier, 2013). Evidence shows that damaged neural circuits resulting from childhood trauma can be corrected, and individuals' brains, and consequently their behaviors, can be reshaped, even into adulthood (Hosier, 2013). Therefore, the adults who work in the schools are in a prime position to actually change the brain development of their students and, by doing so, offer the possibility of a healthier, more successful future! How could we NOT do this?

In her book, *Reaching and Teaching Children Exposed to Trauma*, Dr. Barbara Sorrels (2015) discussed the "fear and hope connection." Dr. Sorrels referenced a study conducted by Dr. Karyn Purvis and Dr. David Cross in 2007 that examined adopted children with behavioral challenges related to abuse and/or neglect. The study, which eventually became known as "The Hope Connection," started as a 3-week day camp. The researchers began to notice a significant change in the behavior of the children, and as a result, they began to look at the neurochemical profiles of the children before,

during, and after the camp (Sorrels, 2015). Purvis and Cross found that prior to entering the camp, most of the children had neurochemistry profiles similar to those of adults diagnosed with PTSD (Sorrels, 2015). The researchers referred to PTSD in children as "the neurochemistry of fear." However, as the children spent time in an environment that was safe (emotionally and physically), was rich in sensory input, and offered opportunities for positive attachment, their observable behavior began to change significantly (Sorrels, 2015). Further, a statistical correlation existed between the changes in brain chemistry and the children's observed behaviors (Sorrels, 2015).

By the end of the 3-week camp, the brain chemistry of the children who participated began to approach typical levels, and they began to display positive behavioral changes (Sorrels, 2015). Even more significant, the children's behavior improved in areas that had been thought of as the most resistant to "developmental catch-up" (i.e., attachment, self-regulation, and prosocial behavior; Purvis, Cross, Federici, Johnson, & McKenzie, 2007). This study was one of the first to show that the brain could change as a result of environmental changes (Sorrels, 2015).

Value and Impact of Trauma-Informed Care

Creating a trauma-informed school environment means implementing and modeling procedures and strategies that help students (and staff) feel safe physically and emotionally. A trauma-informed environment also encourages and fosters positive relationships. Putting trauma-informed strategies into practice gives the adults a powerful opportunity to actually change the trajectory of a child's life from negative to positive. Having a positive relationship with just one adult is widely understood to be one of the strongest, most impactful resiliency factors a child can have. Unfortunately,

some children in schools, probably more than we know of, do not have anyone in their homes or neighborhoods who can be that adult. Because many children spend a great deal of time in school, the school setting is an ideal place to build the connections and relationships that they need. In addition to creating a positive climate and fostering positive adult relationships in the school setting, a trauma-informed environment might also physically change the negative neural connections that were made because of the trauma. As discussed earlier, the brain is malleable, and neural connections respond to the environment (Hosier, 2013; Sorrels, 2015).

Resilience

Appropriate intervention may support and/or increase an individual's resiliency. Resilience, as defined by the American Psychological Association (2018), is the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress, such as family and relationship problems. According to Herrman et al. (2011), the several sources of resilience includepersonal factors, biological factors, and environmental-systemic factors, as well as the interaction among the three. Sporleder and Forbes (2016) identified caring and supportive relationships as a key resilience factor for children.

Similar to resilience, individuals can draw on resources, skills, strengths, and coping skills, known as protective factors, when faced with adversity. For students who experience adversity within their homes, the school may be the next closest system of support available for that child (Sporleder & Forbes, 2016). Therefore, school systems must help boost the external protective factors, such as supportive relationships and a safe environment, for all students (Sporleder & Forbes, 2016).

Importance of Trauma-Informed Care in Schools

Childhood trauma has the potential to impact all areas of a child's functioning, including academics, behavior, socialization, and emotional development and regulation (Cole et al., 2005). This information is important to school professionals because all domains of a child's functioning impact the child's ability to perform and succeed in the school setting and beyond. Because of the amount of time that children spend in school, schools are in an ideal position to act as a resilience factor, as well as a safe place for intervention and treatment that may not be available elsewhere.

Chapter 3: Initiation and Implementation of the TIPS Program

Let's start by being honest. Implementing this program will not necessarily be quick or simple, but starting something new is not always easy. In fact, it almost never is! Some people will not jump on board right away – that is okay. Some people may flat out refuse to change the way they are doing things – that is okay too (for now). You will encounter obstacles and barriers while implementing a trauma-informed approach. Therefore, you are not alone in your frustration. What is encouraging and wonderful is that you are here, reading this manual because you know how important this information is. Don't give up! Persevere! Your students need you!!

Barriers You May Face in the Beginning

Administrator Buy-in

Even with careful presentation of facts and a compelling argument in favor of the need for this approach, several administrators still might not see the immediate need for trauma-informed training. This was certainly the case during the pilot program that this manual was based on. The variety of reasons leading to some hesitation among administrators included a new reading curriculum that was rolled out and required attention and training, the perception that teachers would think trauma informed care was "one more thing" they had to do, and the argument that the district already had a "social-emotional curriculum" in place, and therefore, trauma training was not needed. Sometimes, getting people on board takes time. Don't give up. Keep bringing information to the attention of those in administrative positions by sending relevant news and/or research articles, relating this need to the everyday work that is done in the school, and requesting to facilitate or attend trainings.

Teacher Buy-in

Time: Training an entire school, let alone an entire district, requires time. And with everything else that teachers and school staff are responsible for, they are not all jumping at the chance to include something else.

Awareness: Although this topic is extremely important, it is still fairly new in the education world. Teachers and other school staff may not be aware of the significant impact childhood trauma may have on their students or of the active role they can play in minimizing the impact.

Staff Training Overview

In order to create a trauma-informed school environment, all school staff members must receive some level of training. This includes not only administration and teachers, but also paraprofessionals, cafeteria staff, bus drivers, and maintenance staff. Admittedly, a complete training of all staff is nearly impossible as any organization transitions to a trauma-informed approach. Therefore, the phases and guidelines for trainings are flexible and designed in such a way that allows for a gradual implementation.

What to say to administration

One of the best places to start in a school district is administration. Feedback from the authors of the pilot program from which this manual is based indicated that buy-in and support from the top down are crucial factors to the success of such an overarching program. At the end of this manual in Appendix C, you will find example slides that can be modified and presented to administration. The main points that should be communicated include the impact of trauma on learning, research surrounding the impact

of trauma-informed care in schools, and a connection between TIPS implementation and the school/district mission statement. You will want to make administration aware that implementing a trauma-informed approach in school creates opportunities to change the physical brain structure of their students, thereby possibly making them more available for learning. In a nutshell, by implementing a trauma-informed approach, we are making a positive difference in the lives of our students and therefore setting them up for success!

How to begin teacher/staff trainings

Initial training may be best presented to a small group of interested teachers/staff. For example, grade level team leaders or a small group of teachers who sign up because of personal interest may be a good starting point. Based on the pilot program that this manual is modeled after, a small group setting is best, when possible, to increase participation and allow for discussion.

Chapter 4

Phase 1: Trauma Awareness

The main objective of the first phase of training is to make participants trauma aware. More specifically, during this phase, participants will be presented with the definition of trauma, will receive trauma-related statistics regarding the prevalence of childhood trauma, and will be encouraged to think about and recognize the impact of trauma on their students.

First, please note that hearing the presented information related to trauma can be upsetting for some people, and we need to remember to be sensitive to the audience. Before beginning any training on the topic of trauma, the audience should be reminded to take care of themselves. If they need to get up and walk out for a few moments, they can. If they need to speak with someone after the presentation, make sure a professional is available. (School psychologists, school counselors, and social workers are typically most helpful.) This is also a good time to engage the participants in a self-care activity (discussed more in depth later in this manual). At a basic level, the participants should be asked to write down three strategies or activities hey could do when they need to decompress. Further, the audience should be reminded that there is hope and that the point of becoming trauma trained is to help their students.

Resources for Phase 1

If time allows and the district can obtain a copy, a showing of the film *Paper Tigers* during staff training is a great way to spark interest and introduce the need for change. You can find the film's trailer at https://vimeo.com/110821029. Please note that

the cost of the film and the district license was approximately $425 at the time this manual was written. The authors of the pilot program applied for a grant and were able to use some of the funds to purchase the film. If someone in the district is willing to put in the work, grants are often available. In addition, an informative TED talk is available for free on youtube.com (https://www.youtube.com/watch?v=95ovIJ3dsNk). In this TED talk, pediatrician Nadine Burke Harris discusses the Adverse Childhood Experiences (ACE) study, the widespread impact that childhood trauma has on people across their lifespans, and the importance of recognizing childhood trauma as a public-health crisis. Dr. Burke Harris also offers hope by noting that we have the power to significantly decrease the impact of childhood trauma by recognizing that we all play a role.

Phase 1 Focus

The focus of Phase 1 is on presenting the definition of trauma, providing statistics (national and local if available), and introducing the ACE study. During the initial training, you should also present specific examples of causes and types of trauma, the educational impact of trauma (i.e., academic, social, emotional, and behavioral), and the value and impact of trauma-informed care. Overall, Phase 1 presents the WHAT, WHY, and HOW.

What: What is childhood trauma? What is its impact on development?

Why: Why is this important, and why does school staff need to know the information?

How: How can we make a difference?

Regardless of the method used to present the information (example slides can be found in Appendix C), the first presentation needs to include the following information.

Trauma Definition

The definition of trauma used for the purposes of this training sequence is as follows:

> …experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being (Substance Abuse and Mental Health Services Administration, 2014, p. xix).

Examples of Trauma

Remember to point out that trauma can include any event that disrupts a child's sense of safety and interferes with his or her ability to cope. Some examples of traumatic experiences are listed as follows, but note that this list is by no means exhaustive.

- Separation from a parent, such as from divorce or incarceration
- Death or serious illness of the child or of a close family member
- Natural disasters
- Abuse or neglect - either witnessed or experienced
- Exposure to criminal activity
- Homelessness
- Bullying

Another important point that should be presented and repeated during staff trainings is that experiences of trauma are extremely personal and are based on the individual's PERCEPTION of the event(s). Therefore, an event that may be traumatic for one person may not necessarily be traumatic for another person.

ACE/Statistics

Participants should be presented with facts about the ACE study and the prevalence of childhood trauma. That information is presented in the introduction to this manual, and example slides are provided in Appendix C.

Why Is Childhood Trauma Important for School Staff to Understand?

Childhood trauma has the potential to impact all areas of a child's development, including cognitive, academic, social/emotional, and behavioral. All of these domains are directly intertwined with a child's overall school success. This information is presented earlier in this manual, and additional resources and example slides can be found in the appendices.

How Can We Make a Difference?

School staff members are in an optimal position to change the trajectory of a child's life. Children generally spend more time in the school setting than they do anywhere else. Additionally, for some children who experience trauma at home or in the community, the school setting may be the one place they can feel safe and loved. Although consequences that result from childhood trauma are known, also known is that those consequences can be minimized or even reversed through the use of appropriate and consistent intervention (Rossen & Hull, 2013; Sorrels, 2015). By implementing trauma-informed strategies, some as simple as a morning greeting, we have the power to create positive change and brighter futures for our students.

Strategies

Before Phase 1 training ends, the participants need some "take-aways." We want the participants to feel as though they can walk out of the training and

immediately begin to apply the information they learned. The strategies presented in this section represent ideas that can be modeled and practiced on a daily basis, no matter the phase of the training sequence the school is in. Individual, classroom, and school-wide strategies will be added and expanded on throughout the phases. The more these practices are modeled as the norm, the wider the impact can be for all students.

Based on Maslow's Hierarchy of Needs, the strategies for Phase 1 focus on the basic needs of our students.

Food and Water

Have snacks and water available at all times. Pay attention to the students who never have a snack with them or who don't eat lunch.

Safety

Students need to feel safe in their environment. Create a safe classroom environment by engaging students in a loving, nurturing, calm way. One simple strategy is for the teacher to stand at the door or in the hallway and individually greet each student with a smile as they enter the classroom. Safe, calm classrooms may also incorporate some of the following: a "cool down" space within the room (e.g.,i.e. beanbag chair or rocking chair), fidget toys/stress balls/stuffed animals, a fish tank or class pet, books, sensory materials (e.g., putty, Play-Doh,), and coloring books and crayons.

Chapter 5

Phase 2: Trauma Sensitivity

The second objective of the training sequence is to increase trauma sensitivity of school staff. The expectation is that participants have begun applying what they know about trauma-informed care in their daily work. Phase 2 provides further knowledge and skills that support adult-student relationships. In addition, this phase encourages staff and administration to review school policies to determine where trauma-sensitive language/changes could be made.

One of the main goals of this phase is to review and possibly present changes for school policies and procedures so that they are more trauma sensitive. For example, school discipline policies may need to be changed to reflect a trauma-informed mindset. One suggestion is to create a committee of five to seven school staff members who have received some training in trauma-informed care to focus on reviewing current school policies and drafting a plan for making them more trauma sensitive. This task may begin fairly early in the process of becoming trauma informed, but it will likely continue to be a main focus of the committee for months as members review and revise policies and procedures and submit them for review and approval from administration.

Examples of Changes That May Be Made

Discipline

Wording of discipline policies may include a requirement that any student who is disciplined for a major infraction (i.e., resulting in suspension) should see the school guidance counselor, school psychologist, or social worker as soon as possible (preferably the same day) in order to debrief and check in regarding the incident.

Additional strategies to consider regarding discipline follow:

Eliminate Suspension Altogether

In-School Suspension: In-school suspension rooms should be flexible, structured environments with a goal of teaching students how to act differently next time they are in a similar situation (Sporleder & Forbes, 2016):

> In-school suspension rooms should be 'safe places' that are supervised by a staff member with knowledge regarding trauma-informed practices, strong relationship building skills, and who understands that the purpose of in-school suspension is to teach, not to punish (Sporleder & Forbes, 2016).
>
> Further, the authors explain,
>
> In-school suspension should allow for students to complete school work so they do not fall (possibly) further behind, but can also be used to grab a hold of 'teachable moments' that allow adults to model and teach skills such as regulation strategies, social language, social interaction, emotional intelligence, and communication skills (Sporleder & Forbes, 2016).

Implement "Supportive Detention": Similar to in-school suspension, supportive detention should focus on teaching students new ways of dealing with situations as opposed to on punishing students. An adult who meets the same criteria as the in-school-suspension supervisor should monitor supportive detention. Additionally, supportive detention can also serve as an environment that allows for practice of important social and problem-solving skills.

Communication

How does the staff communicate when they think or know a potentially traumatizing incident has occurred?

Communicating with the Child: The concerned adult should calmly ask the student if he or she is okay and if he or she needs anything.

Communicating with Other Adults/Supports: Concerned adults should seek support from the school counselor, school psychologist, or school social worker if they have continued concerns or just are not sure what to do next. The concerned adult must NOT discuss the student or his or her concerns with other teachers and paraprofessionals who do not work with the student and who do not need to know such information. We need to be sensitive to the confidentiality of such information, minimize gossip, and respect the child's privacy.

Team Meetings: Paraprofessionals who support students one on one should be invited to provide input for meetings or to physically attend meetings about the student they work with to provide their day-to-day observations of the student.

Take-Away Strategies for Phase 2: All About Building Relationships!

Greeting Students

Greet students at the bus or the door. Greet them by name, smile, and use eye contact. By doing so, you can start the day on a positive note, and you reinforce positive interactions and relationships**.**

Morning Meeting

Teachers should be encouraged to implement some variation of a morning meeting in their classroom. Doing so gives the students a way to ease into their day and

gives opportunities for relationship building, increases a sense of trust and safety, and creates a community environment within the classroom.

Mentors

Assign students a mentor. Having a mentor can provide yet another opportunity for a positive adult relationship.

Positive Reinforcement

Let students know when they have done something good! A good rule of thumb is to provide four positive comments for every one correction or redirection. (Examples are provided later in this manual.)

In addition to the presented strategies, a great deal of information and suggestions can be found in the book, *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success.* This book is available for free download athttp://www.k12.wa.us/compassionateschools/pubdocs/TheHeartofLearningandTeaching.pdf and is highly recommended. The authors provide suggestions for six general principles, three curricular domains, and specific strategies that can be incorporated into the TIPS framework.

Chapter 6

Phase 3: Trauma Responsive

The third overarching objective of the training sequence is becoming trauma responsive and teaching self-care. Being trauma responsive means putting knowledge and skills regarding trauma-informed care into practice and integrating the trauma-informed strategies into all aspects of the school culture.

Self-Care

We, the adults, must take care of ourselves. If we do not take care of ourselves, how can we ever be expected to care for our students? With all that teachers are expected to do, supporting and educating children in general can be a challenge, but working with children who display behavioral, academic, or social/emotional difficulties can have an even greater impact on the adults who work with them on a daily basis. Vicarious trauma and compassion fatigue are two terms that refer specifically to the impact that can be experienced by caregivers.

Vicarious Trauma

The transmission of traumatic stress to the caregiver who hears the stories of trauma.

Compassion Fatigue

The cumulative buildup over time of traumatic stress, which can be a result of chronic lack of self-care (Ludick & Figley, 2017).

During this phase, participants will learn about personal self-care plans: what they are, how to create them, and why they are important. Participants should be given time to create their own plans. A variety of templates for personal self-care plans are

available on the Internet. The following are several examples with links. Please note: I did not create these documents.

http://www.elsa-support.co.uk/my-self-care-plan/

Image from http://socialworktech.com/2011/05/25/making-a-self-care-plan/

After the participants create their own self-care plans, information regarding how to implement these plans with students should be presented. Following the pilot program, one of the school counselors in the district began having her fifth-grade students create self-care plans. Her feedback indicated that the information she gleaned from them was eye opening. The school counselor reported that she has been able to use the student-made self-care plans as conversation starters. She reported that students have written that they have no one to trust or that students have left "hopes and dreams" blank. In those situations, she has been able to begin conversations focusing on the areas that appear to be the most needed for each group she works with. The information you can find out about a child just by asking is amazing! The self-care plans completed by students can guide interventions and open lines of communication.

Further, we must recognize that many of us feel good when we do for others. Therefore, an important part of self-care also involves expressing gratitude and respect

for those around us.

What Is Self-Care?

Self-care is the term that describes the actions that an individual may take to reach ideal physical and mental health.

Why Is It Important?

Let's be honest. If you are not taking care of yourself, how can you expect to take care of your students? Additionally, by engaging in self-care, we can model for our students how to do the same.

What Counts as Self-Care?

Self-care can be just about anything. The following list of ideas is just a short glimpse at the possibilities:

- Ride a bike.
- Take a long walk.
- Listen to music.
- Paint.
- Call a loved one.
- Exercise.
- Meditate.

The list goes on and on because self-care is very personal. Remember, self-care does not require extended periods of time. Sometimes, even just 15 minutes engaging in a positive, uplifting activity can make a huge difference.

Self-Care Plan

A self-care plan is important for stress management and personal well-being. Remembering to take care of ourselves can be difficult, especially in times of stress, which is when we need self-care most. Further, many of us who work in the education

field tend to take care of everyone else. However, as mentioned, we need to take care of ourselves in order to best care for others and to prevent burnout.

We are more likely to do or remember something if we write it down, and self-care is no exception. That is why creating a self-care plan is so important. A self-care plan is personal, so everyone's approach will be different. Many templates are available online (a few examples were presented earlier in this chapter), and participants should be provided with two or three of them to choose from. Participants should also be given the option to create their own.

During this session, provide templates, markers, crayons, stickers, and/or other crafting materials that seem appropriate. Give participants some time to fill out a self-care plan of their own. Once they have done so, participants should be encouraged to hang them up where they can be referenced often. Another idea is to take a photo of the plan with a cell phone so that it is accessible at all times. Please note that even though we don't think we need to be reminded of the activities we enjoy, in times of stress these ideas and strategies can be difficult to access. Having a visual reminder can be very helpful!

Empower Each Other!

Many school settings have systems in place that ensure we will recognize our students for a job well done (e.g., "caught being good" tickets). However, rarely (at least in my experience) do we take the time to recognize and encourage each other. The following list includes some ideas/tips for doing just that!

- Acknowledge when you see someone doing something great!
- Tell others when someone does something great!
- Ask someone you admire/respect/look up to for advice or ideas
- Implement a "star staff of the week" activity

- Gift a tangible token of your appreciation to team members
    - See the following visual example submitted by Elizabeth Mikolajczyk, School Psychologist, in Delaware. It includes sweet treats and statements of appreciation and positive affirmations. Elizabeth reported that everything was purchased at the Dollar Store.
- Point out and compliment a coworker who has achieved a goal, including outside of the work environment (e.g., finished a marathon, published an article, bought a new home).
- Be genuine

Photo submitted by Elizabeth Mikolajczyk

Many ideas are on the Internet. You can find them on websites, such as Pinterest. Below are links to additional ideas:
https://fun-squared.com/brighten-your-day-gift-idea/

http://www.technologyrocksseriously.com/2016/09/treat-tags-tootsie-rolls.html?utm_source=feedburner&utm_medium=email&utm_campaign=Feed:+technologyrocksseriously/AfRK+(technology+rocks.+seriously.)#.Wq19V5PwZsN

General Classroom Strategies

In Phase 3, the specific strategies begin to focus more on the whole classroom and school environment. The following strategies focus on integrating trauma-informed care into daily school living.

Structured classroom environment

Classroom rules should be clear and consistent. Classroom rules should also be posted and discussed and reviewed as necessary, specifically after long breaks (e.g., winter holiday break, spring break).

Schedule

The classroom schedule should be posted, and whenever possible, students should be warned prior to schedule changes.

Movement

Classrooms should allow for movement. "Brain breaks" can be found online, such as those at gonoodle.com. Typing in "brain breaks for children" or "movement breaks for children" into the YouTube.com search engine will also produce options. Also, as long as doing so is not distracting, some students may need to walk or stand while they work.

Noise

Loud noises may be a trigger for some students, and therefore, some students might need to be warned before a fire drill or similar event. Additionally, adults should use a calm, even tone when speaking with students at all times. Raised voices or yelling may cause retraumatization or activate the fight-or-flight response.

School-Wide Strategies

Discipline Policy

By this time, the new discipline policies should be well on the way to including trauma-informed language. Therefore, all school staff should be made aware of the changes so that everyone implements new procedures.

Recognition and Praise

The school culture should encourage trust and growth in both students and adults.

Adults should aim to give four positive comments for every one redirection. You can ALWAYS find some way to compliment a child. If you can't, you aren't looking hard enough.

Examples of positive praise/encouragement for students:

"I love how hard you worked on that picture."

"I can tell you put a lot of time into that story."

"I noticed you helping Johnny with ____. That was very kind of you!"

"Thank you for raising your hand."

"I'm so happy you shared that thought with me."

"I love how you're walking in the hallway!"

Staff should feel valued as individuals and members of a team and connected to each other, their students, and their environment.

-Staff member of the week

-Staff compliments/recognition board: A bulletin board where staff members can post positive comments about their colleagues.

-Positive praise, expressions of gratitude, and tokens of appreciation

Chapter 7

Phase 4: Trauma Informed

At the end of the training sequence, the school environment and school staff should feel more confident in their ability to respond to children who have experienced trauma. Please note that Phase 4 is not necessarily the *end* of training, but rather an ongoing maintenance phase.

These phases are not necessarily linear, nor do they have a clear beginning or end, meaning that revisiting certain objectives will likely be necessary as questions or situations arise. Reviewing the information as individual understanding deepens is also a good idea because, like many situations in life, we may receive and retain only the information we are ready for at a particular time. However, as teachers, administrators, and staff become more sensitive, aware, and ready to make changes, they may see the information through a new lens. Therefore, constant review and practice can only drive forward the mission of creating a trauma-informed school climate. On that note, one should remember that becoming trauma informed is not the end of the process. Becoming trauma informed should be seen as more of a wide spectrum of understanding, practice, commitment, and general attitude to be strived for on a daily basis by administrators, teachers, and all school staff.

Phase 4 training should be the time for participants to ask questions that have arisen and to share situations and experiences they have encountered, as well as to describe how they approached those situations in a trauma-informed way. Allowing time for participants to share will allow them to learn from each other and increase personal

investment in the strategies. Phase 4 also includes creating and promoting the ongoing training that will be offered to new staff as well as the opportunities for existing staff to attend additional training. The strategies for Phase 4 include expanding on and deepening strategies that were previously learned. For example, in Phase 1 teachers/staff were encouraged to greet students as they enter the classroom. In Phase 4, that greeting can be taken a step further by addressing students by name or taking the time to ask one or two students each day about their previous evening/weekend.

General Tips and Takeaways

- Take note of the students who do not appear to have positive adult connections. Now, make a connection!! Learn the names of those children, provide verbal praise and encouragement, find out their interests, and engage with them on topics related and not related to school/academics.
- Build self-esteem. Create opportunities for success! Praise effort, not product!
- Do what you say you will do, and be where you say you'll be! One of the hardest beliefs to change is that people can't be trusted. By doing what you say you will do, you can help to show the children you work with that they will not always be let down.
- Recognize changes in behavior and mood.
- Incorporate movement and calming strategies into the day. Take a hold of the day-to-day "teachable moments" by modeling and having students practice calming strategies, such as deep breathing.

- Use movement breaks throughout the day to keep students' bodies and minds active and alert in a safe and calm setting. Using such sites as gonoodle.com make breaks easy and fun!
- Communicate clearly and consistently.
- Stay informed. Do your best to stay informed about triggers such as dates/anniversaries because the child may display more difficult behaviors around those times and therefore may need extra care.
- Advocate for restorative discipline practices.
- Implement classroom management practices, such as posting rules and expectations, providing warning regarding schedule changes, and setting aside time for morning meeting.

Chapter 8

Section 1: Program Reviews

"The manual is user friendly in that it is jargon-free and easy to read."

"It is easy to read and makes sense. Ideas are well defined, and there are good examples. It truly is user friendly!!"

"Could definitely use the information as professional development. I would love to know more about how many sessions were run, who were the trainers, initial barriers, etc."

"I like the idea of a district wide trauma sensitive committee. Support is needed from the top administrators. I also agree that all personnel need to be trained. It would be great after the trainings to implement in-school suspension and supportive detention with 'safe place' and trained teacher."

"This manual provides information that is easy to read while offering high level information that can be useful when creating a trauma informed education community."

"Great job explaining the research and implications as well as establishing why being trauma informed and interventions are important. I was pleased that the point about distinguishing between trauma symptoms and other educational/psychiatric disabilities was included."

"Very helpful, practical, easy to implement provides good supportive ideas and examples backed by research."

Stephanie Boldin, School Counselor (Pennsylvania), on using self-care plans with her upper elementary students:
"I use these self-care plans as a screen. I like to see what interests the children have, what makes them happy, who they are connected to, what they like about school, etc. If they say that they like nothing about school we may need to put some supports in place so they feel better about school. Sometimes they benefit from an older mentor.

If a child struggles to put interests down it could be an indicator that we need to get to know more about them. If they put down that sleeping makes them happy, or that nothing makes them happy I may talk with them individually to find out what is going on. If they struggle to put down any supportive family members that could be a sign that I should talk with them further to find out more information. I also ask them about friends, and if they are struggling with friendships I may suggest adding them to a friendship or lunch group. I also use the hygiene section to talk with them about the importance of showering, washing their hands, brushing their teeth, using deodorant, etc. We also talk about nutrition and trying to eat healthy. The children usually enjoy doing these self-care plans."

Section 2: Future of the Program

By initiating a trauma-informed approach to education, you are creating a system that is more sensitive to all students and their needs. In order to continue growing and improving as a trauma-informed school, considering the following may be helpful:

- Require new teachers to attend sessions on trauma during orientation.
- Assign mentors to all new staff so that they can observe and learn the strategies that are in place.
- Discuss trauma-informed care practices at building level staff meetings throughout the school year.
- Offer in-service training on trauma-informed care for new and veteran staff.
- Expand training beyond teachers to cafeteria staff, bus drivers, custodians, and other support personnel.

Chapter 9

References

American Psychological Association. (2018). *The road to resilience.* Retrieved from http://www.apa.org/helpcenter/road-resilience.aspx

Carrion, V. G., & Wong, S. S. (2012). Can traumatic stress alter the brain? Understanding the implications of early trauma on brain development and learning. *Journal of Adolescent Health, 51*(2), S23-S28. doi:10.1016/j.jadohealth.2012.04.010

Centers for Disease Control and Prevention. (n.d.). Adverse childhood experiences: Looking at how ACEs affect our lives and society. Retrieved from https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html

Cole, S. F., O'Brien, J. G., Gadd, M. G., Ristuccia, J., Wallace, D. L., & Gregory, M. (2005). *Helping traumatized children learn: A report and policy agenda.* Massachusetts Advocates for Children. Retrieved from https://traumasensitiveschools.org/.

Cook-Cottone, C. (2004). Childhood posttraumatic stress disorder: Diagnosis, treatment, and school reintegration. *School Psychology Review, 33*(1), 127-139.

Cronholm, P. F., Forke, C. M., Wade, R., Bair-Meritt, M. H., Davis, M., Harkins-Schwarz, M.,…Fein, J. A. (2015). Adverse childhood experiences: Expanding the concept of adversity. *American Journal of Preventive Medicine, 49*(3), 354-361.

Crosby, S. D. (2015). An ecological perspective on emerging trauma-informed teaching practices. *Children & Schools*, *37*(4), 223-230.

Felitti, V. J. ,& Anda, R. F. (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare. In R. Lanius & E. Vermetten (Eds.), *The hidden epidemic: The impact of early life trauma on health and disease* (pp. 77-87). Cambridge University Press.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V.,…Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine,14*(4), 245-258. doi:10.1016/S0749-3797(98)00017-8

Herrman, H., Stewart, D. E., Diaz-Granados, N., Berger, E. L., Jackson, B., & Yuen, T. (2011). What is resilience? *The Canadian Journal of Psychiatry, 56*(5), 258-265.

Hochman, A., & Stevens, J. (2017). Mechanisms by which adverse childhood experiences influence health and well-being throughout the lifespan. *Community resilience cookbook*. Retrieved from http://communityresiliencecookbook.org/your-body-brain/

Hosier, D. (2013). Recovery: How the brain can rewire itself (neuroplasticity). *Childhood trauma recovery*. Retrieved from http://childhoodtraumarecovery.com/2013/07/18/recovery-how-the-brain-can-rewire-itself-neuroplasticity/

Jaycox, L. H., Morse, L. K., Tanielian, T., & Stein, B. D. (2006). *How schools can help*

students recover from traumatic experiences: A tool kit for supporting long-term recovery. Retrieved from http://www.rand.org/content/dam/rand/pubs/technical_reports/2006/RAND_TR413.pdf

Kataoka, S., Langley, A., Wong, M., Baweja, S., & Stein, B. (2012). Responding to students with PTSD in schools. *Child and Adolescent Psychiatric Clinics of North America, 21(*1), 119-124. http://doi.org/10.1016/j.chc.2011.08.009

Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and reduction: Reimagining a theory of secondary traumatic stress. *Traumatology*, *23*(1), 112.

The National Child Traumatic Stress Network. (n.d.). Impact of complex trauma. Retrieved from http://www.nctsn.org/trauma-types/complex-trauma/effects-of-complex-trauma

Oehlberg, B. (2008). Why schools need to be trauma-informed. *Trauma and Loss: Research and Interventions, 8*(2), 1-4. Retrieved from https://www.starr.org/sites/default/files/articles/whyschoolsneed.pdf

Overstreet, S., & Chafouleas, S. M. (2016). Trauma-informed schools: Introduction to the special issue. *School Mental Health, 8*(1-6). doi: 10.1007/s12310-016-9184

Pachter, L. M., Lieberman, L., Bloom, S. L., & Fein, J. A. (2017). Developing a community-wide initiative to address childhood adversity and toxic stress: A case study of the Philadelphia ACE Task Force. *Academic Pediatrics, 17*(7), S130-S135.

Purvis, K. B., Cross, D. R., Federici, R., Johnson, D., & McKenzie, L. B. (2007). The hope connection: A therapeutic summer day camp for adopted and at-risk children with special socio-emotional needs. *Adoption & Fostering*, *31*(4), 38-48.

Rossen, E., & Cowan, K. (2013). The role of schools in supporting traumatized students. *Principal's Research Review, 8*(6), 1-7.

Rossen, E., & Hull, H. (2013). *Supporting and educating traumatized students: A guide for school-based professionals.* New York, NY: Oxford University Press.

Sherin, J. E., & Nemeroff, C. B. (2011). Post-traumatic stress disorder: The neurobiological impact of psychological trauma. *Dialogues in Clinical Neuroscience, 13*(3), 263-278.

Sorrels, B. (2015). *Reaching and teaching children exposed to trauma*. Lewisville, NC: Gryphon.

Sporleder, J., & Forbes, H. T. (2016). *The trauma-informed school.* Boulder, CO: Beyond Consequences Institute.

Stevens, J. (n.d.). ACEs science 101: ACEs science FAQs. Retrieved from https://acestoohigh.com/aces-101/

Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services: Treatment improvement protocol (TIP) Series 57.* HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Walkley, M., & Cox, T. L. (2013). Building trauma-informed schools and communities. *Children and Schools, 35*(2), 123-126. doi:10.1093/cs/cdt007

Chapter 10: Appendices

Appendix A

Where to Learn More

Books:

Fostering Resilient Learners: Strategies for Creating a Trauma-Sensitive Classroom by Kristin Souers (https://www.amazon.com/Fostering-Resilient-Learners-Strategies-Trauma-Sensitive-ebook/dp/B01BKUI99W)

Supporting and Educating Traumatized Students by Eric Rossen and Robert Hull (https://www.amazon.com/Supporting-Educating-Traumatized-Students-Professionals/dp/0199766525)

The Trauma Informed School by Jim Sporleder and Heather Forbes (https://www.amazon.com/Trauma-Informed-School-Step-Step-Implementation/dp/0997850159)

The Leader in Me by Stephen Covey (https://www.amazon.com/Leader-Me-Schools-Inspiring-Greatness/dp/1476772185)

The Restorative Practices Handbook for Teachers, Disciplinarians, and Administrators by Bob Costello, Joshua Wachtel, and Ted Wachtel (https://www.amazon.com/Restorative-Practices-Handbook-Disciplinarians-Administrators/dp/193435502X)

YouTube Videos:

Understanding Trauma: Learning Brain vs Survival (Jacob Ham, https://youtu.be/KoqaUANGvpA)

How Childhood Trauma Affects Health Across a Lifetime (Nadine Burke Harris, https://youtu.be/95ovIJ3dsNk)

Brené Brown on Empathy(Brené Brown, https://youtu.be/1Evwgu369Jw)

Every Kid Needs a Champion (Rita Pierson, https://youtu.be/SFnMTHhKdkw)

Films:

Paper Tigers (Trailer: https://vimeo.com/110821029)

Resilience (Trailer: https://vimeo.com/137282528)

Appendix B: Trauma Informed Care: A Toolkit for Educators.

See below for reproducible document

Appendix B

Trauma Informed Care:
A Toolkit for Educators

What school staff need to know to support traumatized students in the classroom

Kerri Flatau, Ed.S, NCSP
Elizabeth Mikolajczyk, Ed.S. NCSP, BCBA

Contents:

Dear Educator,

On average, one out of every four students have experienced a traumatic incident, and this number may be higher depending on your district's demographics. Therefore, it is highly likely that you have, and will continue to have, these children in your class. Many teachers have come to us asking how they can support these students in the classroom. If you have ever wondered what you can do to help your students, this booklet is for you.

Several districts are making an effort to become trauma informed. If your district is on that path, this information and these strategies will fit in nicely. If your school or district is not yet trauma informed, you can implement these strategies in your classroom independently and perhaps motivate others to do so.

There are an increasing number of resources being published that discuss ways to create trauma informed schools. Although this toolkit is not comprehensive, nor does it replace the advice or guidance of qualified professionals, our intention was to create a quick reference for teachers. This toolkit includes the most important components from the literature and is presented in a quick, easy to read booklet with plenty of resources for you to follow up with if you choose. We hope that this booklet is useful to you.

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Introduction

During the 2016-2017 school year, the authors of this toolkit created and implemented a training sequence for the educators in a Pennsylvania school district. The training sequence included four phases, with each of the four trainings being approximately two hours long. Throughout the training sequence, participants were, among other topics, presented with information regarding the definition of trauma, statistics, and the impact of trauma on the brain and development. Additionally, participants learned specific strategies that can be implemented in the school setting to help minimize the impact of childhood trauma as well as information about self-care and why it is so important, even though it is often neglected.

This toolkit is our attempt to combine the research we have conducted, the feedback we received, and lessons we learned throughout the creation and implementation of the program into a quick reference for school districts. This toolkit would be best used as a supplement to more formal or in-depth trauma training. Our hope is that this toolkit and the strategies that are included within will be used by teachers and school staff as a way of interacting with all students.

What is trauma?

There is no single universal definition of trauma, but most definitions share several components. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma using the "three E's" as resulting "from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014).

It is very important that we pay attention to the second 'E', experience. The way the individual experiences the event will affect whether it is traumatic or not. The same event may be experienced in completely different ways by different people, so it is very important that we do not put our own expectations on our students' experiences.

Trauma can be the result of a single event or repeated/prolonged exposure (complex trauma). Traumatic experiences may not always involve violence. Potentially traumatic experiences include:

- Separation from a parent, such as incarceration
- Death or serious illness (of student or loved one)
- Natural Disasters
- Abuse or neglect – Witnessed or experienced
- Exposure to criminal activity
- Homelessness
- Bullying

How many students actually experience trauma?

Adverse Childhood Experiences (ACE) Study:
The landmark ACE study revealed that between half and two-thirds of all school aged children are exposed to one or more adverse childhood experiences that may lead to trauma (Felitti, 1998). Since then, many cities and states have created their own ACE studies. Many have been able to compare differences using race, sex, SES, and education levels. For more information on your state, go to The ACEs Connection website.
http://www.acesconnection.com/g/state-aces-action-group/blog/behavioral-risk-factor-surveillance-system-brfss
Put simply, ACEs are very common, and happen in every walk of life.

Some people may wonder if they will be able to help a student without knowing the specific details of the trauma. The answer to that is YES! Trauma informed strategies work with all students, regardless of the level or impact of trauma.

How does trauma affect learning and the brain?

When students have experienced trauma, especially chronic trauma, safety becomes the priority, and everything else becomes secondary. As a result, students may be impacted in several areas:

Cognitive Capacities:

- Surges of arousal, or the complete absence of it
- Complete disconnection when overwhelmed
- Lack of coping skills
- Difficulty sharing feelings

(Rossen & Hull, 2013)

Academic Performance:

Childhood trauma can disrupt a child's ability to:

- pay attention
- organize one's thoughts and environment
- comprehend language
- communicate expressively
- produce work

(Cole et al., 2005)

The symptoms of childhood trauma that may be evident at school can look very similar to other educational or psychiatric disabilities. These similarities can make it difficult for teachers and other school staff to distinguish one from the other (Rossen & Cowan, 2013).

How does trauma impact social/emotional/behavioral development?

Behavioral:
Children who are exposed to trauma may behave negatively or act out in an attempt to gain attention or as a way of acting out their personal pain (Cole et al., 2005). In order to avoid retraumatization, children who have experienced trauma may adopt coping strategies such as:

- Social withdrawal
- Aggressive behaviors
- Self-medication (i.e. substance abuse)

Additionally, due to hyperarousal, traumatized children may react in a way that is disproportionate to the situation.

Social:
Children who have experienced trauma may have a difficult time forming positive relationships with adults and with peers.
Children who have a history of trauma may:

- Withdraw from people or activities
- Express distrust of others
- Express feelings of hopelessness
- Overreact to seemingly benign situations
- Have a difficult time reading the social cues of others
- Be socially isolated due to aggressive and/or impulsive behavior

Fortunately, research indicates that children's brains are malleable, and the effects of trauma can be reversed!
What does trauma "look like" in a student?

Just as trauma is experienced differently by each student, it also presents differently. Students in survival mode may exhibit the following:

Flight responses:

- Withdrawal
- Eloping from the classroom/Skipping class
- Daydreaming
- Appearing to sleep
- Hiding or wandering
- Easily overwhelmed

Fight responses:

- Acting out
- Aggression/Defiance
- Being silly
- Hyperactivity
- Arguing/screaming/yelling

Freeze responses:

- Exhibiting numbness
- Refusing or unable to answer/Blank stare
- Refusing to attempt to get needs met
- Appearing unable to move or act

Teachers may also notice rapid changes in facial expression and "emotional communication." Students may be hesitant to try anything new or take risks in order to avoid failure.

(Souers, 2016)
(Rossen, 2013)

How can I foster resilience in my students?

Resilience, as defined by the American Psychological Association, is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress-such as family and relationship problems (http://www.apa.org/helpcenter/road-resilience.aspx).

By helping students learn the core elements of resilience, you can help them build their ability to adapt when faced with problems.

- Build an internal locus of control by helping them understand how they have power over their decisions and lives
- Help them see the value in friends, teachers and other mentors
- Teach conflict resolution
- Teach them self-regulation strategies by showing them ways to calm themselves.
- Help them learn to take responsibility for their own actions
- Teach the value of taking care of oneself
- Teach the value and power of optimism
- Cultivate integrity

(Rossen and Hull, 2013)
(Covey, 2014)

What is a "trauma informed approach?"

Many teachers are skeptical of "another thing to do." It is important to understand that a trauma informed approach is not another thing to add to your plate. It is simply a better way to do what you are already doing.

First,

- Change your trauma lens from "what's wrong with them" to "what happened to them?"

"The kids who need the most love will ask for it in the most unloving ways." -Russel Barkley

  - Remember that all behavior has a function and purpose. Students use behavior to communicate. What are they trying to say?
  - Understand that the brain is impacted physically, chemically, and functionally by trauma.
  - Remember that a brain in "survival" mode cannot learn!
  - You don't need to be a therapist to help!

Also,

- Create a classroom with consistency and routine
- Learn to how to recognize survival mode (noted previously) and how to respond with trauma informed strategies
- Make a conscious effort to watch for those who "fly under the radar"
- Students with trauma histories may believe they don't matter. Give them lots of opportunities to shine
- Praise often, and praise publicly. Criticize privately
- Learn self regulation strategies you can teach your class
- Don't be afraid to ask what you can do to help them calm down/feel better
- Don't forget to take care of yourself

What can I do to make my classroom trauma sensitive?

Basic Needs - Make sure to ask students if they have had breakfast/lunch.
Have snacks and water available at all times.

Building Relationships - This is very important! Positive relationships increase feelings of safety and trust. The students who need it the most may be the most difficult to connect to. It may take days, weeks, months, or more to build that relationship. Don't give up- you may be exactly what that child needs!

Greeting students

Greet students at the bus or the door.
Greet them by name, smile, and use eye contact.
Show genuine interest in students and their interests.

Morning meeting

Create a forum for students to share information about themselves in a safe, respected space.

Mentors

Assign students a mentor.
Mentors can be peers or adults depending on environment and needs.

Positive Reinforcement

Let students know when they have done something good!
A good rule of thumb is to provide 4 positive comments for every 1 correction or redirection.

Build Self-Esteem

Build in opportunities for them to "win."
Praise effort (not product).

Trauma Informed Classroom Strategies

Structured Classroom Environment
Classroom rules should be clear and consistent.
Classroom rules should also be posted and discussed and reviewed as necessary, specifically after long breaks (i.e. winter holiday break, spring break, etc.).

Schedule
The classroom schedule should be posted.
Whenever possible, students should be warned prior to schedule changes.

Movement
Classrooms should allow for movement.
There are "Brain Breaks" that can be found online, such as on gonoodle.com.
Allow students to walk or stand while they work (as long as it is not distracting to them or others).

Noise
Loud noises may be a trigger for some students.
It may be necessary to warn some students before a fire drill (or similar event).
Adults should use a calm, even tone when speaking with students at all times.

Calming strategies
Practice a few mindfulness, progressive muscle relaxation, or deep breathing strategies with the class for a few minutes each morning so they have strategies they can use when needed.

What do I do if a student gets "triggered" in my classroom?

- ASK! "What can I do to help you?"
- Give space and time.
- Stay calm-- speak in a soft, calm tone.
- Reassure them of their safety.
- Offer safe space (if available).

Examples of things to say:
"I'm here. You're not in trouble."
"It's okay to feel."
"Sit with me."
"You're allowed to have a voice. Let's talk."
We'll get through this together."
"I'm sorry this is so hard."

(Sporleder and Forbes, 2016)

When should I get others involved?

When working with children who have experienced or are experiencing trauma it is important to follow the rules and regulations regarding mandated reporting.

If an individual reports thoughts of suicide or of harming someone else, you should follow district protocols. It may be necessary to seek out district professionals such as the school psychologist, school counselor, or social worker.

It is important to gauge your own feelings. If a situation arises that you are uncomfortable with or triggers your own personal feelings it may be best to seek out support from the appropriate people in your school.

What is self-care? Is it really that important?

Adults who work with children who have experienced trauma are at risk for burnout. It is absolutely necessary that we take care of ourselves. You can't pour from an empty cup!

There are an endless number of things you can do for yourself. If you do not have a "go-to" stress reliever or if you are looking to try something new there are a few suggestions below for you:

- Create a Personal Care Plan (see example on pages 18 & 19)
- Exercise
- Read for pleasure
- Join a league/team that allows you to do something you enjoy with others
- Create (paint, color, draw, sculpt)
- Meditate

Definitions related to secondary trauma:

Vicarious Trauma

The transmission of traumatic stress to the caregiver who hears the stories of trauma.

Compassion fatigue

The cumulative buildup over time of traumatic stress, which can be a result of chronic lack of self-care

How can I get my school interested in taking a trauma informed care approach?

- Become familiar with the ACE study and subsequent research about outcomes for traumatized children
- Talk to administration
- Seek/attend local trainings
- Offer professional development
- Set up movie screenings for the films, Paper Tigers and/or Resilience
- Set up your classroom as an example of what a trauma informed classroom looks like
- Be persistent! Let your administration know that this is an important topic that staff need training on.
    - Find trainings in your area and tell others about them
    - Offer to present the information

Self Care Plan

A self care plan is important for stress management and personal wellbeing. It can be difficult to remember to take care of yourself, so having a go-to plan can not only prompt you to do so, but also provides reminders of HOW to do so!!

A self care plan is personal and everyone's approach will be different. Some aspects that may be considered in a self care plan are professional obligations, physical health, mental health, spiritual beliefs, and social/relationships.

Download a template or make your own! The following websites are just a few of the many that are available (see next page for images):

http://socialworktech.com/2011/05/25/making-a-self-care-plan/

https://schools.au.reachout.com/articles/developing-a-self-care-plan

http://www.elsa-support.co.uk/my-self-care-plan/

Then, fill in with activities that you enjoy and that support your personal wellbeing.

Post your self care plan where you can see it and refer to it regularly.

Practice your self care activities regularly and make changes as needed.


_____'s Self-Care Plan!
MIND
BODY
SUPPORTIVE PEOPLE IN MY LIFE
SPIRIT
I WANT TO ACCOMPLISH
Social Work Tech
Self Care Plan by Social Work Tech | Ignacio Pacheco
This work is licensed under a Creative Commons Attribution-NonCommercial-NoDerivs 3.0 Unported License.
Based on a work at socialworktech.com .
Permissions beyond the scope of this license may be available at socialworktech.com/about


My self care plan
I can exercise my body by...
I can be a good friend by ...
Important people Who I trust
This is me
I can relax my body and mind by...
I can keep myself clean and tidy by...
I can make myself happy by...
My hopes and dreams...
I can eat healthy foods...
www.elsa-support.co.uk

Resources:

Books:

Fostering Resilient Learners: Strategies for creating a trauma-sensitive classroom by Kristin Souers

Supporting and Educating Traumatized Students by Eric Rossen and Robert Hull

The Trauma Informed School by Jim Sporleder and Heather Forbes

The Leader in Me by Stephen Covey

The Restorative Practices Handbook for Teachers, Disciplinarians, and Administrators by Bob Costello, Joshua Wachtel, and Ted Wachtel

YouTube Videos:

UNDERSTANDING TRAUMA: LEARNING BRAIN VS SURVIVAL BRAIN

- Jacob Ham https://youtu.be/KoqaUANGvpA

HOW CHILDHOOD TRAUMA AFFECTS HEALTH ACROSS A LIFETIME

- NADINE BURKE HARRIS HTTPS://YOUTU.BE/95OVIJ3DSNK

Brené Brown on Empathy

- Brene Brown https://youtu.be/1Evwgu369Jw

EVERY KID NEEDS A CHAMPION

- RITA PIERSON HTTPS://YOUTU.BE/SFNMTHHKDKW

Films:

Paper Tigers

Resilience

References

Cole, S.F., O'Brien, J.G., Gadd, M. G., Ristuccia, J., Wallace, D.L. & Gregory, M. (2005). Helping traumatized children learn: A report and policy agenda. Massachusetts Advocates for Children. Retrieved from https://traumasensitiveschools.org/.

Covey, S. R. (2014). *Leader in Me*. Simon and Schuster.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction tom any of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine, 14(4), 245-258

Rossen, E. & Cowan, K. (2013). The role of schools in supporting traumatized students. *Principal's Research Review, 8(6).*

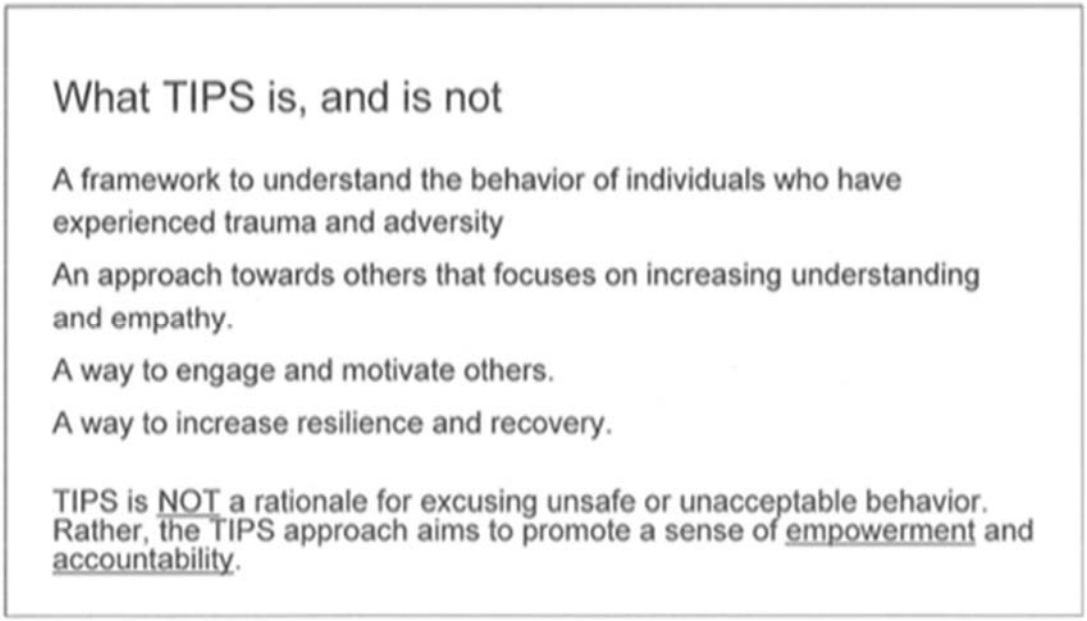
Rossen, E., & Hull, R. V. (Eds.). (2012). *Supporting and educating traumatized students: A guide for school-based professionals*. Oxford University Press.

Souers, K., & Hall, P. (2016). *Fostering resilient learners: Strategies for creating a trauma-sensitive classroom*. ASCD.

Sporleder, J. & Forbes, H.T. (2016). *The trauma-informed school.* Boulder, CO: Beyond Consequences Institute, LLC.

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Appendix C Example Slides



Objectives

After today, participants will know/understand:
-Overview of the TIPS program
TIPS Phase 1:
-The definition of trauma
-Overview of ACEs study
-The prevalence of trauma
-Causes and examples of trauma
-The educational impact of trauma
-Values of trauma informed care
-Terminology related to trauma informed care

What is Trauma

Trauma can include any event that disrupts a child's sense of safety and overwhelms their ability to cope

- Can be a single event or repeated exposure
- Potentially traumatic experiences may include
  - Separation from a parent, such as from incarceration
  - Death, serious illness, of the child or a close family member
  - Natural disasters
  - Abuse or neglect - either witnessed or experienced
  - Exposure to criminal activity
  - Homelessness
  - Bullying

Adverse Childhood Experiences (ACEs) Study

- Original study began 1995, California, 17,000 adults enrolled with Kaiser Permanente Insurance.
- Middle class population, able to afford private insurance.
- An ongoing longitudinal study, most significant public health study of natural history of trauma/adversities.
- Goal: to determine relationship between adverse child experiences (ACEs) and later health outcomes.
- Health outcomes tracked for adults over time.
- Ten ACE categories, involving maltreatment (5) & family stressors/dysfunction (5).

The Ten Adversities of the ACE Survey

- Physical neglect
- Emotional neglect
- Emotional, physical, and sexual abuse (three items)
- Parental separation or divorce
- Parental/caregiver mental illness or suicide attempt
- Parental/caregiver alcohol or drug abuse
- Parental/caregiver incarceration
- Domestic abuse against mother or stepmother

Adverse Childhood Experiences (ACEs) Study

Scoring and key findings of the ACE study (1)

•Range of ACE scores = 0-10.

•ACE scores based only on applicable *categories* of exposure, not frequency within categories.

•ACE exposure of respondents:

–50% reported at least 1 exposure (ACE score of 1).

–25% had ACE score of 2 or more.

•Outcomes from adversities found to be additive: Higher the ACE score = poorer the outcomes.

Negative outcomes – mental health & substance abuse, physical health, and social functioning

Representative ACE findings: ACE score of 4 vs. 0

•Suicidality: 12 times more likely to make a SA.

•Domestic abuse: 5 times more likely.

•Substance abuse:

–Alcohol abuse 5-7s times more likely.

–With ACE of 6: IV drug use **46 times more likely.**

•Physical health:

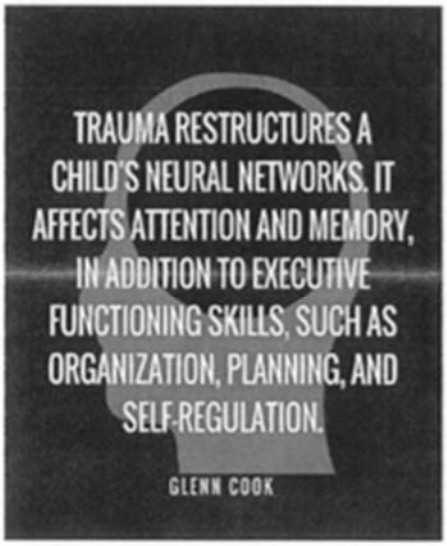
–Twice as likely for smoking, heart disease, cancer.

–Four times more likely for emphysema.

Why is it important for educators to understand trauma?

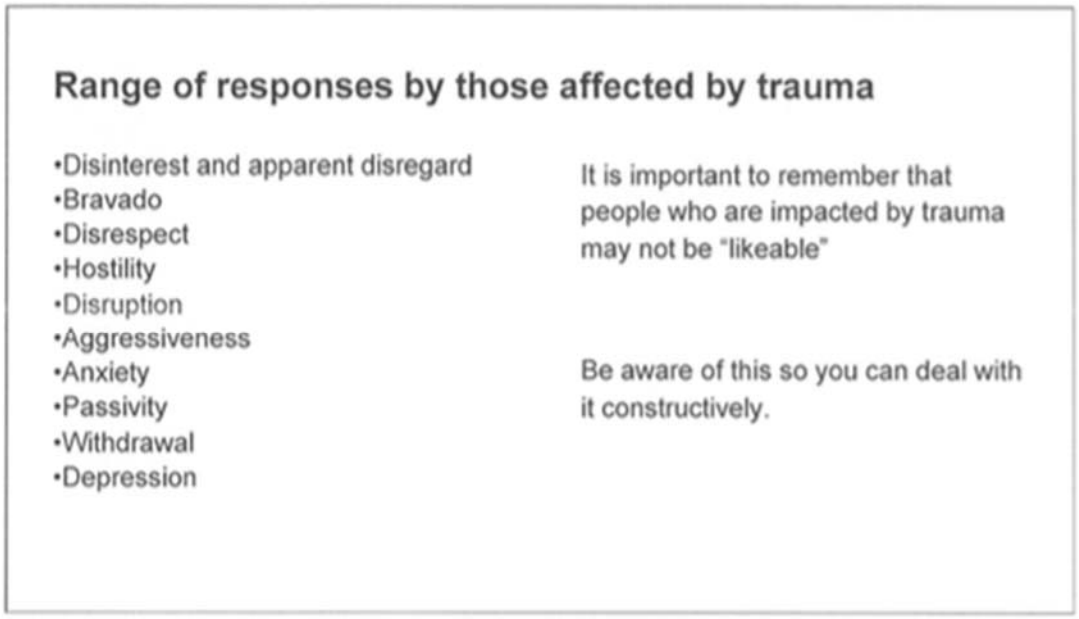
Research shows that children/ adolescents who experience trauma are at risk for the following:

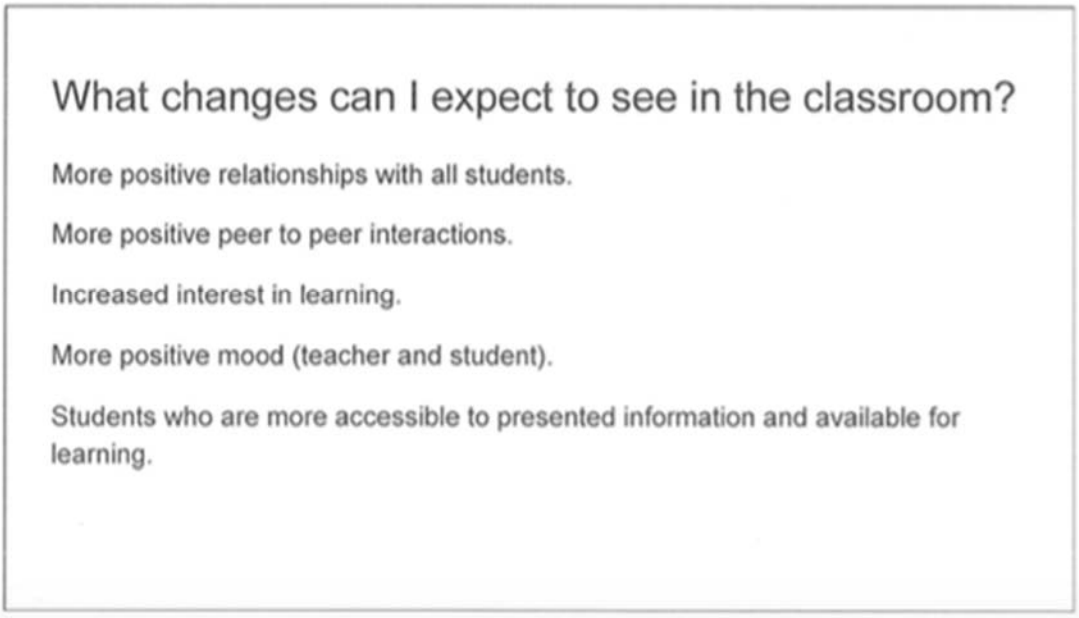
Decreased IQ
Lower reading ability
Lower GPA
Increased school absence
Decreased social competence
Increased peer rejection
Decreased rates of high school graduation



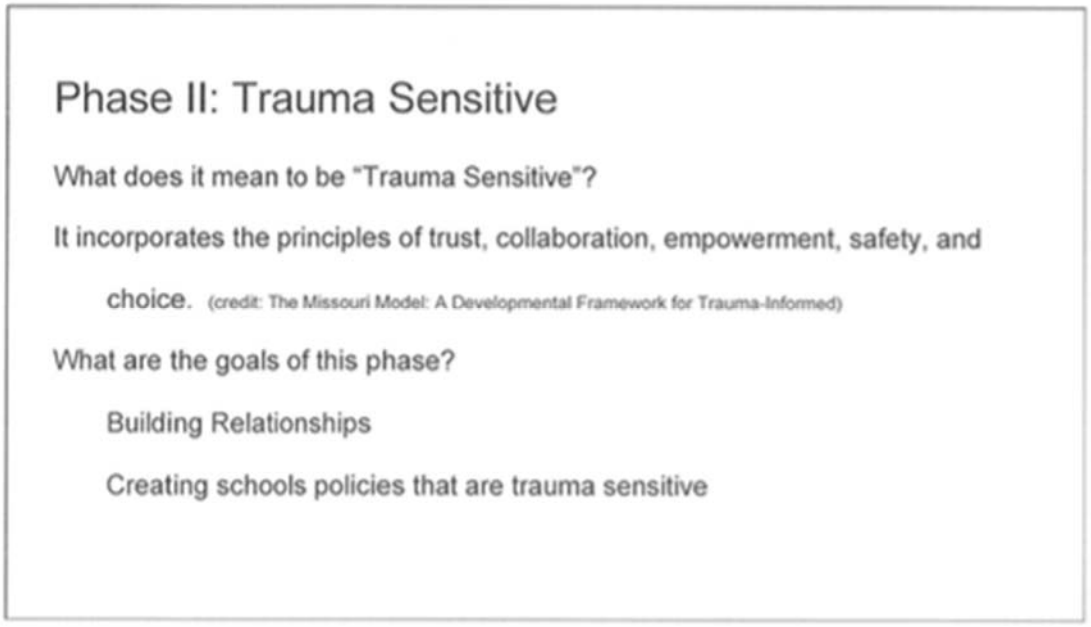
Common beliefs of those with severe trauma:

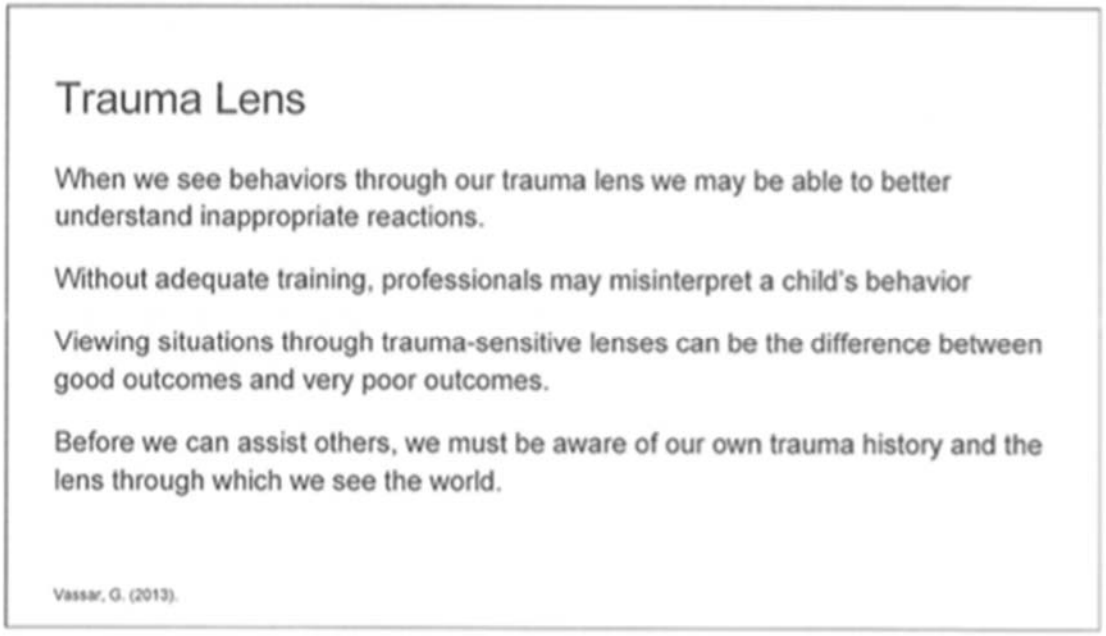
"The world is unsafe, threatening, and bewildering."
"The world is punitive, judgmental, and blaming."
"People are unpredictable."
"Very few are to be trusted."
"I don't have control over my life."
"My survival is uncertain."
"If I admit a mistake, things will be worse."
"When challenged, I must defend my honor & self-respect."

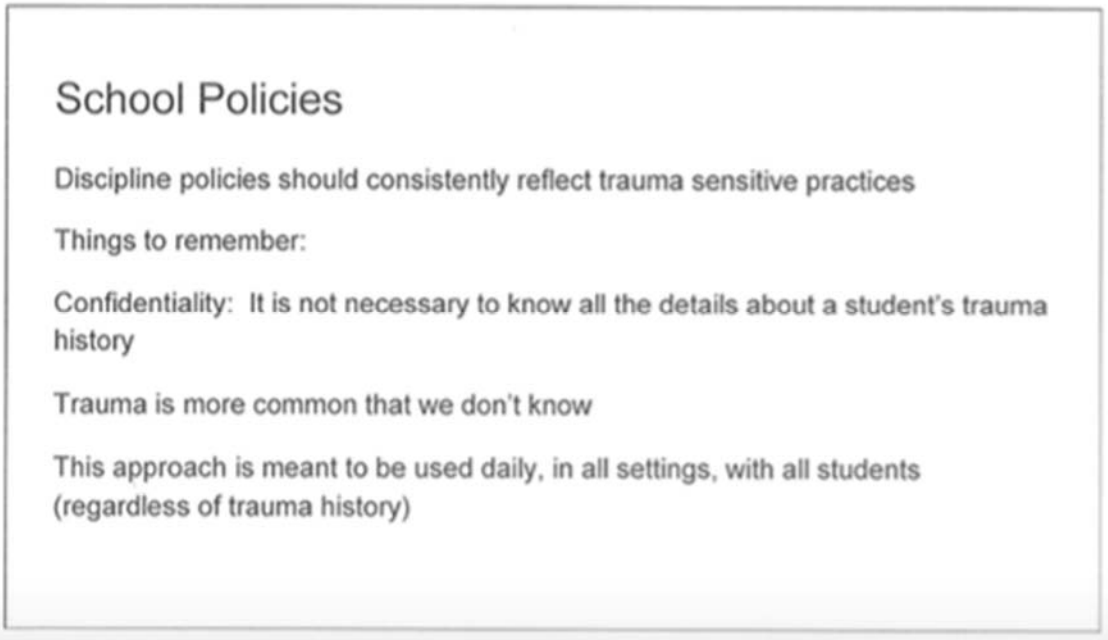

Range of responses by those affected by trauma
•Disinterest and apparent disregard
•Bravado
•Disrespect
•Hostility
•Disruption
•Aggressiveness
•Anxiety
•Passivity
•Withdrawal
•Depression
It is important to remember that people who are impacted by trauma may not be "likeable"
Be aware of this so you can deal with it constructively.


What changes can I expect to see in the classroom?
More positive relationships with all students.
More positive peer to peer interactions.
Increased interest in learning.
More positive mood (teacher and student).
Students who are more accessible to presented information and available for learning.


Example Slides for Phase 2:
Trauma Sensitive


Phase II: Trauma Sensitive
What does it mean to be "Trauma Sensitive"?
It incorporates the principles of trust, collaboration, empowerment, safety, and choice. (credit: The Missouri Model: A Developmental Framework for Trauma-Informed)
What are the goals of this phase?
Building Relationships
Creating schools policies that are trauma sensitive


Trauma Lens
When we see behaviors through our trauma lens we may be able to better understand inappropriate reactions.
Without adequate training, professionals may misinterpret a child's behavior
Viewing situations through trauma-sensitive lenses can be the difference between good outcomes and very poor outcomes.
Before we can assist others, we must be aware of our own trauma history and the lens through which we see the world.
Vassar, G. (2013).


School Policies
Discipline policies should consistently reflect trauma sensitive practices
Things to remember:
Confidentiality: It is not necessary to know all the details about a student's trauma history
Trauma is more common that we don't know
This approach is meant to be used daily, in all settings, with all students (regardless of trauma history)

School Policies

Discipline

Current discipline policies:

New wording/addition: When a student is involved in a major discipline incident, they should meet with the school counselor, psychologist, or social worker in order to debrief and explore underlying issues. *The student should still receive consequences as appropriate under school policy.

Strategies to use every day

Take note of the students that don't appear to have positive adult connections (they can be very quiet and fly under the radar they can be the student that is constantly being corrected and told to pay attention and anywhere in between.

Now that you've taken note-- make an effort to show that student they are special (i.e. learn his/her name if you don't know it and then consistently acknowledge him/her in the hallway)

Compassion Fatigue/Vicarious trauma

Vicarious Trauma is the transmission of traumatic stress to the caregiver who hears the stories of trauma

Compassion fatigue is the cumulative buildup over time of traumatic stress, which can be a result of chronic lack of self care (Ludick & Figley, 2016)

Signs of Compassion Fatigue

Bottled-up emotions

Impulse to rescue anyone in need

Isolation from others

Sadness, apathy

Lack of interest in self-care practices

Difficulties concentrating/mentally tired

Recurring nightmares/ flashbacks

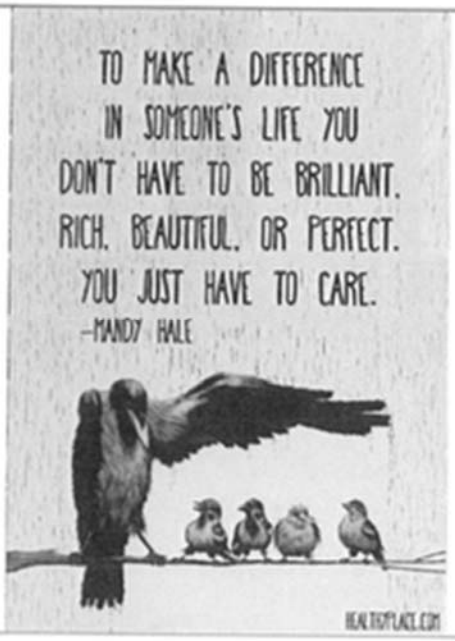
Persistent physical ailments

Prone to accidents

Often feels the need to voice excessive complaints about management/colleagues

(Compassion Fatigue Awareness Project, 2009)

Example Slides for Phase 3: Trauma Responsive



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- Recurring nightmares/ flashbacks
- Persistent physical ailments
- Prone to accidents
- Often feels the need to voice excessive complaints about management/colleagues

(Compassion Fatigue Awareness Project, 2009)

Healthy vs. Unhealthy Caregiving

What is Healthy Caregiving?

Being healthy in mind, body and spirit is having the ability to put ourselves in win-win situations.

In recognizing and honoring our own internal pain, we release its power over us.

This process allows us the space to experience true compassion for others while not taking on their suffering as our own.

What is Unhealthy or Chronic Caregiving?

Unhealthy caregiving puts us in lose-lose situations where everyone ends up hurting.

This occurs when the caregiver hasn't reconciled his or her own pain and suffering.

Unhealthy or chronic caregiving negates the compassionate, loving spirit that allows sustainable healing.

(Compassion Fatigue Awareness Project, 2009)

Compassion Satisfaction

"Compassion Satisfaction is the pleasure we derive from being able to do our work well. Higher levels of compassion satisfaction are related to your ability to be an effective caregiver."

-- Dr. Beth Hudnall-Stamm

Director, Institute of Rural Health

Idaho State University

The best known way to lessen compassion fatigue symptoms (and avoid burnout!) is to raise compassion satisfaction levels.

Self-Care

What is self-care?

The term self-care describes the actions that an individual might take in order to reach optimal physical and mental health.

Why is this important to me and my student(s)?

If you don't take care of yourself, how can you expect to be helpful to your student(s)?

Self-Care

How can we take care of ourselves?

Exercise

Spend time (even just 15 minutes) doing something you love (knit, paint, cook, etc).

Call a friend, sibling, or loved one

Meditation/mindfulness

Other suggestions?

Personal Care Plan

Please take a few moment to complete a self-care plan of your own.

Writing things down makes us more likely to do them.

Refer to your plan often, modify as needed, and encourage others (students, co-workers, family members) to create Self-Care Plans as well!

Empower each other

We do a lot to empower and recognize our students:

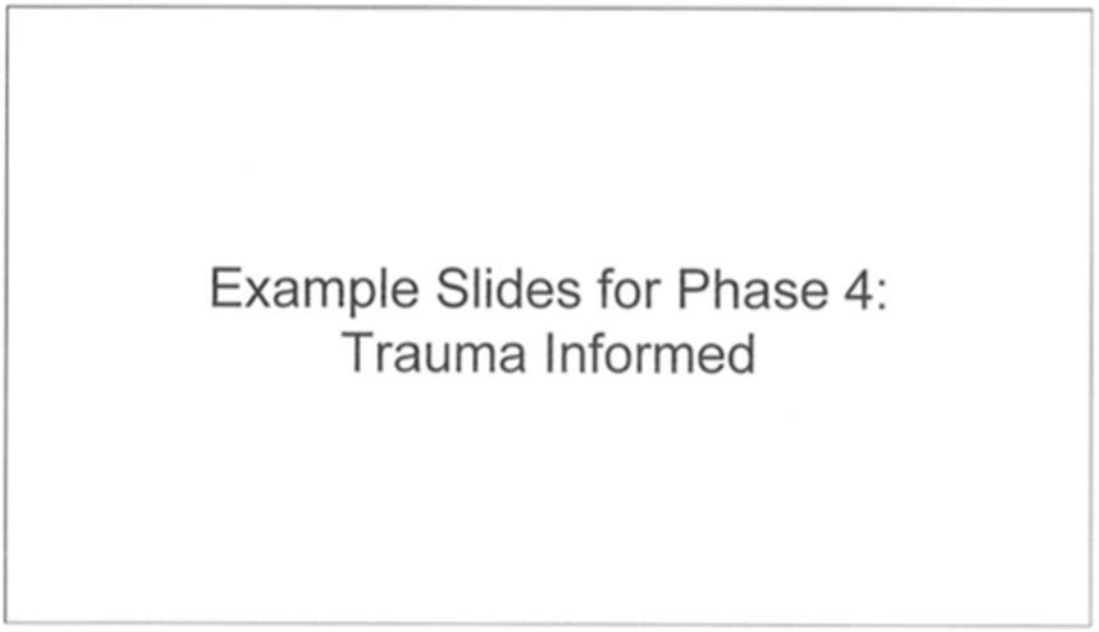
"Caught being good"

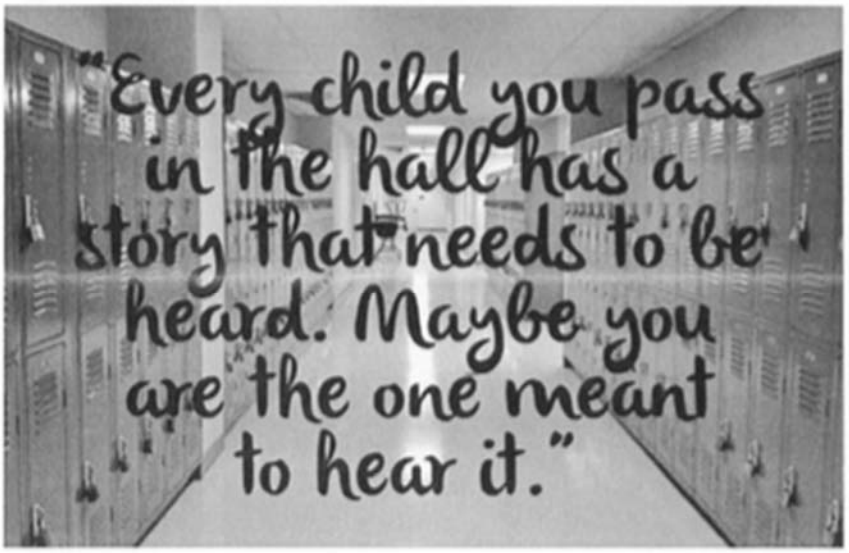
Others?

What do we do to empower and recognize each other?

- Teacher Kudos Board
- All about me/Star Staff of the Week
- Mystery staff member of the week


Ways to Empower Each Other
Tell someone when you see them doing something great!
Be genuine
It feels good to be recognized/praised, especially when we aren't expecting it.


Example Slides for Phase 4:
Trauma Informed



"The effects of trauma can be powerful and profound. Trauma impairs the most essential elements of learning, including thinking, attentiveness and the ability to process new information. It can interfere with the basic tasks of child and adolescent development—social, emotional, cognitive and physical—by literally changing physical function and connections within the brain."

"When school professionals understand these dynamics and how to respond in a trauma-informed manner, a whole new range of possibilities opens up."

http://www.etr.org/blog/my-take-trauma-informed/

People in this room have experienced trauma, we know people who have experienced trauma, and we work with children who have experienced trauma.

Trauma is not an easy topic to talk about

We cannot change someone's history or their reaction to their experiences… BUT Research shows that there is something we can do to change their FUTURE. We can be the adult that a child needs.
We can increase, enhance, and grow RESILIENCE in our students!

General Tips and Takeaways

Take note of the students that do not appear to have positive adult connections. Now, make a connection!! Learn that child's name, provide verbal praise and encouragement, find out their interests and engage with them on topics related and not related to school/academics.

Build self-esteem: Create opportunities for success! Praise effort- not product!

Do what you say will you do and be where you say you'll be! One of the hardest beliefs to change is that people can't be trusted. By doing what you say you will do you can help to show the children you work with that they will not always be let down.

Recognize changes in behavior and mood.

Incorporate movement and calming strategies into the day. Take a hold of the day-to-day "teachable moments" by modeling and having student's practice calming strategies such as deep breathing.

More Tips and Takeaways

Utilize movement breaks throughout the day to keep students' bodies and minds active and alert in a safe and calm setting. Using sites such as gonoodle.com make this easy and fun! Clear and consistent communication

Stay informed. Do your best to stay informed about things like dates/anniversaries because the child may display more difficult behaviors around those times and therefore, may need extra care.

Advocate for restorative discipline practices.

Implement classroom management practices such as posting rules and expectations, providing warning regarding schedule changes, and setting aside time for morning meeting.

Appendix B: Voluntary Comments from Reviewers

The program manual was made available for review to individuals who expressed interest. Participation was strictly voluntary, and each reviewer had the option to participate anonymously. Respondents included school psychologists, a school counselor, a school social worker, and a social worker currently working as a trauma initiatives impact manager in Pennsylvania. Reviewers were provided with the following open-ended questions:

- **Is the TIPS manual user friendly? What, if anything, would you change to make it more reasonable to implement?**
- **Do you think your school/district has the time and resources to implement the trainings as recommended in the TIPS manual? Please describe what resources you have, or would need to have, for successful implementation.**
- **If this manual were widely available, would you recommend your district use it? Why or why not?**
- **What was the most helpful part of the manual?**
- **What would you change about the manual?**
- **Please share any other comments/feedback.**

Reviewers provided the following answers:

1. **Is the TIPS manual user friendly? What, if anything, would you change to make it more reasonable to implement?**

Assistant Principal
"Yes! It is well-written, easy to read and very comprehensive. I like that there are specific ideas and strategies for implementing the program. The sample slides are helpful as well."

School Psychologist #1
"The manual is user friendly in that it is jargon-free and easy to read."

School Psychologist #2

"Yes it is very user-friendly. I would add some color and pictures. Perhaps a step-by-step guide on how to implement some of the strategies for teachers."

School Psychologist #3
"Very clear and user friendly."

School Psychologist #4
"User-friendly, great information and practical! Suggestions: Have a visual/graphic organizer with the 4 phases and components on one page before describing in detail -I would like more info regarding the specific training sequence - is it one afternoon with check-ins later? Also, who did you have on your team of trainers? Any adaptations for elementary, middle, high school to consider? May be helpful to describe the pilot project."

School Counselor
"Yes. It is easy to read and makes sense. Ideas are well defined and there are good examples. It truly is user friendly!!"

School Social Worker
"Yes, I like it as is."

Social Worker, Trauma Initiatives Impact Manager
"TIPS manual is very user friendly! I cannot wait to get them in hand to share."

2. **Do you think your school/district has the time and resources to implement the trainings as recommended in the TIPS manual? Please describe what resources you have, or would need to have, for successful implementation.**

Assistant Principal
"I definitely think that it is an important topic and I hope that we can find a way to implement the trainings as a school and district. Finding time is always difficult, especially given that we have so many initiatives going on. However, I think this topic is worth finding the time for."

School Psychologist #1
"Right now, my school/district is trying to implement so many changes that I think we are spread too thin to successfully implement at this time. However, I know a number of staff have gone to trainings about ACEs and being trauma informed. We just need someone to lead that push at the building/district level."

School Psychologist #2
"Yes, we are currently using the strategies as they were presented at the NASP convention."

School Psychologist #3

"Our district values the trauma sensitivity - they should make the time - there is a group of us interested in pushing the issue of training staff."

School Psychologist #4
"Could definitely use the information as professional development. I would love to know more about how many sessions were run, who were the trainers, initial barriers etc."

School Counselor
"I like the idea of a district wide trauma sensitive committee. Support is needed from the top administrators. I also agree that all personnel need to be trained. It would be great after the trainings to implement in-school suspension and supportive detention with 'safe place' and trained teacher."

School Social Worker
"Currently trying to implement but having some difficulties due to time and buy-in from top administrators. Implementing some on the program level. Need more time to provide training to staff."

Social Worker, Trauma Initiatives Impact Manager
"I do not work in a school district but think it is an amazing resource that schools could and should make available."

3. If this manual were widely available, would you recommend your district use it? Why or why not?

Assistant Principal
"Yes."

School Psychologist #1
"Yes, the mental health team is and some teachers are already using it."

School Psychologist #2
No response.

School Psychologist #3
"Yes easy to understand holistic approach - child - staff – caregiver. Alternatives to the traditional suspension."

School Psychologist #4)
"Yes."

School Counselor
"Yes. I would highly recommend this manual!"

School Social Worker
"Yes."

Social Worker, Trauma Initiatives Impact Manager
"Absolutely. This manual provides information that is easy to read while offering high level information that can be useful when creating a trauma informed education community."

4. What was the most helpful part of the manual?

Assistant Principal
"It was easy to read and follow."

School Psychologist #1
"Great job explaining the research and implications as well as establishing why being trauma informed and interventions are important. I was pleased that the point about distinguishing between trauma symptoms and other educational/psychiatric disabilities was included."

School Psychologist #2
"It reads as a help guide."

School Psychologist #3
"Facts & data are helpful to use when communicating with staff and administrators."

School Psychologist #4
"Practical information (books, slides)."

School Counselor
"I like the suggestions of how to help children in school who have been exposed to trauma."

School Social Worker
"Manual was comprehensive and easy to follow. Has lots of information. Liked the part about options for making the classroom trauma sensitive and samples of self-care plan."

Social Worker, Trauma Initiatives Impact Manager
"The images and resources."

5. What would you change about the manual?

Assistant Principal
"I wonder if it would be helpful to add some sort of evaluation piece to help schools and districts determine what they are already doing that is in line with the trauma informed philosophy and where they need to focus their efforts. Then, after implementing the trainings and making changes to policies, discipline, etc., it would be helpful to evaluate the impact that the changes are having."

School Psychologist #1
"The take-away strategies were helpful, but the chapters on the TIPS phases were very short and seemed lacking. Good, clear focus for Phase 1 (what, why, how), but overall I expected more information about implementing a program/plan rather than being instructed to train staff and integrate those skills. Expected more of a plan for how. For me, the manual sends the message to educate staff about trauma and its impact then build positive relationships between students/staff and implement strategies….Is the focus of this manual Tier 1? What about strategies/implementation at the Tier 2/Tier 3 levels? Also the manual encourages advocating for restorative practices, but doesn't explain what those are and how/why they fit in with trauma informed practices. The intended audience is a little unclear (admin, psychs, teachers?), particularly when the "Trauma Informed Care: A Toolkit for Educators" is included near the end of the manual. It is unclear to me why it is included as the information is redundant/repeats what was written earlier in the manual. However, the section of the toolkit that explains what a 'trauma informed approach' is was good and I liked that it discussed the shift from a 'what's wrong with them' to a 'what happened to you' lens as well as the reminder that behaviors have functions."

School Psychologist #2
"Color and font. Some visuals."

School Psychologist #3
"Very helpful, practical, easy to implement provides good supportive ideas and examples backed by research."

School Psychologist #4
"It may read a little like a research paper but great info! Having some graphic organizers of the info in point form would be helpful as an appendix."

School Counselor
"Add one idea of a way to connect with student - have a lunch with them."

School Social Worker:
"Nothing I can think of."

Social Worker, Trauma Initiatives Impact Manager
"Nothing."

6. Please share any other comments/feedback.

Assistant Principal
"I really loved the section on discipline. I think there are some simple changes that we could make to our policies/code of conduct and to our consequences that would make discipline more effective and that would include an educational component."

School Psychologist #1

“The manual seems to be written in a conversational manner and something I personally am not used to in such a context. The use of "we" and "I" as well as exclamation points seems informal.”

School Psychologist #2
No response.

School Psychologist #3
No response.

School Psychologist #4
No response.

School Counselor
“It is wonderful!! I like the idea to get staff to change ‘What's wrong with them’ to ‘What happened to them.’"

School Social Worker
No response.

Social Worker, Trauma Initiatives Impact Manager
“As I mentioned earlier, I am eager to share this manual with education communities in the region.”