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Supporting Child Survivors of Trauma at School: Depathologizing Behaviour and Educating Teachers

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Abstract

Childhood trauma is a substantial concern in our education system in Ontario, as it has been noted that approximately 32% (Afifi et al., 2014) to 36% (Findlay & Sutherland, 2014) of Canadian adults report that they were exposed to abuse as children. Trauma can have significant impact on a child's learning (Vasilevski & Tucker, 2016), behaviour (Greeson et al., 2014), and wellness (Roberts, Ferguson, & Crusto, 2013), and puts them at an increased risk of being retraumatized or further punished in schools due to the Western education system relying on the behavioural model (Costa, 2017). A 450-hour social work practicum was completed with the Mental Health Team at the Sudbury Catholic District School Board (SCDSB) as a partial requirement of the Laurentian University MSW program. This practicum project report employs structural and anti-oppressive social work perspectives and a trauma theory lens to undergo an exploration into: (a) what trauma-informed practices (TIPs) and primary models are used by the SCDSB to inform their practice in supporting students who have been exposed to trauma, (b) to what extent school-based social work in this setting reflects certain models that function to further harm child survivors of trauma, such as the behavioural model, and its relationship to understanding student experiences through the lens of trauma, and (c) how trauma theory can be used to establish alternatives to pathologization in regards to children within schools who have experienced trauma. Trauma-informed professional development lunch-and-learns were presented to teaching staff in four schools as the intervention provided during this practicum.

Résume

Les évènements traumatiques durant l'enfance ont une préoccupation majeure dans notre système d'éducation en Ontario, environ 32% (Afifi et al., 2014) à 36% (Findlay et Sutherland, 2014) des adultes au Canada déclarent d'être exposés à des évènements traumatiques durant leur enfance. Les évènements traumatiques peuvent avoir un impact significatif sur l'apprentissage d'un enfant (Vasilevski et Tucker, 2016), son comportement (Greeson et al., 2014), et son bien-être (Roberts, Ferguson, et Crusto, 2013). De plus, ces évènements leurs exposent à un risque accru de se traumatiser de nouveau à l'école en raison du système éducatif occidental s'appuyant sur le modèle comportemental (Costa, 2017). Un stage de travail social de 450 heures a été complété avec l'équipe de santé mentale du conseil scolaire de district catholique de Sudbury, comme exigence partielle de la Maîtrise en Travail Social (MSS) de l'Université Laurentienne. Ce rapport de projet de stage utilise des perspectives de travail social structurelles et anti-oppressives et une perspective de la théorie du traumatisme pour l'exploration de: (a) éclairer les pratiques et modèles utilisés par l'équipe de santé mentale du conseil scolaire de district catholique de Sudbury, (b) dans quelle mesure le travail social en milieu scolaire reflète certains modèles qui fonctionnent pour nuire aux enfants survivants d'un traumatisme, tels que le modèle comportemental et son lien avec la compréhension des expériences des élèves à travers l'affaiblissement du traumatisme, et (c) comment la théorie du traumatisme peut être utilisée pour établir des alternatives de la pathologisation des enfants dans les écoles qui ont subi un traumatisme. Des déjeuners-conférences de perfectionnement professionnel axés sur les traumatismes ont été présentés aux personnel d'enseignants et d'enseignantes de quatre écoles au cours de l'intervention fournie pendant ce stage.

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Chapter 1: Introduction

It has been said that clinical social work practice can be considered a humanistic artform (Coady & Lehmann, 2016) in which clinicians interweave various theories, therapeutic modalities, and practices creatively in order to thoughtfully mold their practice into something that is a unique fit for the each individual (Coady & Lehmann, 2016). Using this artform, I would suggest that part of the role of clinical social work practice is to assist others in creating beauty from adversity. The adversity faced by individuals may be a result of societal deficits, oppression, and/or individual struggle; one of which may be childhood trauma. Social structures and institutions, such as those that are underpinned by patriarchy (Herman, 2015; Wilkin & Hillock, 2014) or racism, continue to elevate rates of trauma (Wilkin & Hillock, 2014). The systemic racism that exists within the child welfare system is evidenced by race being one of the most highly correlated factors associated with child welfare involvement (Carrière & Strega, 2015). Likewise, child welfare investigations are ratified approximately three times more often for Indigenous family cases opposed to non-Indigenous families, with Indigenous children being taken away from their families and put into the foster system at a higher rate (Fallon et al., 2015). As such, the Canadian child welfare system can be used as an example to portray how social institutions can increase the existence of childhood trauma as a result of systemic racism. Despite the intention of the foster care system to provide a safe home for youth, in actuality children and adolescents are at greater risk of experiencing maltreatment and neglect after being placed into foster care (Yang & Ortega, 2016). Additionally, youth report experiencing more difficulty as a result of being removed from their home, not being placed in a home with their sibling(s), and having to change schools (Riebschleger et al., 2015). The frequent upheaval and transient

lifestyle of the foster system poses significant and ongoing challenges for youth (Riebschleger et al., 2015) and puts them at risk of being exposed to further trauma.

In order to move towards a society that begins to disable the existence, oppression, and marginalization of childhood trauma and support survivors, it is essential that social workers and the professionals that work in children's services, including school settings, are trauma-informed and work in an anti-oppressive way. When I talk about being "trauma-informed" throughout this paper, I am talking about a perspective that is adopted which gives recognition to the various ways trauma can be present and expressed in an individual's life (Evans & Coccoma, 2014). As a result of trauma being so closely tied to Westernized societal structures and institutions, van der Kolk (2014) recognized that you cannot talk about trauma without acknowledging the oppression that exists within Western society. For example, low socioeconomic status leaves individuals more vulnerable to being exposed to trauma due to the safety and condition of the area and home in which they live (Hart, 2008; van der Kolk, 2014). Thus, I suggest that in order for social workers to practice in a trauma-informed way adopting an anti-oppressive practice (AOP) is necessary. Acknowledging the existence of oppression is an important first step towards AOP, in which one recognizes the hierarchies that are present in our society based on a group's descriptors, which gives some identified groups and individuals advantage while others are marginalized (Kumashiro, 2000). Social workers who have an AOP perspective have to intentionally and systematically protest oppressions that are present in society and societal systems (Sakamoto, 2005).

School-based social workers frequently provide support to students who have experienced trauma and/or who are connected with child protective services (Kelly et al., 2015). Using a multi-tiered system of support, school-based social workers provide services to students through

three levels of interventions which start broad and progressively move towards individualized student supports based on their need (Kelly et al., 2015; Erchul & Ward, 2016). This progression is reflected in the mental health promotion, prevention, and intervention framework. Kelly et al. (2015) identified that the goals of this framework are to "promote protective factors and prevent risk factors" (p. 175) while providing students who require higher levels of mental health support with clinical intervention.

As a partial requirement of the Master of Social Work Program I completed a 450-hour practicum at the Sudbury Catholic District School Board (SCDSB) working under the supervision of a school-based social worker with the Mental Health Team in the Learning Support Services department. The inquiries that directed my practice during my practicum and those explored in this paper are: (a) what trauma-informed practices (TIPs) and primary models are used by the SCDSB to inform their practice in supporting students who have been exposed to trauma, (b) to what extent does school-based social work in this setting reflect certain models that function to further harm child survivors of trauma and their relationships to understanding student experiences through the lens of trauma, and (c) how can trauma theory be used to establish alternatives to pathologization in regards to children within schools who have experienced trauma? This exploration is informed by structural and anti-oppressive social work perspectives and a trauma theory lens. I define a trauma theory lens or trauma lens—terms which are used interchangeably throughout this paper—as a perspective that first considers the possibility of trauma exposure and the diverse impact trauma can have on an individual in all situations and encounters. As such, adopting a trauma lens means that the behaviour of children at school may be explained by the experience of trauma, whether or not school staff are aware of such events. An intervention I chose to implement during my practicum with the SCDSB was to

create and present a trauma-informed professional development lunch-and-learn for teaching staff.

The current chapter provides a scholarly discussion of childhood trauma and the impact of trauma on schooling. In this paper, I establish the sociopolitical context, detail the guiding questions for the completed practicum and current paper, discuss how I came to this area of focus, and reflect on my social location and its implications on my practicum process. Trauma theory and anti-oppressive theory are reviewed as the two foundational theories to the current work. To give further context to this area of focus a rationale for the practicum project is highlighted along with a description of the practicum site and the ethical considerations.

Background

This section establishes how trauma, specifically childhood trauma, is defined within this paper. Additionally, how childhood trauma broadly impacts child survivors and what influence childhood trauma has in adulthood is also presented. As the current paper explores childhood trauma in a school setting, it is important to take a detailed look at how childhood trauma impacts children who are attending school.

Overview and impacts of trauma. To begin, many people worldwide are exposed to trauma and can be profoundly impacted as a result (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014). Moreover, trauma is something that can be experienced by anyone, at any stage of their life (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014). In this paper trauma is defined as,

> … 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. (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014, p. 7)

Trauma impacts approximately 70% of individuals worldwide (Benjet et al., 2016), whereas, Canadian prevalence studies have found that 32% (Afifi et al., 2014) to 36% (Findlay & Sutherland, 2014) of adults report that they were exposed to abuse as children. With 83% of perpetrators of childhood abuse being the child's guardian(s) (Raby, Labella, Martin, Carlson, & Roisman, 2017); teachers, principals, classroom support staff, and school-based social workers may or may not be aware of the trauma that children carry with them to school, from their home environment. Therefore, there is an alarming number of individuals, including children, who experience trauma and we may not be aware of their exposure to trauma or their need for trauma-informed support, as many children do not disclose about the trauma they have experienced until they are adults (Herman, 2015).

Trauma in childhood has been associated with children experiencing adversity in a broad number of areas including: difficulty sleeping (Herman, 2015; Teicher et al., 2017); elevated experiences of anxiety, depression, and anger (Herman, 2015; Teicher et al., 2017); bodily discomfort and difficulties with attention, following rules, aggression, and engagement (Greeson et al., 2014); challenges with social interactions (Greeson et al., 2014; Herman, 2015; Putnam, 2006); difficulty with self-regulation (Bloom, 2014a; Greeson et al., 2014; Herman, 2015; Music, 2014; Record-Lemon & Buchanan, 2017); challenges with remembering and planning (Music, 2014; Vasilevski & Tucker, 2016); lower self-esteem and conflict resolution skills (Herman, 2015); adversity in forming secure attachments (Herman, 2015; Putnam, 2006); and engagement in risky behaviours such as purging, overeating, sex at an early age, self-harm, and

the use of drugs and alcohol (Anda et al., 2006; Bloom, 2014a; Herman, 2015). Abuse by a child's guardian takes away the security, protection, and healing attributes that the caregiver relationship should provide to the child (van der Kolk, 2014). This leaves the child in charge of protecting themselves and often results in difficulty with relationships and self-regulation (van der Kolk, 2014). Furthermore, children who have experienced trauma are often pathologized and labelled with mental illnesses (Berkowitz, 2012; Brunzell, Waters, & Stokes, 2015; Heim & Nemeroff, 2001; Kavanaugh & Holler, 2014), which is discussed in more detail in the next chapter.

I recognize that detailing such a long list of adversities that can be experienced following trauma further blames, labels, and identifies negatives in the child for reacting to trauma in ways that seek to maintain their safety, instead of identifying the blame in the perpetrators that caused the trauma (Costa, 2017; Herman, 2015). However, it is important to acknowledge the reality of the challenges faced by survivors and to identify how trauma is commonly looked at as being a deficit of the survivor (Herman, 2015), in order to challenge the harm that exists. It is through awareness that we can identify what is lacking in society to support survivors (Quiros & Berger, 2015). These challenges faced by child survivors, can in part be attributed to the influence childhood trauma has on brain formation and processing (Record-Lemon & Buchanan, 2017), the socialization of children (Herman, 2015; van der Kolk, 2014), and societal structures (Herman, 2015; Quiros & Berger, 2015). These areas are unpacked throughout the remainder of this paper.

The longer-term effects of childhood trauma are widespread and significant. Adult survivors are more likely to experience anxiety or depression (Thoresen, Myhre, Wentzel-Larsen, Aakvaag, & Hjemdal, 2015), along with other mental health concerns including

substance abuse or dependence, thoughts of suicide, and attempts to end their lives (Afifi et al., 2014; Cloitre, 2015). Furthermore, adults who are survivors of childhood trauma have higher rates of convicted criminal offenses in the criminal justice system (Papalia, Ogloff, Cutajar, & Mullen, 2018) whereas survivors are also more likely to experience intimate partner violence (Herman, 2015; Thoresen et al., 2015). The rates of post-secondary education are lower for survivors of childhood trauma (Afifi et al., 2014) and employment rates in adulthood show the same trend (Morgan, Pendergast, Brown, & Heck, 2015; Putnam, 2006).

Childhood trauma and school. The experience of trauma impacts students in school in a number of different ways. The biological reactions that exist to keep humans safe can lead to education-based conflicts for students who have experienced trauma. The fight-flight-freeze response is activated in the brain as a protective factor when faced with dangerous situations by initiating and increasing combative functioning, motivating escape behaviour, or decreasing an aggressor's attack by minimizing self-activation and/or faking death (Bloom, 2014a). Education can be impacted as a result of child survivors trying to cope with trauma triggers existing within the classroom environment, which are signalling danger in their brain, making it difficult for them to fully engage in the learning activity at hand (Crosby, Somers, Day, & Baroni, 2016) but also has an impact on stress levels overall.

Prolonged exposure to stress, such as that experienced in childhood trauma, demands the body and brain to perform at an elevated state of arousal, which is termed hyperarousal (Bloom, 2014a). Hyperarousal leads to challenges in self-regulation as a result of the individual's body and brain becoming nonresponsive to certain hormones and more sensitive to others (Bloom, 2014a). On the other end of the spectrum is hypoarousal, which is a state at which the brain performs a sense of disconnection which allows for survival through dissociation (Bloom, 2014a;

Wilkinson, 2017). The dysregulation caused by these two functions is likely associated with the elevated accounts of inattention (Music, 2014), rule breaking, aggression (Greeson et al., 2014), and rates of disciplinary exclusion from school or incomplete education (Putnam, 2006) experienced by child survivors of trauma at school. Lacking trauma knowledge, school staff often put blame on the student (Crosby et al., 2016) for something outside of their control (Bloom, 2014a) and as a result the child receives punitive reactions that can lead to retraumatization (Crosby, Howell, & Thomas, 2018).

Additionally, survivors can experience difficulty with learning and memory (Bloom, 2014a; Vasilevski & Tucker, 2016), which is said to be a result of impairment in the hippocampal area of the brain caused by elevated and prolonged levels of the stress hormone, cortisol (Bloom, 2014a). Compounding this, survivors of childhood trauma can find it challenging to concentrate (Music, 2014; Vasilevski & Tucker, 2016), regulate their emotions and behaviours, and do introspection (Music, 2014). These abilities are achieved through higher order cognitive function requiring the performance of the prefrontal cortex of the brain (Music, 2014), which is often unavailable to students who are currently bound within the limbic area of the brain (Music, 2014) functioning for survival (van der Kolk, 2014).

Within the education system, Indigenous children have lower graduation rates (Harper & Thompson, 2017). The structure of our Canadian society, including the education system, is based in dominant ways of operating, with its practices, guidelines, and social norms grounded in the Western discourse, and therefore Indigenous students are oppressed within the system (Harper & Thompson, 2017). Thus, it is important that when we are looking at trauma as a result of violence for Indigenous children, we must consider the societal policies that continue to act as perpetrators of this violence today through colonialism (Clark, 2016).

Some adult survivors have come forward to acknowledge that they were not afforded adequate assistance in school that was essential to supporting their learning needs which resulted from experiencing trauma in childhood (Kopels, 2015). The lack of adequate trauma support being provided in schools may be leading to the statistics we see of child survivors. The numbers suggest that child survivors are approximately 2.7 times more likely to fail a grade and approximately 2.6 times less likely to be engaged in school compared to students who had not been exposed to trauma (Bethell, Newacheck, Hawes, & Halfon, 2014, p. 2111). Correspondingly, child survivors of trauma are at an increased risk of not completing their schooling (Tanaka, Georgiades, Boyle, & MacMillan, 2015).

Trauma and oppression. Much of the literature in the field acknowledges the interconnectedness of trauma and oppression (Herman, 2015; van der Kolk, 2014; Wilkin & Hillock, 2014). Oppression is the existence of hierarchy in our society between people based on the descriptive group in which they belong, where some identified groups are privileged while others are marginalized (Kumashiro, 2000). Violence, as a result of structural oppression, is enacted in order to denounce members of a marginalized group, or the group as a whole, through means of physical acts, threat, and/or criticism (Mullaly & Dupre, 2019). The violence that is acted out through structures of oppression can be traumatizing (Wilkin & Hillock, 2014) and individuals belonging to oppressed groups live in fear of being exposed to such aggressions (Mullaly & Dupre, 2019). Acts of oppressive violence also include microaggressions, which are frequent biases conveyed through what someone says, how they act, or systemic practices which are oppressive to individuals based on their race (Sue et al., 2007) or sexual orientation (Swann, Minshew, Newcomb, & Mustanski, 2016). Microaggressions can include biases that are embedded within a system that may go unnoticed as the individuals within the system may be

unaware of the power imbalance and insidious psychological and social aggressions that they are perpetrating (Blitz, Anderson, & Saastamoinen, 2016). Despite microaggressions usually being performed quickly (Sue et al., 2007), survivors are significantly affected by these acts of aggression (Swann et al., 2016). Identifying how structures of oppression such as sexism, heterosexism, colonialism, ageism, and classism are connected to trauma is something that I argue is important for school-based social workers to understand in order to have an anti-oppressive trauma-informed practice. However, Herman (2015) said that in order to truly unite survivors and bystanders everyone must acknowledge and oppose the societal frameworks which allow trauma to exist.

Without recognizing and confronting our patriarchal society that allows for the abuse of women and children, studying trauma becomes inauthentic (Herman, 2015). Sexism views women as inferior to men and defines masculine gender norms (Garza & Feagin, 2019). As such, acts of violence are used in order to preserve this gendered privilege (Garza & Feagin, 2019). Females are sexualized and believed to be illogical, sensitive, and fragile, among other subordinate attributes as a result of the beliefs of sexism. Thus, it is no surprise that female children experience higher rates of psychological and sexual abuse whereas male children experience higher rates of physical abuse (Thoresen et al., 2015). Socialized gender norms lead boys to under report sexual abuse (Easton, Saltzman, & Willis, 2014). Male survivors reported that, they felt shame as children/adolescents for not being “strong” enough to stop the abuse, fear of being labelled as homosexual, and they believed that disclosing would make them fragile (Easton et al., 2014).

In a study done in the United States, it was found that sexual minority children and adolescents—who identified as lesbian, gay, or bisexual (LGB)—experience the highest amount

of trauma compared to heterosexual children and adolescents (Clements-Nolle et al., 2018). The findings suggested that of the individuals who identified as LGB approximately 24% reported experiencing childhood sexual abuse, nearly 34% reported experiencing childhood physical abuse, and almost 27% reported experiencing childhood domestic violence (Clements-Nolle et al., 2018). In comparison, of the individuals who identified as heterosexual approximately 7% reported experiencing sexual abuse, nearly 13% reported experiencing physical abuse, and almost 15% reported experiencing domestic violence during childhood (Clements-Nolle et al., 2018). Overall, approximately 23% of individuals that identified as LGB had two traumatic experiences during childhood, compared to almost 15% of individuals who identified as heterosexual (Clements-Nolle et al., 2018). Likewise, approximately 33% of individuals who identified as LGB reported having had 3-5 traumatic experiences during childhood, compared to almost 10% of individuals who identify as heterosexual (Clements-Nolle et al., 2018).

Given the disproportionate amount of trauma experienced among sexual minority children (Clements-Nolle et al., 2018), I suggest heterosexism is a contributing factor. Heterosexism is a structure of oppression in which those who do not identify as heterosexual or do not subscribe to socialized gender norms are believed to be, and are treated, as inferior (Moore, 2017; Mullaly & West, 2018). As a result of these attitudes, D'haese, Dewaele, and Van Houtte (2016) indicate that sexual minority children can be exposed to homophobic violence in verbal, physical, sexual, and material forms (material forms referring to their belongings being harmed). Recognizing that the Sudbury Catholic District School Board (SCDSB) is connected to a religious institution, it is also important to recognize that heterosexism can be perpetrated on a systemic level through religious beliefs and proclamations claiming that homosexuality is immoral (Moore, 2017). Additionally, sexual minority youth are often exposed to microaggressions, such as

microinvalidations (Munro, Travers, & Woodford, 2019) and undersexualization (Platt & Lenzen, 2013), which have a direct negative influence on their mental health (Swann et al., 2016). I provide further detail about these forms of microaggressions in the third chapter where I also reflect upon how microinvalidations and undersexualization were present in the SCDSB.

Trauma experienced by Indigenous peoples in Canada as a result of the colonial practices enacted by the settler government, such as the Residential School System, the Sixties Scoop, and the seizure of Indigenous lands, continues to have intergenerational impact on Indigenous peoples today (Bombay & Anisman, 2009; Bombay, Matheson, & Anisman, 2014; Fast & Montgomery, 2017; Gone, 2013; Manitowabi & Maar, 2018). A Canadian study that investigated historical trauma among four racialized and minoritized groups (Indigenous peoples, Black people, Jewish people, and a diverse group of women), found that Indigenous peoples experienced the highest rate of trauma and discrimination (Matheson, Foster, Bombay, McQuaid, & Anisman, 2019). Colonialism persists today in Canada through provincial and federal government policies that dictate Indigenous affairs and ensure that Indigenous peoples are reliant on settler government programs (Manitowabi & Maar, 2018) with Indigenous lands still being occupied and allocated by the Canadian government (Fast & Montgomery, 2017). We continue to see elevated levels of childhood sexual abuse, neglect, domestic violence, addiction, mental health concerns, and substandard access to basic rights within Indigenous communities (Haskell & Randall, 2009). The systemic constructs in place for health care needs and intervention practices are grounded in dominant colonial views (Clark, 2016). Colonial views normalize the maltreatment and trauma experienced by Indigenous females of all ages, while also defining what constitutes as trauma (Clark, 2016). Within these views is the idea that Indigenous peoples who experience trauma need to be helped by Western societal structures and practices (Clark,

2016). Therefore, when addressing childhood trauma, systemic violence is enacted by policies, practices, and systems catering to Western society's knowledge and recovery while failing to acknowledge such practices of systemic violence within the definition of trauma (Clark, 2016). Colonial views also result in the overrepresentation of Indigenous youth being connected with child welfare services, being place in correctional facilities, and pathologized within the mental health system (Clark, 2016).

Colourblindness is a microaggression that can exist within the education system, in which the appreciation for race is not considered, meaning that everyone is viewed as the same, regardless of race (Matias & Liou, 2015). This is a problem because it masks racism (Sue et al., 2007) and leads to the inequitable treatment of racial minority students (Blitz et al., 2016). Inequitable treatment results from the needs of students within the school system being defined based on the dominant culture instead of appreciating the unique needs and varied realities that are experienced with racial diversity (Blitz et al., 2016). Additionally, when differences in race are recognized by individuals of racial privilege, it tends to be viewed in a paternalistic way in which the dominant racial group can help the non-dominant racial students (Matias & Liou, 2015). Race needs to be considered and examined within the schools and the larger system in order to determine what trauma-informed practices need to be implemented in order to address the needs of the students and families that are within their school community (Blitz et al., 2016). One way this microaggression is carried out is through supportive practices of schools being grounded in the dominant White culture (Blitz et al., 2016). Although staff may endorse the idea that every student is treated the same, the definition they hold of what equality means is measured against the benchmark of the dominant society (Blitz et al., 2016).

Age is also a factor by which children can experience oppression (Mullaly & West, 2018). This structure of oppression is called ageism (Mullaly & West, 2018). As a result of children not yet being fully developed, cognitively or physically, and/or not being able to provide for themselves they are exposed to prejudice and discrimination (Westman, 2019). Children are perceived to be a person of lesser rank due to the level of adult support that they require (Westman, 2019). Putting this all together, I believe it is clear that adults hold more power over children, including in the school system, and that ageism can relate to the experience of childhood trauma when adults benefit from exercising their authority and hierarchy over a child, at the expense of the child's rights or equality, by exploiting, demeaning, or neglecting children (Westman, 2019).

Lastly, children can also experience trauma in relation to classism. Classism is when individuals are oppressed based on their socioeconomic status in society (Westman, 2019). Individuals in poverty may be unable to meet their needs independently which may make them reliant on others who may violate their safety (Hart, 2008). Notably, Hart (2008) acknowledges that violence is not contained within income brackets; however, systemic factors and an individual's limited resources can complicate one's decision to exit violent relationships or stop perpetrating violence. In a Canadian child welfare study done by Lefebvre, Fallon, Van Wert, and Filippelli (2017), it was found that children experience "physical abuse, sexual abuse, neglect, emotional maltreatment, or exposure to intimate partner violence" (p. 7) at a rate that is two times higher when they live in a household that was unable to afford to meet the basic needs of the family compared to a household which could afford to meet the family's basic needs.

Sociopolitical Influence of the Education System on Child Survivors

In this section, I turn to an exploration of the sociopolitical context for the practicum and paper, including the impact of the neoliberal Ontario education system and its relationship to the oppression and marginalization of children who have experienced trauma. The education system in Ontario, which is grounded within neoliberal values, affects children in our schools (MacDonald-Vemic & Portelli, 2018); especially those students who have experienced trauma. The underpinnings of Western neoliberal society seek to continue the market economy through the education and training of children in Ontario schools (MacDonald-Vemic & Portelli, 2018). The Ontario education system maintains the desire for results that are indicative of neoliberal and free market principles which are shown by keeping children responsible to outcome measures through province-wide testing (MacDonald-Vemic & Portelli, 2018) such as the Education Quality and Accountability Office (EQAO) tests (Fedeli, 2019). As a result of keeping students accountable to outcome measures, student behaviours and perspectives are interpreted through the lens of their personal responsibility for their outcome (Keddie, 2016). For example, students may study at home and/or view their achievement as being a result of how much they applied themselves (Keddie, 2016). Standardized testing allows for rivalry on a broad scale, ranging from competition between students, schools, national standings, and on a global level (Connell, 2013). The saturation of neoliberal values unto children within the education systems is evidenced by elementary students in the United Kingdom reporting that in order to attain respectable and profitable employment it is essential to be well educated (Keddie, 2016). Although the study that was done by Keddie (2016) was not based in Ontario or Canada, it is useful to showcase how an education system under neoliberal discourse, such as that of the

Ontario education system, influences students and perseverates the values of competition, hierarchy, and economic growth that are characteristic of a neoliberal society.

The performance of individuals creates a divide, which is viewed as a direct reflection of the person, not the Government (MacDonald-Vemic & Portelli, 2018). With the known learning challenges faced by children who have experienced trauma (Bloom, 2014a; Music, 2014; Vasilevski & Tucker, 2016) I suggest that the Ontario education system systemically oppresses survivors by creating divide between students who have difficulties learning through the use of standardized testing (MacDonald-Vemic & Portelli, 2018). Based on student achievement on standardized tests, students are divided into being identified as "thriving" (p. 127) students who are academically strong and capable, or "at risk" (p. 126) students who are inadequate and who have exceptional needs (Kearns, 2016). Buried within educational standardized tests are norms of the neoliberal Western society that give advantage to students that fall into the dominant "cultural, social, political, and economic" (p. 125) standards (Kearns, 2011). In the Ontario education system, marginalized students are not only labelled *at risk* because of factors such as belonging to a visible minority group or having low socioeconomic status but they are also given this label for not performing well on standardized testing (Kearns, 2011). Furthermore, students who show difficulty in meeting standards can be seen as negatively impacting the education of other students, due to the additional time that is involved in supporting these children, and lowering the prestige of the school based on their marks (MacDonald-Vemic & Portelli, 2018).

Youth within the Ontario education system have reported that failing the standardized testing emotionally impacted them as it made them feel embarrassed, anxious, and lesser than others (Kearns, 2011). Moreover, youth who failed to meet the measures on the standardized tests also felt incompetent and incapable, thus lowering the student's confidence in their ability

to be successful (Kearns, 2011). I suggest that employing the use of standardized testing poses a significant issue of inequity for students who are survivors of trauma, as child survivors are more likely to have difficulty with learning (Bloom, 2014a; Vasilevski & Tucker, 2016), be part of a minority group (Clements-Nolle et al., 2018; Lee & Chen, 2017), and/or have low socioeconomic status (Danese & McCrory, 2015). The negative emotional impacts that result from failing to meet the measures of the standardized testing, not only affects a student's self-esteem (Kearns, 2011), which is often already low due to experiencing childhood trauma (Herman, 2015), but can also decrease a student's confidence that they can succeed or cause them to reconsider whether they should continue or are meant to study certain subjects (Kearns, 2011). This leads me to propose that standardized testing may be a contributing factor in the increased drop out rates that are seen among students who are survivors of trauma (Tanaka et al., 2015).

Moreover, the Ontario education system has applied unequal disciplinary action towards marginalized students (MacDonald-Vemic & Portelli, 2018). As a result of disciplinary actions targeting marginalized students at a greater rate, the zero tolerance policy was eliminated (MacDonald-Vemic & Portelli, 2018). As we already know, marginalized children are more likely to be exposed to trauma (Clements-Nolle et al., 2018; Lee & Chen, 2017). Punitive disciplinary actions do not meet the emotional needs of students who have experienced trauma; instead they invalidate the child's needs and reinforces that school staff do not understand them (Nash, Schlösser, & Scarr, 2016). Such behavioural management strategies can result in a child survivor being further traumatized (Costa, 2017). Thus, with marginalized students experiencing higher school discipline rates (MacDonald-Vemic & Portelli, 2018) I suggest that the exposure to

trauma that they experience is further compounded. This information is important to consider when reflecting on how children who have experienced trauma are supported in schools.

Foundational Questions, Personal Interest, and Social Location

In this section, I introduce the foundational questions guiding this paper and I ground myself in this work. I identify myself as the writer of this paper and explain what led me to this area of focus. Additionally, I provide insight into my social identity and how it influenced my work.

Foundational questions. The initial intent that guided my practicum and to which this paper explores is what trauma-informed practices and primary models are used by the Sudbury Catholic District School Board (SCDSB) to inform their practice in supporting students who have been exposed to trauma. Additionally, I explored to what extent school-based social work in this setting reflected certain models that function to further harm child survivors of trauma, such as the behavioural model, and its relationship to understanding student experiences through the lens of trauma? This exploration was informed by a structural and anti-oppressive social work perspective. Lastly, I reflected on how trauma theory can be used to establish alternatives to pathology in regards to children within schools who have experienced trauma.

Personal interest in study focus. My interest in the topic of childhood trauma and working within a school setting was discovered by reflecting on my work history, self-identifying an area of weakness in my experience, and exploring my clinical interests within the literature. I have worked with both children and adults in community and hospital mental health programs in Ontario. Through reflection, I identified that many of the individuals I worked with had experienced trauma. However, my professional practice approach lacked trauma-informed knowledge and I had limited insight into the oppression that existed within the Westernized

social structures and institutions, including the Ontario mental health system. As such, I realized that many of the errors I had made in my past work experience had been a result of not being trauma-informed or not practicing from an AOP approach.

My clinical interest for my future social work practice is to work with children in the field of mental health. Through engagement in reading about the exposure of trauma during childhood, the literature seemed to refer to schools as being a beneficial setting for healing from trauma (Howard, 2018; van der Kolk, 2014); yet it appeared to be and area which still required growth and development (Cavanaugh, 2016; Moon, 2017). As I was not familiar with working in the education system, this seemed like a great development opportunity for myself as a future clinical social worker and something I hoped would make a meaningful contribution to the SCDSB.

Social location. I identify as a 31-year-old, married, heterosexual female who is a first and second generation Canadian with Italian and Dutch heritage. Based on my own social location, I can identify that I am very privileged in terms of the family I grew up in and the care and nurturing with which I was provided. This sets me apart in some circumstances from the individuals I work with who have experienced trauma. I have to consciously challenge the bias I have that family is safe, secure, and loving. Through self-reflection I recognize my own prejudices I hold about guardians who do not always provide a safe, secure, and loving environment to their children. Additionally, I recognize that I held power within my role as a practicum student within the Sudbury Catholic District School Board (SCDSB). This power shifted depending on the relationships I held and the situations that arose. I acknowledge that I held more power in my relationships with students which required me to reflect upon how I held

this power and used this power in order to work anti-oppressively. Conversely, I held less power in my relationship with my agency supervisor and SCDSB staff.

I grew up in Northern Ontario in a middle class, Roman Catholic, nuclear family and I am the second eldest of four children. Throughout my elementary and secondary education, I attended Catholic schools. I do not hold strict religious views or beliefs and I do not agree with all that is taught in the religion I identify with; however, I do see positivity within God. I consider myself to be spiritual with an independent understanding of my relationship with God and the teachings and practices of the Church. Although religion and spirituality are always something I ask individuals about when I start working with them, it has never been part of my clinical practice unless specified by the individual. Working within the Catholic school system, I anticipated that there would be a heavy influence of religion on clinical social work practice. With this in mind, I had to identify myself not only in a school system, but within a religious system as well, and had to have an appreciation and understanding of where others held themselves within these systems to mitigate oppression and embrace religion and spirituality within my practice.

The education that I have been provided with has privileged me within a Western society. I was privileged within the Ontario education system as a result of being light-skinned, able-bodied, middle class, not having experienced childhood trauma, and having a stable home that provided me with a secure attachment and social-emotional learning. As such, I was advantaged because I fit into the dominant cultural norms of the education system. I was destined to succeed before I even stepped foot into a classroom. I have a Bachelor of Science degree in Psychology and an Advanced Diploma in Behavioural Science Technology. I have worked in mental health programs both in community and hospital settings and held positions providing behavioural

services in children mental health programs. I would identify the majority of my workplace environments as medical and behavioural model driven with my own natural pull towards anti-oppressive practices. In terms of my education and work history I need to let go of the medical and behavioural models' desires to focus on labels, disability, illness, and deficits and instead put more emphasis on breaking down labels and barriers, as well as recognizing and building upon strengths. I have to be mindful to loosen my grasp on the medical and behavioural models to challenge the oppression these models bring into practice.

Theories in Practice

I consider theory to be an integral part of clinical social work practice because theories can provide social workers with a guide for practice and information on human and societal function. It has been suggested that social workers should draw from various theories within their practice in order to provide each person with assistance that is representative of their individualized needs (Coady & Lehmann, 2016). In an Australian study done by Smith, Cleak, and Vreugdenhil (2015), 263 undergraduate social work students were surveyed to determine what elements of their practicum experience were most beneficial for their educational and professional development. According to this study, social work students identified that having the ability to blend theory within their field practicums during professional supervision was very beneficial to their learning process (Smith et al., 2015). The social work students whose practicums did not weave analysis of theory and clinical practice together felt that their learning was not advanced within this area (Smith et al., 2015). The main theories that guided my practice and intervention during my practicum experience and inform this paper are trauma theory and anti-oppressive practice theory.

Trauma theory. Trauma theory, or contemporary trauma theory (CTT) as some refer to it, is a way in which clinicians look at trauma and address it in treatment, by acknowledging the biopsychosocial impacts trauma has on an individual (Goodman, 2017). Trauma theory appreciates the roles social factors and patriarchy play in the mental health of women (Tseris, 2019). Within CTT there are five areas identified in which childhood trauma impacts an individual (Goodman, 2017). These areas are: dissociation, attachment, reenactment, influence in adulthood, and impact to emotional function (Goodman, 2017).

In order to help an individual survive a traumatic event the brain may initiate dissociation to prevent the consolidation of information from the traumatic event (Bloom, 2014a). Dissociation is a neurological process in which the sensory experiences of the traumatic event are disconnected from each other and thus the memory of the event may hide away in bodily sensations (van der Kolk, 2014). As such, survivors may not recognize that their experiences are related to a traumatic event (van der Kolk, 2014). In this way a survivor can experience flashbacks from memories packaged in intrusive visual, auditory, or physical format or experience hallucinations of the traumatic event (Bloom, 2014a). Hyperarousal is what is said to cause this dissociation (Bloom, 2011) which is triggered by the fight-flight-freeze response (Bloom, 2014a)(described in the “Childhood trauma and school” section above). Furthermore, during a state of hyperarousal cognitive functioning is weakened and thus the brain’s ability to assign words to the traumatic event as it is happening is restricted, resulting in the inability or difficulty for the survivor to be cognitively capable of talking about the event (Bloom, 2014a).

Exposure to trauma in childhood, as a result of abuse and neglect, often results in difficulties forming secure attachments with others (Godbout, Daspe, Runtz, Cyr, & Briere, 2019; Herman, 2015). Abuse often leaves the child feeling as though they cannot have true

connections with others (Herman, 2015). This feeling of isolation and difficulty in forming attachments following maltreatment can result from having to keep the abuse concealed and/or from their trust in others being ruptured as a result of the maltreatment they experienced (Herman, 2015). Feelings of mistrust can be exacerbated if others did not provide the child with protection or support after they experienced trauma (Herman, 2015). Instead of initiating connection with others out of enjoyment, relationships may be practically developed in order to blend in (Herman, 2015). Additionally, the perpetrator often uses their dominance to evoke social exclusion and control which also may be used to create divide between non-perpetrating family members and the child (Herman, 2015). Unfortunately, the child may feel resentment or the perpetrator may plant the idea of resentment towards non-perpetrating family members due to their lack of identification of the abuse or protection (Herman, 2015).

Reenactment is the phenomenon that occurs when an individual's repressed memory of trauma is duplicated "not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it" (Freud, 1914, p. 150). It is common for survivors of trauma to reenact the traumatic event(s) or experiences which they have been exposed to in the past (Bloom, 2010, 2014b; van der Kolk, 2005, 2014). Over the years there have been numerous rationales provided for why reenactment occurs. Some have argued that reenactment is the social communication tool available, in the presence of language suppression, that results from trauma; that it helps integrate the communication about the traumatic event across the two hemispheres of the brain; that it acts as a beacon that help is needed (Bloom, 2010); and/or that it does not provide any purpose for survivors (van der Kolk, 2014). Nonetheless, it is said that according to trauma theory, enactment within the relationship between the survivor and the clinician always surfaces in the process of trauma recovery (Miehls, 2011). Therefore, it is essential that the

clinician monitor what they have done prior to the enactment to determine what behaviours or responses elicited this response (Miehls, 2011).

The last two areas considered in CTT that Goodman (2017) identified, are the continued effect of childhood trauma into adulthood and the decline to a survivor's emotional capacity and functioning. These areas have been covered in more detail elsewhere in this paper (refer to subheading above titled "Overview and impacts of trauma" for more information). Thus, the breadth of this information is not restated here.

Overall, CTT considers the intricate biopsychosocial impacts trauma has on a survivor. However, an initial concern when talking about trauma is the fact that the term "trauma" does not have a universal definition (Tseris, 2019). Instead, it holds binary implications of either identifying as a specific event or describing the impact the event has had on an individual (Tseris, 2019). Additionally, trauma theory has been criticized for focusing on the deficits of survivors and fixed intervention methods, which highly reflect a psychiatric model (Tseris, 2019). The consensus of some is that trauma theory has migrated away from a feminist perspective and towards pathologizing survivors and establishing evidence-based treatments (Tseris, 2019).

With further analysis into CTT, some have criticized it for being a model that puts everyone into the same box (Quiros & Berger, 2015). Like many of our theories and models, the foundation and practices of CTT are based on, and were made to be effective for, the dominant White culture (Quiros & Berger, 2015). As a result of CTT being grounded in the dominant White culture, consideration is not given to the influence intersectionality of oppressions have on the experience of trauma and in determining more effective interventions for recovery for all (Quiros & Berger, 2015).

It is typical of colonizers to view Indigenous peoples as inferior and blame them for how they have been impacted by trauma, as a result of colonialism (Cote-Meek, 2014). For example, some individuals who work in Western mental health and social service fields identify Indigenous parents as the source that continues the cycle of intergenerational trauma (Maxwell, 2014). Further to this, "professionals" working from this erroneous understanding superficially acknowledge the historical trauma faced by Indigenous peoples and, instead of identifying the colonial structures that continue to reproduce the trauma that they face, the workers encase Indigenous peoples' experiences within Western practices and knowledge and pathologize them using Western diagnostics (Maxwell, 2014). The diagnostic practice of Western mental health pathologizes the trauma experienced by Indigenous peoples as mental illnesses, such as posttraumatic stress disorder (PTSD) (Maxwell, 2014). Labelling Indigenous peoples' experience of trauma places blame and identifies the need for intervention in the survivor instead of the Western societal structures that enact violence on Indigenous peoples (Cote-Meek, 2014), such as the Western mental health system. Conversely, within Indigenous communities, historical trauma is more of a focus than PTSD among mental health professionals as it is thought that historical trauma better represents the trauma and experiences that Indigenous people face as a result of colonialism (Gone, 2013). As a result of changing the perspective from PTSD to historical trauma, the treatment changes from medication and therapy to recovery that is based in traditional healing practices (Gone, 2013). Thus, with trauma theory being situated in Western knowledge and practices it acts as a mechanism to subject Indigenous children into the colonial structures of society (Clark, 2016).

Anti-oppressive theory. Anti-oppressive theory was used to create a foundation for my anti-oppressive practice (AOP) approach throughout the practicum experience and is used within

my reflection to challenge the systems, barriers (Baines, 2017), and oppression (Robbins, 2017) that exist within the school system for children who have been exposed to trauma. The driving force behind anti-oppressive theory and AOP is the feat for justice within society (Robbins, 2017). Grounded within this theory is the idea of oppression. As previously discussed, acts of abuse towards children are gendered (Thoresen et al., 2015), trauma is more prevalent among sexual minority children/adolescents compared to heterosexual children/adolescents (Clements-Nolle et al., 2018), Indigenous children in Canada experience higher levels of trauma (Haskell & Randall, 2009), children can be exposed to trauma by adults due to discrepancy in age (Westman, 2019), and/or childhood trauma is more prevalent in families who cannot afford to meet the family's basic needs (Lefebvre et al., 2017). These examples, support that there is a connection between oppression and trauma (Becker-Blease, 2017). When oppression is considered within theory, attention is given to "… power, privilege, domination, stratification, structural inequality, and discrimination" (Robbins, 2017, p. 376). With its foundation in this theory, the objectives of AOP are to identify the systems and practices that exist which establish, continue, or sanction oppression (Robbins, 2017), and to make micro- and macro-level changes in order to confront injustice on individual and societal levels (Baines, 2017).

Taking an anti-oppressive perspective in terms of trauma requires one to understand that little room has been made for marginalized individuals within societal systems—their voices lay primarily unheard and suppressed—and the structural components that lead to trauma are unacknowledged (Quiros & Berger, 2015). Likewise, the popular knowledge that has been created around trauma and trauma-informed practices (TIPs) has been based on research that neglects to include oppressed voices and systemic responsibility (Quiros & Berger, 2015). As a result, we get a community that, "… is horrified with trauma survivors; their symptoms; and the

burdens it places on the health care, child welfare, criminal justice, and educational systems—and insufficiently horrified by the systems of oppression that underlie so much trauma, violence, and abuse" (Becker-Blease, 2017, p. 134).

With my practicum experience being situated in a school setting, anti-oppressive theory and AOP are well suited for the questions that were set out to be answered within this paper because it has been suggested that oppression and further traumatization can exist and occur even within the systems that intend to support children (Berkowitz, 2012). For example, living in foster care within the child welfare system increases the probability that a child will be exposed to maltreatment and neglect (Yang & Ortega, 2016). When the numbers are analyzed to consider the proportion of the Canadian population that is made up of minority groups versus the amount of minority children in our child welfare system, we find that racial minority children are present in greater numbers within the child welfare system than non-racialized children (Ontario Human Rights Commission, 2017). One concern with this is that the system gives no regard to the social factors, such as poverty, that are often the cause for more minority families being connected with the child welfare system (Ontario Human Rights Commission, 2017). Moreover, systems can intensify the lack of control a child feels following trauma if they assert their dominance in an uneducated way, or contrarily, systems can fill a role in which they are seen as supportive (Berkowitz, 2012). Thus, in order to better support children who have experienced trauma we can use anti-oppressive theory to examine societal systems, including the education system, that may be unintentionally retraumatizing children through oppressive practices.

Critics of anti-oppressive theory feel that it is not specific enough to attend to the different foci of the postmodern theories (Robbins, 2017). Therefore, it was adapted to include different theories within it to be able to attend better to the various oppressions that exist (Robbins, 2017).

As such, some refer to it as oppression theory (Robbins, 2017). One critique of AOP is the lack of specificity in the target population and intent (Lynn, 1999). For example, the umbrella term could encompass the pursuit for abolishing oppression for one group of people, for all minorities, or the power inequality among people (Sakamoto, 2005). Having such a broad overarching term can make it confusing for clinicians to identify whether their work is considered to be AOP (Sakamoto, 2005). Also, due to the diversity within the term, it is limited in its ability to form a collective body of research (Sakamoto, 2005). It has been suggested that within the clinical practice field, AOP could be met with resistance and a sense of offensiveness, as practicing clinical social workers may become defensive if it is suggested that they adopt AOP (Sakamoto, 2005). This could imply that they were not previously practicing in a way that was eliminating oppression for individuals (Sakamoto, 2005).

The integration of trauma theory and anti-oppressive theory guided my clinical practice approach and gave me a lens through which to be inquisitive about the trauma-informed practices (TIPs) and the oppressions that exist within the education system for child survivors of trauma. Additionally, these theories assisted me in intervening on a system-level by providing professional development lunch-and-learns to teaching staff on trauma-informed information and school-based practices. These theories continue to inform the discussions within this paper as I reflect upon the guiding questions and the trauma-informed professional development lunch-and-learns I provided to teachers. Utilizing these two theories allowed for reflection on the education system in effort to assist in building upon its strengths and progressing its trauma-informed knowledge and practices, with the ultimate goal of better supporting child survivors of trauma in school.

Rationale for Practicum Project

According to data collected from the 2016-2017 school year, the suspension rate in Ontario was approximately 2.7% (Ontario Ministry of Education, 2018b). Students who are receiving support from their school's special education programs or services make up approximately 47% of the students who were suspended during the 2016-2017 school year (Ontario Ministry of Education, 2018a), which includes students accessing school-based mental health services (Ontario Ministry of Education, 2016). Reports from teaching staff do not support that suspension is effective in managing student behaviour (Howard, 2018). This is congruent with the findings that suspension is associated with having a higher probability of engaging in future antisocial behaviour (Hemphill, Broderick, & Heerde, 2017; Hemphill, Toumbourou, Herrenkohl, McMorris, & Catalano, 2006) and violence (Hemphill et al., 2017). Trying to assist students who have experienced trauma through the use of behavioural methods such as suspension is not apt to work in supporting the needs of the child (Howard, 2018).

In a report covering some of the findings collected from the principals and vice principals in Ontario from the 2018 Annual Ontario Schools Survey, it was found that they have identified mental health to be a growing and profuse concern in their schools (People for Education, 2018). Consequently, they report that much of their time is devoted to attending to behavioural concerns (People for Education, 2018). Conversely, when students are connected to their schools through prosocial opportunities they are less likely to engage in antisocial behaviour (Hemphill et al., 2006) and more likely to graduate (Lemkin, Kistin, Cabral, Aschengrau, & Bair-Merritt, 2018).

The literature on the implementation and utilization of trauma-informed practices (TIPs) in a school setting is limited (Cavanaugh, 2016; Moon, 2017). This is surprising due to the literature supporting the effectiveness of TIPs (Bartlett et al., 2016) and identifying that

childhood trauma is a prevalent concern (Afifi et al., 2014; Benjet et al., 2016; Findlay & Sutherland, 2014) which can create a number of challenges in a survivor's life both inside and outside of school (Bloom, 2014a; Greeson et al., 2014; Herman, 2015; Music, 2014; Putnam, 2006; Record-Lemon & Buchanan, 2017; Tanaka et al., 2015; Teicher et al., 2017; Vasilevski & Tucker, 2016), with the effects carrying on into adulthood (Afifi et al., 2014; Herman, 2015; Putnam, 2006). The importance of more clinical and academic research being allotted to this area, as well as the necessity for TIPs to be implemented into school-based settings and school-based social work practice is justified by the fact that mental health programs within the education system are the primary providers for youth mental health care (Farmer, Burns, Phillips, Angold, & Costello, 2003) and trauma treatment (Chafouleas, Koriakin, Roundfield, & Overstreet, 2019; Dorsey et al., 2017). However, school social workers, mental health staff, and non-mental health staff often have minimal trauma or TIPs training (Ko et al., 2008). Yet, teaching staff have indicated that if they were provided with trauma training then they would be more inclined to endorse supporting the needs of child survivors in their classrooms (Howard, 2018).

Adult survivors of childhood trauma have differing opinions about the support that they were provided with during their education. Some literature recognizes supportive professionals, such as a teacher, as the difference maker in students' lives, from which recovery can begin (van der Kolk, 2014). Others report poor experiences during childhood with school-based mental health staff or teachers when they attempted to gain support regarding the trauma they had experienced (Morrow, Clayman, & McDonagh, 2012). In some cases, survivors reported feeling that school-based staff downplayed their disclosures, did not do anything about it, did not know what to do about it, and shared their private information with other staff (Morrow et al., 2012).

As a result some survivors felt that disclosing about trauma to school staff made things more challenging and caused more stress for them (Morrow et al., 2012).

Educating teachers on childhood trauma and developing their knowledge and skills using TIPs will promote a safe and nurturing school setting that can better support the mental health and education of students (Cole et al., 2009), and can likely assist students in recovering from trauma (Howard, 2018). The literature in the field underpins the importance of professional development for teachers on trauma-informed knowledge and practices so that they may increasingly support students who have experienced trauma (Howard, 2018; Perry & Daniels, 2016; West, Day, Somers, & Baroni, 2014). In order to be able to effectively support child survivors of trauma the system itself has to be trauma-informed (Beidas et al., 2016). Depathologizing how we view trauma, through recognizing the influence social structures and oppression have on the experience of trauma, and understanding how individuals can be impacted by trauma, can promote a safe environment for survivors to disclose their exposure to trauma (Quiros & Berger, 2015). School-based social workers could assist in increasing the awareness about the impact of childhood trauma among teaching staff through trauma-informed professional development lunch-and-learns in effort to better support students and decrease the pathologization of behaviours that occurs in schools for children who are survivors of trauma.

Overview of Practicum Site

In order to answer the *questions from the onset* listed above, a 450-hour practicum was completed with the Sudbury Catholic District School Board (SCDSB) in the Learning Support Services department with the Mental Health Team. I worked within the elementary schools, exclusively. The SCDSB's office is located in Sudbury, Ontario and it provides publicly funded Catholic-based education to children and adolescents from Kindergarten to Grade 12. There are

13 elementary schools governed by the SCDSB spanning the Greater City of Sudbury, Markstay, and Killarney (SCDSB, 2019a). Within the SCDSB's 13 elementary schools there are 4,021 students (SCDSB, 2019d). The mission, vision, and values of the SCDSB include striving to identify and cultivate the strengths of students with focus on their "mind, body, and spirit" (SCDSB, 2019b); with excellence in education and spirituality; and exemplifying God through the care for others and education (SCDSB, 2019b).

Mental health programming in the education system has three realms of care: promotion, prevention, and intervention (SCDSB, n.d.). In line with the SCDSB's mental health strategy, schools concentrate on mental health promotion and prevention strategies (SCDSB, n.d.). This strategy was created with the goal of having mental health wellness enmeshed into the school environment and system (SCDSB, n.d.). Information on the demographics of the student population was not available. Therefore, the diversity of the student body is unknown.

In terms of school registration, students within the SCDSB elementary schools typically require a baptism certificate or for one of their guardians to have been baptized (SCDSB, 2012, 2019c). Students who do not meet this criterium can apply for enrollment and the school principal will determine acceptance, taking into account, "the reasons given by the parent(s)/guardian(s) for their request to register the child(ren) in a Catholic school" among other factors (SCDSB, 2012, p. 8). However, enrollment into SCDSB secondary schools is open to everyone, therefore it is not required that a high school student or their guardian(s) be baptized (SCDSB, 2019c).

The provincial average of suspension and expulsion rates across Ontario for the 2016-2017 school year were 2.67% and 0.02%, respectively (Ontario Ministry of Education, 2018a). On a municipal level, the suspension and expulsion rates for the 2016-2017 school year for the

Sudbury Rainbow District School Board (SRDSB) were 3.29% (Ontario Ministry of Education, 2018b) and 0.04% (Ontario Ministry of Education, n.d.) respectively, whereas the SCDSB rates were 1.05% (Ontario Ministry of Education, 2018b) and 0.01% (Ontario Ministry of Education, n.d.), respectively. Suspension and expulsion are more common among children who have experienced trauma (Mallett, 2017). This could be a result of child survivors of trauma demonstrating externalized behaviours such as aggression, rule violation, and inattention at school (Greeson et al., 2014). However, discipline practices that exclude children from school do not support the child in their learning and can further the difficulty that the child experiences (Nash et al., 2016) as a result of trauma.

Ethical Considerations

Because I completed an advanced practicum rather than a research thesis, Research Ethics Board approval from the Laurentian University Ethics Board was not necessary. In the time leading up to the practicum, during the completion of the practicum hours, and in writing the current practicum project report, ethical professional conduct was upheld in adherence to the Ontario College of Social Workers and Social Service Workers (OCSWSSW) Code of Ethics and Standards of Practice Handbook (OCSWSSW, 2018). According to the OCSWSSW (2018), "college members promote social justice and advocate for social change on behalf of their clients" (p. 13). As such, in the time leading up to my practicum I worked to develop a focus for a practicum topic that was purposeful in assisting others and included a component of social justice. With this intention, my practicum focused on supporting child survivors of trauma in a school setting by advocating for mezzo level change by providing trauma-informed professional development to teaching staff in effort to increase the trauma-informed support that child survivors receive at school. Additionally, I upheld the OCSWSSW standard of practice on record

keeping during my practicum by completing notes to document my contact with students or consultation with others in regards to students who were being provided with school-based social work support (OCSWSSW, 2018). To be in compliance with the OCSWSWW standards, the notes I wrote were identified with a date and were completed on the same day of the contact, as it is indicated that documentation should promptly be completed (OCSWSSW, 2018).

Overview of Paper

The current Advanced Practicum Project Report divides into the following four chapters: (1) Introduction, (2) Literature Review, (3) Reflection, and (4) Conclusion. As this section brings the introductory chapter to a close, I next review the literature in the field that is relevant to the present exploration. The literature review details the primary models that support child survivors of trauma in schools, which include the trauma model with trauma-informed practices (TIPs) and the multi-tiered system of support framework. Additionally, the literature review provides an overview of the behavioural model as the primary model that is used in schools that functions to further harm students who are survivors of trauma. The literature review also unpacks the pathologization of behaviour from students who have been exposed to trauma using trauma theory. Lastly, the literature review chapter provides an overview of trauma-informed professional development for teaching staff. The purpose of the reflection chapter is to integrate my clinical practicum experience and literature in the field in pursuit of responding to the inquiries that commenced this process. This includes discussing: the trauma model including TIPS and the multi-tiered system of support framework as the primary models that were used by the Sudbury Catholic District School Board (SCDSB) to support students who have been exposed to trauma, the behavioural model as the primary model that functions to further harm child survivors of trauma including how school-based social workers reflect the behavioural

model, how trauma theory can be used to challenge the pathologization of behaviours in a school setting for students who have been exposed to trauma, the intervention of trauma-informed professional development for teachers, and my position on supporting child survivors of trauma in a school setting. The final chapter concludes the practicum report by discussing the implications for schools and school-based social work practice, and offering a summary of the current paper before providing the final thoughts.

Chapter 2: Literature Review

The importance of being trauma-informed, especially when working with students in a school setting, cannot be understated. Assuming the numbers of adult Canadians who reported having experienced trauma in childhood are accurate and are representative of the current population of children in Canada, then approximately 32%-36% (Afifi et al., 2014; Findlay & Sutherland, 2014) of Canadian children have been exposed to trauma. Given that 1,392,269 students were attending elementary schools in Ontario during the 2017-2018 school year (Ontario Ministry of Education, 2019), it is suggestive that approximately 445,526 to 501,216 elementary students have been exposed to trauma. Likewise, with the Sudbury Catholic District School Board (SCDSB) having 4,021 elementary students enrolled during the 2017-2018 academic year (SCDSB, 2019d), it can be deduced that roughly 1,286 to 1,447 of their students had been exposed to trauma. Despite these high numbers, there is hope for the recovery from trauma and it is important that action is taken in supporting survivors in a trauma-informed way. As van der Kolk (2014) said, "… we have the knowledge necessary to respond [to trauma] effectively. The choice is ours to act on what we know" (p. 358).

Schools can nurture children's authentic genuine identity and self-governance, build relationships, develop emotion and behavioural self-regulation skills, and provide education, all of which can make a difference in the lives of children who have experienced trauma (van der Kolk, 2014). For these reasons the literature has suggested that classrooms can be a therapeutic setting that supports children in healing from trauma (Brunzell et al., 2015; van der Kolk, 2014). As I suggested in the previous chapter, it is likely that many children experience trauma without the school being aware. Therefore, it is my opinion that in order to support all children who are survivors of trauma at school, not just those who have been identified and connected to school-

based social work support, an integral role for school-based social workers is to focus on creating a system-wide trauma-informed school setting. Much of the literature within this chapter explores trauma-informed educational practices that can support all children within classrooms and schools and therefore the information presented is not solely based in school-based social work practice. However, I suggest that school-based social workers have a role in creating such systemic change in the school system which includes supporting school staff from other disciplines in increasing their capacity to support child survivors of trauma. Therefore, although I explore educational practices that are typically viewed as being outside of school-based social work practice, I identify the role and influence school-based social workers have in such practices and creating systemic change in the Ontario education system.

This literature review provides an overview of how the trauma model, trauma-informed practices (TIPs), and the multi-tiered system of support framework are used as the primary models for supporting students in school who are survivors of trauma. The behavioural model is discussed as a primary model that functions to further harm child survivors of trauma within schools. Additionally, I explore how trauma theory has been used to challenge the pathologizing of behaviour in schools for children who have experienced trauma. Lastly, an overview of trauma-informed professional development for teaching staff is explored. All of the literature outlined within this chapter aids in my critical reflection of the experiences I had, as a school-based social work student, with the SCDSB in an attempt to answer the guiding questions of this paper.

Models that Support Child Survivors of Trauma at School

Whether trauma-informed models are used within schools has a lot to do with the leadership of the system and their endorsement of trauma-based models (Wiest-Stevenson &

Lee, 2016). Their guidance and support of such a model is what establishes the means of implementation, such as the protocols and staff roles and responsibilities (Wiest-Stevenson & Lee, 2016). However, executing a trauma model within schools requires the collaboration and engagement of leadership and school staff (Wiest-Stevenson & Lee, 2016), including teachers and school-based social workers. Another consideration is that mental health programming in schools are governed by the promotion, prevention, intervention framework (SCDSB, n.d.), therefore the model that is established for supporting children in school who have experienced trauma also needs to fit within the multi-tiered system of support framework.

Trauma model and TIPs in schools. Examining the literature on the trauma model and the use of school trauma-informed practices (TIPs) is integral to the application of school-based social work practice and the development of the trauma-informed lunch-and-learn presentation as means of professional development for teaching staff. Schools that use a trauma model integrate TIPs within the system (Cole et al., 2009; Morgan et al., 2015). Schools can be an effective environment for implementing TIPs (Record-Lemon & Buchanan, 2017), as attachment can be provided by any adult who works with children, including school-based social workers and non-clinical professionals, such as teachers and school staff (Bath, 2015; Rolfsnes & Idsoe, 2011). Creating partnerships between the different stakeholders is encouraged amongst the literature of school-based TIPs (Record-Lemon & Buchanan, 2017). School-based social workers and teachers should be aware that many students are routinely exposed to trauma in their daily lives and thus services must reflect and provide appropriate support to meet their needs (McCrea, Guthrie, & Bulanda, 2016). The trauma model is discussed through a collection of TIPs that are descriptive of the use of the trauma model in schools, and which include: building safety relationships, trauma-informed teaching, addressing student behaviour in a trauma-informed

way, trauma-informed programs for a school-based setting, and trauma-informed school-based social work.

Building safety relationships. Much of the research in the field of trauma identifies that the first phase of trauma treatment is to establish safety (Bath, 2015; Carello & Butler, 2015; Herman, 2015). Creating a foundation of physical, mental, and emotional safety leads to healing, as fear and safety are mutually exclusive to one another (van der Kolk, 2014). It is well agreed upon that establishing healthy relationships with others is what allows for healing from trauma to happen (Bath, 2015; Herman, 2015; van der Kolk, 2014). Herman (2015) expressed the importance of this so simply and with such power when she said, "recovery [from trauma] can take place only within the context of relationships; it cannot occur in isolation" (p. 133). Moreover, Herman (2015) suggests that cultivating self-determination, the autonomy within the survivor, and control over their recovery gives rise to a clinical therapeutic relationship (Herman, 2015).

Conversely, van der Kolk (2014) proposes that developing awareness within the individual of the connection between their body, their brain, and the trauma is the initial phase to healing. The rationale for this position is that whether or not the individual is able to recall the traumatic event, the brain and body cannot heal from trauma until it has been processed (van der Kolk, 2014). Therefore, triggers will continue to provoke survival responses until this connection is consciously acknowledged, emotions are labelled, and self-regulation is learned (van der Kolk, 2014).

Herman (2015) identified fostering safety and empowerment as the first step to trauma treatment whereas van der Kolk (2014) identified establishing self-awareness as the first step to recovery. However, I argue that one likely cannot exist without the other when establishing a

trauma-informed relationship. I suggest that empowerment (Herman, 2015) and consciousness raising (van der Kolk, 2014) are both entailed in building safety within relationships. This is supported by the literature identifying that when building a safe rapport one must consider physical, emotional, social, and cultural components (Bath, 2015). I argue that part of building emotional and social safety is establishing the survivor's voice in the relationship (van der Kolk, 2014), renouncing the "professional" dominance and control within the relationship, and offering that authority back to the individual, which leads to empowerment (Bath, 2015). Furthermore, consciousness raising and developing self-regulatory skills instill safety (van der Kolk, 2014), to which I further develop this point by proposing that these elements build emotional and physical safety.

Certainly, a therapeutic relationship between a school-based social worker and a student should involve creating safety, facilitating empowerment, and raising consciousness. However, in order to create the systemic change that is needed to establish and progress a trauma-informed culture within the education system it is arguably more valuable for the student-teacher relationship to exude safety and empowerment. In effort to support students who have experienced trauma, schools can create safety (Bath, 2015), facilitate empowerment, and nurture self-regulatory awareness and skills (Brunzell, Stokes, & Waters, 2016) in their relationships with students by adopting trauma-informed teaching practices (Crosby et al., 2018). Despite the effort that may be put into breaking down the hierarchies of power and status that exists between teacher-student and adult-child, these power inequities can never be eliminated. Therefore, making a conscious effort to minimize these imbalances through trauma-informed teaching practices, such as providing choice and not engaging in power struggles, is one way in which the power imbalance can be mitigated for child survivors in a school setting (Wolpow et al., 2009).

Trauma-informed teaching. Teachers may find it difficult to determine what position they play, and how they can assist students who have experienced trauma (Crosby et al., 2016). Trauma-informed teaching means that teaching staff appreciate the impact trauma has on students and incorporate TIPs and trauma knowledge into the classroom (Crosby et al., 2018). Realizing that learning cannot happen when a student is experiencing hyper- or hypoarousal (van der Kolk, 2014) until safety is assured (Carello & Butler, 2015), trauma-informed teaching integrates curriculum teaching, emotional learning, and relationship building elements (Crosby et al., 2018). It calls for the teacher to be knowledgeable on the impact of punitive versus supportive consequences on students who have experienced trauma, and how to incorporate TIPs into their teaching methods (Crosby et al., 2018).

The literature identifies the need for advancing school-based social work practice to be more involved in academic matters (Gherardi & Whittlesey-Jerome, 2018). Since social elements are intertwined with education, having school-based social workers cross the boundaries that have historically secluded them to working with students independently or in administrative roles is justified (Gherardi & Whittlesey-Jerome, 2018). As such, social work needs to permeate academics (Gherardi & Whittlesey-Jerome, 2018). To do so, clinical workers, such as school-based social workers, can educate school staff, including teachers, on trauma-informed practices (TIPs) (Perry & Daniels, 2016). This education can be provided to teaching staff by school-based social workers through professional development sessions (Costa, 2017) which is discussed later in this chapter.

It is important that school staff are aware that student survivors may be met with factors within the school environment that can prompt emotional responses as a result of trauma (Carello & Butler, 2015). The setting into which students are inserted and expected to adapt is at the root

of the issue in schools for students who have experienced trauma (Carello & Butler, 2015). Triggers could be presented in any form of sensory stimulation, whether it be sight, touch, taste, sound, or smell (Sutton, Wilson, Van Kessel, & Vanderpyl, 2013). Thus, trauma-informed teaching does not ask the student to fit into the teacher's box, but instead embraces the idea that the classroom environment should adapt to the student's needs and include the student's voice in determining what may be helpful for them (Carello & Butler, 2015). Considering the classroom environment can enhance positive emotions and signal learning (Brunzell et al., 2015), environmental strategies such as utilizing music or sounds; having organized, motivating, and tranquil classroom décor; keeping low or natural lighting; and creating inclusive seating arrangements that also allow for independent work can help to establish positive emotions within the classroom and promote a good learning environment (Brunzell et al., 2015).

Additionally, teachers can help students in their classrooms who have experienced trauma through building a supportive connection, helping in times of transition, teaching affect-regulation, and enhancing learning aids (Wright & Ryan, 2014). When a teacher views a student's behaviour as a mechanism of survival, invests time into getting to know the student personally, and provides consistent affectionate connection, a supportive relationship can be established (Wright & Ryan, 2014). Strategies such as using and following a visual classroom agenda, preparing students for the arrival of guests, and teaching students how to forecast within their day can help students who have experienced trauma through transitional periods (Wright & Ryan, 2014), which can be challenging times for survivors (Crosby et al., 2018).

Teachers can implement strategies within their classrooms to teach students how to self-regulate their emotions (Wright & Ryan, 2014). They can support the establishment and growth of emotional self-regulation skills by labelling, legitimizing, and talking about a student's

emotions to encourage the child's ability do so in the future; use literature in the classroom that pertains to emotions; encourage de-escalation by providing students with time and a place where they feel comfortable to relax; and/or by connecting them with mental health, education, or family assistance as needed (Wright & Ryan, 2014). Promotion of regulation can be done by integrating emotional learning content into classroom discussions and teaching (Brunzell et al., 2016). This can include educating students on stress and exploring how the students are impacted by stress, along with teaching about how to assess their own readiness to learn and what coping tools can aid in their regulation (Brunzell et al., 2016).

Some teachers have suggested that it is important to teach students who have experienced trauma to utilize rhythmic strategies (Brunzell et al., 2016, 2015) in order to promote regulation for learning, assess and decrease hyperarousal, and increase self-regulation of their heart rate (Brunzell et al., 2016). Such activities can include singing or playing drums (Brunzell et al., 2015). Teachers can schedule rhythmic activities, or "brain breaks", intermittently throughout the day, or as deemed necessary (Brunzell et al., 2016, 2015). Brain brakes are short-duration activities consisting of physical and mindful components (Brunzell et al., 2016, 2015). Mindfulness, can also be utilized as an independent tool to teach students to attend to their surroundings, practice breathing, and ground themselves (Brunzell et al., 2016). As a way to assess a student's hyperarousal and promote self-regulation through activity, some teachers find it helpful to allow their students to engage in physical movement before discussing any behavioural concerns with them when they are experiencing hyperarousal (Brunzell et al., 2016). The activity level that the student is engaged in can signal their arousal state and the activity can also function to promote regulation (Brunzell et al., 2016).

Additionally, teachers can assist in promoting self-regulation by teaching students about their heart rate and how they can intervene on their heart rate to assist themselves in calming down (Brunzell et al., 2016). It was suggested that teachers could integrate heart rate education into various subjects such as health, science, and math to cover different aspects of knowledge in order to increase students' awareness and ability to regulate their heart rate during periods of heightened arousal (Brunzell et al., 2016). One way of promoting de-escalation is to collaborate with the student to develop a safety plan (Brunzell et al., 2016). The safety plan details the periods during the day where the student typically feels they have heightened arousal, the known catalysts for their arousal, a plan for how the student will communicate to the teacher that they are experiencing this state, a plan for how the teacher can support the student in calming down, and a list of preferred coping skills (Brunzell et al., 2016).

Consequently, having a positive learning environment can aid students in emotion and behavioural regulation (Brunzell et al., 2015). The classroom climate can be enhanced to encourage learning by implementing teaching strategies and establishing consistent guidelines, expectations, and outcomes (Wright & Ryan, 2014). When learning, students who have experienced trauma may benefit from instructions that are broken down into components, visual aids, practice time, and learning how to use indicators in their surroundings to forecast outcomes (Wright & Ryan, 2014). Additionally, when presenting material to students, survivors may benefit from teachers utilizing multiple modalities during classroom lessons, the use of factual examples to illustrate the case, and being provided with assistance and inspiration (Wright & Ryan, 2014). Likewise, the classroom climate can be enhanced through maintaining consistency in expectations and outcomes (Wright & Ryan, 2014). This can be achieved by teachers reviewing the guidelines, expectations, and outcomes for the classroom and establishing the

rationale for such policies with students (Wright & Ryan, 2014). Teachers can also build an environment that incubates learning within the classroom by minimizing power dynamics, promoting peaceful interactions, and educating students on maintaining one's safety and effective problem solving strategies (Wright & Ryan, 2014).

Overall, the goal of trauma-informed teaching is to be able to support all students in achieving academic success (Brunzell et al., 2015). However, part of being able to provide a genuinely trauma-informed classroom is for teachers to be mindful of their own emotions, the impact the classroom has on them, and their own ability to self-regulate (Brunzell et al., 2015). In a study done by Perry and Daniels (2016) in the United States, trauma-informed practices were piloted in a school setting. Teachers reported that they had difficulty in changing their practice approach to be trauma-informed and juggling the responsibility of attending to students' trauma needs and academic matters (Perry & Daniels, 2016). Supporting teachers in their transition to trauma-informed teaching practices and continuing to act as a support for teachers in their ongoing trauma-informed teaching practice is likely one role school-based social workers can fill. Clinicians, such as school-based social workers, can be a support to teaching staff in implementing trauma-informed teaching practices by providing consultation and empathetically listening to their worries and challenges (Perry & Daniels, 2016).

Addressing student behaviour in a trauma-informed way. It is understandable and likely that child survivors of trauma may engage in behaviours at school that are seen as inappropriate and difficult to manage (Howard, 2018). The literature in the field points away from traditional behavioural intervention approaches for children who have experienced trauma, as they may not have the same impact (Crosby et al., 2018; Howard, 2018). In times of conflict within the

classroom, teachers can model for the child how to settle such situations (Carello & Butler, 2015).

In a unique effort to address challenging behaviours at school in a trauma-informed way and decrease the amount of punitive discipline, including suspensions, the use of the Monarch Room was piloted in a specialized school in the United States for female adolescents who had experienced trauma, had pending legal matters, and were living in housing that was dedicated to treatment (Baroni, Day, Somers, Crosby, & Pennefather, 2016). This room allowed students, teachers, or support staff to identify a need for the student to take a break from class to help them self-regulate (Baroni et al., 2016). Trauma-informed staff, which can include school-based social workers, assist students in the Monarch Room to self-regulate before going back to class (Baroni et al., 2016). The utilization of this room is meant to be seen as something positive (Baroni et al., 2016). The Monarch Room is equipped with items that allow students to relax themselves through the use of their senses and engagement in physical activity (Baroni et al., 2016). Further to this, trauma-informed staff, such as school-based social workers, provide supportive counselling and help with conflict resolution while in the Monarch Room (Baroni et al., 2016).

School-based social workers can assist schools in developing and amending policies around student discipline (Elswick et al., 2018) in effort to support school-wide practices that address student behaviour in a trauma-informed way. In addition to collaborating in policy and procedure development and amendment, it is also part of the role of school-based social workers to be actively engaged in examining policies and procedures to determine where they can be improved and advocate for such changes (Elswick et al., 2018). This could include improving trauma-informed ways of supporting student behaviour like establishing spaces such as the Monarch Room.

Trauma-informed programs for a school-based setting. There are various different evidence-based programs that schools can adopt that are trauma-informed (Black, Woodworth, Tremblay, & Carpenter, 2012; Dorado, Martinez, McArthur, & Leibovitz, 2016). Many of these are based in cognitive behavioural therapy (CBT) (Black et al., 2012; Chafouleas et al., 2019; Dorado et al., 2016; Rolfsnes & Idsoe, 2011). However, I have chosen not to look at programs solely based in CBT for a couple of different reasons, one being that some of these programs have identified that they were established to intervene on symptomatology that is experienced as a result of posttraumatic stress disorder (PTSD), depression, and anxiety (Jaycox, Langley, & Hoover, 2018; Reinbergs & Fefer, 2018). This suggests that they are based within a perspective of pathology, which is what my practicum and paper is trying to diverge from with the help of trauma theory and anti-oppressive theory. Moreover, these programs incorporate behavioural strategies into their content and endorse the use of behavioural strategies for group management (Chafouleas et al., 2019; Jaycox et al., 2018; Langley & Jaycox, 2015). As trauma theory endorses the development of safety relationships (Bath, 2015; Carello & Butler, 2015; Herman, 2015; van der Kolk, 2014) and an effort to decrease power imbalances (Carello & Butler, 2015; Herman, 2015; Wolpow et al., 2009), and anti-oppressive theory challenges oppressive structures and power inequity (Robbins, 2017) the use of programs that are heavily based in CBT principles and rely on behavioural management strategies would not be well aligned. Therefore, Healthy Environments and Response to Trauma in Schools (HEARTS) (Dorado et al., 2016) and REWIRE which stands for regulate, educate, wellbeing framework, informed, relational, and engagement (Costa, 2017) are two trauma-informed school programs that are not solely based in CBT that are discussed in this paper.

The HEARTS program was piloted in four schools in the United States over the course of 1.5-5 years (Dorado et al., 2016). The program intervened within the multi-tiered system of support framework by providing promotion, prevention, and intervention components (Dorado et al., 2016). On the promotional level, education on trauma, stress, and evidence-based trauma-informed programs was provided to staff, guardians, students, and/or leadership depending on the suitability and the needs of the groups (Dorado et al., 2016). The prevention efforts used by this program provided skill-building for students based on their needs, addressed burn out with staff and guardians through case-consult meetings, and examined school policies related to discipline practices in effort to increase supportive practices (Dorado et al., 2016). The intervention level provided students with trauma-informed therapy, assisted staff through student-related crisis, and examined school-based mental health services for areas of growth (Dorado et al., 2016).

This program was found to be helpful in increasing teachers' knowledge on childhood trauma, TIPs, and vicarious trauma and burnout (Dorado et al., 2016). Students showed improvements in learning; engagement during class; and had fewer incidences of aggression, office visits, and suspensions (Dorado et al., 2016). Consequently, school-based clinicians, such as school-based social workers, reported that students experienced less frequent incidents of distress as a result of trauma after receiving trauma-informed intervention (Dorado et al., 2016).

REWIRE is a school-based model that was developed by Costa (2017) and can be implemented by a school-based mental health worker, such as school-based social worker. As previously stated, REWIRE stands for regulate, educate, wellbeing framework, informed, relational, and engagement (Costa, 2017). Each of these elements represents a dimension or stage of the program, and in this section I outline these. Using this model, schools appreciate that it is

part of their role to be informed about what regulation is and how they can help students regulate their states of arousal (Costa, 2017). Additionally, trauma-informed professional development education is made available to school staff throughout the year which is organized and/or provided by a group of school staff members (Costa, 2017), which could include school-based social workers. The wellbeing framework is the part of the model that is focused on providing individualized learning support to students who have experienced trauma (Costa, 2017). Further, the model expects that staff are informed about the strengths, challenges, triggers, and preferred supportive measures for the students they work with who are survivors of trauma (Costa, 2017). The relational section of this model emphasizes the responsibility of staff in learning how they can build a positive and safe relationship with their students (Costa, 2017). Lastly, the engagement stage assists staff members, students, and/or family members with connecting to supports, as needed, which is typically done by school-based mental health staff (Costa, 2017), such as school-based social workers.

Trauma-informed school-based social work. School-based social workers must recognize the system in which they function in is based on a promotion, prevention, and intervention model and in order to service students who have experienced trauma they need to develop a responsive practice (Frydman & Mayor, 2017). In this sense, one aspect of a responsive practice requires school-based social workers to be proactive in their efforts to instill trauma knowledge in their schools (Frydman & Mayor, 2017), which can include supporting the trauma-informed practices (TIPs) discussed above, including the establishment of safety relationships, trauma-informed teaching practices, addressing student behaviour in a trauma-informed way, and implementing a school-wide trauma-informed program, such as HEARTS or REWIRE. The goal of proactive efforts is to support child survivors at school prior to there being conflict (Frydman & Mayor,

2017). Trauma awareness within schools leads to a system that is comfortable functioning within this perspective (Frydman & Mayor, 2017). Therefore, school-based social workers can work on a school-wide level in effort to enhance the trauma-informed culture and practices to better support students who are survivors of trauma (Costa, 2017).

In regards to clinical school-based social work, most of the students who obtain support from school-based social workers have experienced trauma (Kelly et al., 2015), and thus it is important that school-based social workers are practicing in a trauma-informed way. In general terms, adopting a trauma-informed social work practice entails that the practitioner allows trauma-knowledge to be at the forefront of all their interactions with students (Levenson, 2017). By doing this, positive qualities saturate their working relationship with the child survivor and respect, empowerment, understanding, self-regulation, and connection is nurtured (Levenson, 2017). It is also important for trauma-informed social workers to relate to the individual they are working with on a humane level through the use of empathy and emotional validation, which also helps build connection and a feeling that there is nothing "wrong" with the individual (Knight, 2015). In this same way, trauma-informed social workers focus on considering the influence of oppression in trauma and challenge the pathologizing of behaviour in relation to trauma symptoms (Levenson, 2017).

From my review of the literature it appears that communication is an essential part of trauma-informed school-based social work practice. As such, school-based social workers, who work in a trauma-informed way, play an important role in supporting students who have experienced trauma through building connections and maintaining communication with individuals internal and external to the school system (Crosby, 2015). This includes conversing with students, guardians, teachers, support staff, and leadership (Crosby, 2015). In addition to

this, for school-based social workers to help change the culture of the school to one that is more consistent with the trauma model and TIPs, it is imperative that they have a positive working relationship with the school leadership. Having the support of school administration allows for the trauma model and TIPs to saturate the school's culture and system (Walkley & Cox, 2013; Wiest-Stevenson & Lee, 2016). On top of their collaborative efforts, another important realm of communication for school-based social workers is to disseminate psychoeducation on trauma and TIPs to school staff (Crosby, 2015; Walkley & Cox, 2013).

In my opinion, the research in the field of the trauma model and the application of trauma-informed practices (TIPs) in schools is in its infancy. School-based social workers can play an integral part in establishing a foundation of clinical research that could assist in promoting the trauma model and TIPs on a policy level that could effect changes within the education system provincially, nationally, and internationally (Crosby, 2015). Neglecting to put the trauma model and TIPs at the forefront of mental health services and systemic culture has been suggested to have the potential to do more harm than good for survivors (Quiros & Berger, 2015). Individuals are at risk of their needs not being met or of reexperiencing past trauma if clinical practice inconsistently implements trauma knowledge and practices (Quiros & Berger, 2015).

Multi-tiered system of support. School-based mental health support and programming operates within the multi-tiered system of support framework (Chafouleas et al., 2016; Kelly et al., 2015) and as a result it can also be viewed as the structure that governs how school-based social workers practice within in a school setting. Working within the first tier (promotion) of the multi-tiered system of support framework, school-based social workers provide school-wide programming (Baweja et al., 2016; Kelly et al., 2015) in order to encourage prosperity in different realms of a student's life including how they feel, act, and socialize (Baweja et al.,

2016; Hoover, 2019; Kelly et al., 2015). Transferring choice and power to the student body is important for trauma-informed practice (Perry & Daniels, 2016). Information presented in the promotional classroom sessions could pertain to areas which the students identify as the most pressing topics they want to discuss (Perry & Daniels, 2016). When working within the second tier (prevention), school-based social workers provide specialized programming to small groups of students in need of extra support in order to prevent the development of mental health concerns in students who are showing warning signs (Hoover, 2019). Whereas, when school-based social workers are working within the third tier (intervention), they provide students with independent programming in order to provide assistance to students who may already be identified as having a mental health concern, is in conflict due to their behaviour, and/or is having difficulty functioning (Hoover, 2019). According to a study done in the United States by Kelly et al. (2015), school-based social workers spend approximately 16% of their work time practicing within the promotion tier, whereas approximately 65% of their work time is spent practicing within the prevention and intervention tiers.

The idea behind the multi-tiered system of support framework is to enhance the atmosphere in schools through mental health supports on each level of the framework in order to foster learning for every student (Stephan, Sugai, Lever, & Connors, 2015). On account of this model reaching all students, children who may have been seen as not having high enough needs to receive services in historical models of care, still get assistance (Stephan et al., 2015). The multi-tiered system of support framework strives to provide support to students prior to them being in crisis and their learning being negatively affected as a result (Stephan et al., 2015). A benefit to the multi-tiered system of support framework is that the mental health care of students stays closely connected to the school support system in place and oftentimes an all-

encompassing support plan can be created (Stephan et al., 2015). These components of providing proactive support (Frydman & Mayor, 2017) and establishing continuity of care (Wright & Ryan, 2014) is supported in the literature regarding trauma-informed practices.

The multi-tiered system of support framework can be trauma-informed, if the information and practices that are contained in each tier aligns with this perspective, and functions to be of service to individuals who have experienced trauma (Hoover et al., 2018). This includes the implementation of trauma-informed evidence-based programming within the levels of service delivery (Hoover et al., 2018), as well as encouraging discipline practices that are trauma-informed, and thus promote building supportive relationships instead of relying on practices that are based on punishment (Hoover, 2019).

The Behavioural Model as a Source of Harm

The behavioural model within the Canadian school system and among other Westernized countries, such as the United States and Australia, focuses on a child's behaviour and views it as developing through environmental learning (Armstrong, 2019). There are differing definitions on what is meant when referring to "behaviour", however the general consensus appears to refer to deficits within a child's behavioural functioning that results in challenges in their life (Armstrong, Elliott, Hallett, & Hallett, 2016; Nash et al., 2016). Within the school system in the United Kingdom, these challenges appear to be typified as falling short of the expectations of the class (Nash et al., 2016). Behaviour from this perspective is a tangible experience, and for this reason a student's behaviour is seen as something that can be managed by developing a narrow view of how that behaviour is formed, and intervening on those factors to change the behaviour (Armstrong, 2019) into something that is more desirable. This can be done through observation and assessment of a student's behaviours (Stanton-Chapman, Walker, Voorhees, & Snell, 2016).

The behavioural perspective has likely been entrenched into every level of the education system through the provincial government's endorsement of this model; its presence is ingrained into the Ontario Ministry of Education's policies and procedures. According to the Ministry, Ontario schools respond to challenging behaviours through means of progressive discipline (Ontario Ministry of Education, 2016). In short, the Ministry's document outlining progressive discipline implies that students make the decision to engage in inappropriate behaviours, and it is the school's responsibility to use progressive discipline strategies in order to assist students in correcting their behaviours (Ontario Ministry of Education, 2016). The Ministry acknowledges that the student's developmental level, the seriousness of the student's actions, and what impression the student's behaviour leaves on the milieu of the school needs to be taken into account when determining the discipline that is appropriate for a student's behaviour (Ontario Ministry of Education, 2016). The rationale for the progressive discipline process is framed as a necessary and beneficial way to ensure safety within schools and assist students in making positive changes (Ontario Ministry of Education, 2016).

Classroom management in a sense is viewed as a teacher's ability to get command of their class, which can be developed through professional education (Armstrong, 2019). In a study that examined teacher's opinions about students' behaviours, most considered behaviour to be something that students can govern (Nash et al., 2016). Thus, they have the standpoint that students elect the behaviours that they engage in, including challenging behaviours, and punitive measures can be used to curb these challenging behaviours (Nash et al., 2016). In effect, the classroom environment is considered at risk when children show behavioural challenges in the face of authority (Armstrong, 2019). As a result, students who have experienced trauma may be penalized for the behaviours they express instead of being supported through them (Nash et al.,

2016). Instead of the typical learning response expected from corrective behavioural strategies the behaviours of child survivors of trauma may intensify as they can get emotionally hurt by the invalidating response they receive (Nash et al., 2016).

The literature on how school-based social workers reflect the behavioural model in their work, which in turn further harms students who have experienced trauma, could not be found. However, in a qualitative study done by Nadeem and Ringle (2016) in the United States, school-based social workers were interviewed about a school-wide program called Cognitive Behavioral Intervention for Trauma in Schools (CBITS) to determine what their opinion was on the program and the considerations that went into the continued or discontinued use of CBITS in their schools. After one year of using CBITS, school-based social workers identified that CBTIS was beneficial because it addressed and modified behaviours of students (Nadeem & Ringle, 2016). Although student behaviours were recognized by school-based social workers to be associated with trauma (Nadeem & Ringle, 2016), it appeared to me that the students' behaviours were viewed as an independent entity to be addressed. Furthermore, based on the reports of the school-based social workers it appeared to me that more focus was put on reducing behaviours instead of healing from trauma (Nadeem & Ringle, 2016). Despite the literature not specifically identifying how school-based social workers further harm students who have experienced trauma using the behavioural model the findings of the study done by Nadeem and Ringle (2016) suggest that school-based social workers can also place value in the behavioural perspective when working with students who have experienced trauma.

When we take a deeper look at the research on trauma and the use of behavioural discipline within schools, we discover that using the behavioural approach compounds the harm that is experienced by children from minority groups who are survivors of trauma. The school system is

not void of the influence of society; the education processes cater to the dominant group (Snir, 2016). Illich's article titled "Deschooling Society" (as cited in Snir, 2016), suggested that the goal of schools as an institution is to mold and teach the dominant ideals and religion of society to children under the "hidden curriculum" of obedience. This further adds to the oppression and harm of child survivors of trauma as it reinforces their lack of autonomy and personal identity (Levy, 2016). In the United States, it has been found that students of African American and Latino heritage are disciplined with suspensions at a higher rate than students who are Caucasian and Asian (Morris & Perry, 2016). This systemic discrimination of discipline also correlates with lower scholastic marks (Morris & Perry, 2016). Suspension not only affects the current academic performance of students but has been shown to have impact on academic achievement in the future (Morris & Perry, 2016). Thus, not only do minoritized groups experience childhood trauma at a greater rate, but the structural discrimination that exists within the school system's behavioural discipline model punishes these groups more frequently (Morris & Perry, 2016). This discrimination has long-lasting negative impacts on the academic outcomes of children and thus is a critical piece to examine when looking at oppression existing within the behavioural model in the school system. Recognizing these oppressions are important in order to identify how we can challenge this system in anti-oppressive trauma-informed ways. School-based social workers tend not to perceive their practice as oppressive (Isaksson & Sjöström, 2017), which is evidenced by the lack of literature found in this area. However, I believe it is important to consider how school-based social workers reflect the behavioural model as a model that functions to further harm students who are survivors of trauma because it adds to the literature and the future of trauma-informed school-based social work practice for supporting student survivors in school.

Trauma Theory Versus Pathologization of Behaviour

It is typical in our society to blame trauma survivors as being in some way responsible for the trauma that they were subjected to (Herman, 2015; Mullaly & West, 2018). The traits of survivors are often examined and exposed as weaknesses which are explained as what led to victimization with survivors being further oppressed and blamed by clinicians pathologizing them post-trauma (Herman, 2015). Despite this acknowledgement, Herman (2015) also felt it was necessary to have a proper diagnosis to adequately intervene on trauma. In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), trauma- and stress-related disorders are distinguished from others when "symptoms" such as, loss of happiness, aggressiveness, anger, and/or dissociation are the main features portrayed by an individual after a traumatic or stressful experience (American Psychiatric Association, 2013). The current context of trauma research and posttraumatic stress disorder (PTSD) diagnosis has focused on biological components and has strayed away from the complex underpinnings of trauma, including social and political factors (Herman, 2015). Moreover, a child's experience of trauma has also been pathologized into disorders within the DSM-5, such as reactive attachment disorder (RAD) (American Psychiatric Association, 2013; Berkowitz, 2012; Brunzell et al., 2015) and disinhibited social engagement disorder (DSED) (American Psychiatric Association, 2013; Brunzell et al., 2015). RAD is characterized by a lack of self-regulation, whereas, DSED is characterized by depression and social detachment (American Psychiatric Association, 2013). Additional to diagnoses of RAD and DSED, it is also common for children who have experienced trauma to be identified as having PTSD (van der Kolk, 2014), depression, anxiety (Heim & Nemeroff, 2001; Kavanaugh & Holler, 2014), "attention deficit hyperactivity disorder [ADHD], conduct disorder [CD], oppositional defiance disorder [ODD], … and/or acute stress

disorders" (Brunzell et al., 2015, p. 3). The tendency to over diagnose child survivors of trauma with mental health concerns is rationalized by some as a way to identify the challenges that the child has faced and provide reasons for their presentation and needed support (Berkowitz, 2012).

However, labelling children with disorders as a result of their behaviour in response to trauma places the blame on the child and not on the issue of what leads to and maintains the existence of trauma (Becker-Blease, 2017). Therefore, existing within pathology is the neglect to identify the structural underpinnings that traumatize marginalized populations (Quiros & Berger, 2015) or increase risk factors of trauma. When trauma is examined in a way in which responsibility is assigned to Western societal deficits and not individualized deficiencies, then a non-pathologizing view of trauma is exercised (Gómez, Lewis, Noll, Smidt, & Birrell, 2016).

However, school staff may place negative labels and generalizations upon a child who has been exposed to trauma due to the behaviour which is expressed but misunderstood out of context (Crosby et al., 2016). Students who are identified as having externalized behaviours or a combination of externalized and internalized behaviours are more likely to report current or previous connection to community mental health services, being prescribed medication, and having been admitted for inpatient mental health services (Splett et al., 2018). Whereas, students who are considered to fall into typical behavioural patterns or portray internalized behaviours are less likely to report having ever been connected with the aforementioned mental health services (Splett et al., 2018). The discrepancy in being connected to services based on behaviour does an injustice to students who exhibit trauma signs in the form of observable externalized behaviours, and as a result, may be at greater risk of being pathologized. Furthermore, survivors who may express the impact of trauma in internalized ways also face an injustice as they may be less likely to receive mental health supports. There have also been significant differences between how

teachers perceived externalized and internalized behaviours of their students (Splett et al., 2018). When students demonstrate severe externalized or internalized behaviours teachers have been shown to be equally able to recognize that these students may be experiencing challenges (Splett et al., 2019). However, for the students who demonstrate a moderate level of behaviour teachers were more likely to be able to identify that students may need mental health support if they showed externalized behaviour opposed to internalized behaviour (Splett et al., 2019). Furthermore, teachers reported that they experienced greater worry for students who were showing externalized behaviours and they felt that these students had more serious and severe challenges than students who were experiencing internalized behaviours (Splett et al., 2019). Consequentially, teachers reported that students who demonstrated externalized behaviours were in greater need of both school and outpatient mental health supports than those with internalized behaviours (Splett et al., 2019).

Moreover, school staff can also view students who have experienced trauma as being personally flawed, for example, as a poor student and a misbehaved child (Overstreet & Chafouleas, 2016). As a result, students who have experienced trauma are often excluded from activities or suspended (Costa, 2017; Nash et al., 2016) instead of the school-setting changing to be more supportive toward the student (Sullivan, Johnson, Owens, & Conway, 2014). Viewing the child's behaviours from a behavioural lens leads staff to be inquisitive of the child's deficits (Overstreet & Chafouleas, 2016) which promotes the implication of pathology. In effort to determine a label for the student survivor, as a result of their behaviour at school, schools often recommend the child be assessed by a physician (Costa, 2017). The major issue with this is that, "when we attempt to evaluate the behaviour without ever trying to understand the behaviour, we give up opportunities to know the child, connect with the child and be that one person that

mattered for the child" (Costa, 2017, p. 115). This is a grave mistake when working with children who have experienced trauma as we know that healing from trauma requires connection (Dods, 2013; Herman, 2015; Wright & Ryan, 2014). Thus, instead of attending to the child's needs for trauma recovery, pathologizing trauma behaviour promotes the use of pharmaceuticals and behaviour management strategies (Costa, 2017) pushing the child farther away from connection (Nash et al., 2016).

Trauma theory can be used to challenge the pathologization of behaviours of a child when these behaviours are viewed as the child's survival response to having been exposed to trauma (Bloom, 2014a; van der Kolk, 2014; Wilkinson, 2017). In line with this, comes the recognition that a survivor's behaviour is related to their neuronal connections (Costa, 2017). When we recognize behaviours that appear challenging at school as a result of trauma then the response that follows changes from disciplinary to supportive (Dorado et al., 2016) and non-traumatizing (Costa, 2017). In the trauma-informed version of supporting behavioural challenges at school, staff work to establish safety within the child when dysregulation occurs (Dorado et al., 2016). An important part of this is the staff's recognition of their own responsibility to be mindful of how they are interacting with the child (Costa, 2017). What comes from a trauma-informed way of perceiving and responding to challenging behaviours at school is an increase in the student's learning, and self-regulation, and a decrease in aggressive behaviours and suspensions (Dorado et al., 2016) instead of pathologizing behaviours. Trauma theory endorses the role that schools can play in a survivor's healing through relationship-building (Costa, 2017). Further, it works to identify and confront the oppression within the system (Costa, 2017) instead of the blame that pathologizing behaviour puts on the child (Overstreet & Chafouleas, 2016).

Trauma-Informed Professional Development for Teaching Staff

In order for an organization to be trauma-informed they need to be knowledgeable on the broad effects, indicators, and symptoms of trauma, and informed on the ways in which healing can happen (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014). Moreover, having a trauma-informed organization means that the institution enmeshes their learned knowledge of trauma into their culture, operations, and guidelines, and makes a conscious effort to not retraumatization individuals (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014). Clinicians, such as school-based social workers, can play a lead role in progressing trauma-informed practices and knowledge within their schools through promotional practices directed at educating staff during professional development sessions and during general consultation with staff (Costa, 2017; Perry & Daniels, 2016).

It is so important for teachers to be trauma-informed because they are integral in recognizing challenges their students are experiencing (Splett et al., 2019). According to the research in the field, teaching staff have recognized trauma as an area around which they desire further training, as many of the students they teach have experienced trauma (Cole et al., 2009; Howard, 2018; Moon, 2017; Perry & Daniels, 2016; West et al., 2014). Part of this education, which school-based social workers can provide, needs to address recognizing potential indicators of trauma and where and how to refer a child for services (Iachini, Petiwala, & Deer, 2016). Additionally, providing teachers with trauma-informed professional development may in turn alleviate some of the stress they feel as a result of behavioural concerns in their classroom. As it has been reported that teachers who have knowledge on how to promote a successful classroom

and prevent their students from experiencing challenges within the classroom are less stressed than teachers who function in a responsive way (Nash et al., 2016).

Summary

The literature in this chapter focuses on the educational setting of my placement and therefore the practice of education as it relates to supporting students who are survivors of trauma, but the overall focus of this paper is to explore how school-based social workers can support student survivors by assisting schools in becoming more trauma-informed on a system-wide level. This chapter provides a foundation of literature in the field pertaining to the primary models used within a school setting to support children who have experienced trauma. The primary models that are identified are the trauma model which includes trauma-informed practices (TIPs) and the multi-tiered system of support framework. Through the use of the trauma model and TIPs it is identified that child survivors are supported in school through the establishment of safety relationships, trauma-informed teaching practices, addressing behaviour in a trauma-informed way, trauma-informed school programs such as HEARTS and REWIRE, and trauma-informed school-based social work. As it is the role of school-based social workers to help establish schools that support the needs of students across "social, emotional, and academic" domains (Jarolmen, 2014, p. 45), this chapter also identifies the role that school-based social workers play in supporting TIPs in the school setting. Moreover, the literature establishes how the multi-tiered system of support framework acts as a support to child survivors through school-based mental health promotion, prevention, and intervention programming that is provided by school-based social workers to school staff and students.

In contrast, the behavioural model is identified as the primary model that functions to further harm students who are survivors of trauma within schools. I identified a gap in the

literature in which there is a lack of consideration for how school-based social workers reflect the behavioural model in their practice which further harms students who have experienced trauma. Additionally, the literature that uses trauma theory to challenge the pathologization of behaviours in students who have experienced trauma is reviewed. Lastly, an overview of trauma-informed professional development for teaching staff and how school-based social workers can support this effort concludes the chapter. This information is of valuable use moving forward into Chapter 3, where I reflect on my practicum experience with the Sudbury Catholic District School Board (SCDSB) in order to answer the questions that were sought out to be explored.

Chapter 3: Reflection on Practicum Experience

To me, progression requires reflection and awareness. When we examine and reflect on change, we must give consideration to both the improvements that have been made and the unfavourable outcomes that have arisen (O'Brien & Kardas, 2016). It is also important that systems partake in this type of reflective change process. Although the Sudbury Catholic District School Board (SCDSB) does a wonderful job supporting their students, including those who have experienced trauma, from an anti-oppressive structural social work perspective the education system must continue to progress towards being one which respects the marginalized members of the school community (Quiros & Berger, 2015) and refuses to see child survivors of trauma as burdens on the system (Becker-Blease, 2017). This chapter looks to outline and reflect on my practicum experience including the role that I filled as a school-based social work student, how I sought to answer the guiding foundational questions during my practicum experience, how I met my personal goals, and my experience with clinical supervision. This chapter attempts to answer the guiding questions of my practicum learning through uniting the literature in the field with the experiences I had during my practicum experience with the SCDSB. Furthermore, I describe and reflect on the trauma-informed professional development intervention that I provided to teachers. With consideration given to all of these factors, I configure and outline my own position on the matter of supporting child survivors of trauma in the school setting.

Practicum Experience

As a partial requirement of the Master of Social Work Program at Laurentian University, I completed a 450-hour practicum. The practicum hours were completed full-time from January 28 to May 15, 2019, with days taken off to attend my MSW course blocks. In order to provide context regarding my practicum experience, I outline and discuss the practicum setting and

agency, the role I filled while a practicum student with the SCDSB, the questions sought to be answered through my practicum experience and in this paper, the goals that I had for this practicum experience and how I met them, and my experience with clinical supervision.

Practicum setting and agency. As previously outlined within the introductory chapter (see section titled "Overview of Practicum Site" for more information), my practicum experience was completed with the Sudbury Catholic District School Board (SCDSB) with the Mental Health Team. I worked within the SCDSB elementary schools under the guidance of my agency supervisor who is a masters level school-based social worker. The mental health programming provided by the mental health team, including school-based social workers, is divided into promotion, prevention, and intervention services (SCDSB, n.d.).

Role as a school-based social work student. To begin, my agency supervisor was responsible for providing mental health services to four elementary schools across the City of Greater Sudbury within their[1] role as a school-based social worker with the SCDSB. As such, I worked with them at these four schools. While a practicum student, I was able to observe, co-lead, and independently facilitate promotion, prevention, and intervention services within the schools.

The service that we provided in the first tier included promoting mental wellness through classroom programming, lunch-and-learn professional development sessions with teaching and support staff, impromptu individual professional development discussions and consultation with teaching and support staff, and representation of school-based mental health services at special

[1] Gender neutral pronouns are used throughout this paper to increase the anonymity of individuals and to respect their gender identity.

events. On a classroom level I was able to help co-facilitate some sessions on topics such as mindfulness, emotions, and perspective taking. Additionally, I was able to independently run a five-week evidence-based classroom program called “Kids Have Stress Too!” with a grade three class. This program involved the topic of stress and included sessions that gave an overview of stress, coping strategies, emotions and empathy, flexible thinking, self-talk, and problem solving (The Psychology Foundation of Canada, 2011). The independent professional development lunch-and-learn that I provided to teaching staff was another intervention piece of my practicum experience. For this, I created a trauma-informed presentation (see Appendix A for the presentation slides). This is discussed later in this chapter in more detail. Moreover, independent professional development and consultation was provided to teaching and support staff on an as needed basis. This consultation often came in the form of teachers coming into the office to speak with my supervisor and I for assistance on supporting a child in their classroom, or myself initiating a conversation with a teacher or support staff person in reference to a child who may benefit from the addition of certain supports in the classroom. Additionally, at times throughout the year there are special events in which school-based social workers provide mental health promotion work. For example, during my practicum term, one of the schools hosted a Mindfulness Evening for students and guardians to attend. The event included different booths and stations operated by school staff and community members to provide education and promotion about different mindfulness activities that may be beneficial to children. At this event I helped spread awareness to guardians about the mental health team at the SCDSB, engaged children in fun mindfulness activities, and educated the children and guardians on the benefits of the activities.

Working within the second tier, I provided prevention services by helping to co-facilitate small psychoeducational and skills building groups with students. Some examples of the various topics covered in the groups that I co-facilitated were self-regulation, social skills, worries, mindfulness, emotions, and problem solving. I had the opportunity to independently facilitate two 10-week groups. The first group had three members in it and focused on social skills and self-regulation. Whereas, the second group had two members in it and focused on worries.

Additionally, at the third tier of the multi-tiered system of support framework I provided intervention services to students. This entailed one-on-one therapy for students who may have been experiencing mental health concerns or were requiring a higher level of support than the promotion and prevention levels could offer. I had the opportunity to shadow my supervisor in their one-on-one sessions with students, which was helpful in learning through observation. In addition to this, I had my own caseload of seven students who I saw independently with my supervisor sitting in on the sessions occasionally as part of supervision. The students I saw independently ranged from grade one to grade seven and the foci included parental separation, family dynamics, and trauma. An eclectic approach was employed using clinical techniques from trauma theory, anti-oppressive theory and practice, narrative therapy, art-based methods, mindfulness, bibliotherapy, family-systems theory, and cognitive behaviour therapy.

Furthermore, under the guidance and supervision of the school-based social worker, I was responsible for planning my group and classroom sessions, and keeping documentation. I was also responsible for consulting with guardians and staff, as needed, in order to enhance the care for the student. Additionally, I took part in the mental health staff meetings, community partnership meetings, a SCDSB board meeting, and a multi-board school-based social work meeting.

Foundational questions and methods for discovery. This practicum experience and paper has been building towards answering three questions pertaining to supporting children in schools who are survivors of trauma. To review, the questions that are being explored are: (a) what trauma-informed practices (TIPs) and primary models are used by the SCDSB to inform their practice in supporting students who have been exposed to trauma, (b) to what extent does school-based social work in this setting reflect certain models that function to further harm child survivors of trauma, such as the behavioural model, and its relationship to understanding student experiences through the lens of trauma, and (c) how can trauma theory be used to establish alternatives to pathologization in regards to children within schools who have experienced trauma. Again, structural and anti-oppressive social work perspectives are employed in this exploration.

Through working within my role as a school-based social work student I was immersed into the school environment, processes, and culture which provided one manner in which I was able to gather information in order to answer the above questions. Further, through natural conversations I had with teachers, support staff, and administration additional information that could be used to shed light on these questions was revealed. Information also emerged from more formal discussions with my agency supervisor during clinical supervision, with teachers during the professional development sessions, and with teaching and support staff during consultation. Also, by spending time in the hallways, the classrooms, the clinical room, and the school office, I was able to acquire natural observations that pertained to the questions being answered. Importantly, the students also provided me with assistance into being able to answer these questions, as it is through being an observer of their experience within the school setting that these questions truly get answered.

Advance practicum goals and methods for achievement. Upon commencement of my practicum with the SCDSB the goals that I had set for myself were to develop my clinical practice skills in mental health promotion and prevention along with trauma-informed care in a school-based setting. These goals were coupled with my desire to continue my clinical education through engaging in potential training opportunities with the SCDSB. These goals were achieved through reviewing the literature on how the multi-tiered system of support framework is utilized in school settings to provide mental health education and support to students and faculty. This information, which is discussed throughout this paper, provided me with a conceptual idea of the prevention and promotion tiers, from which point I could begin my work. Practical knowledge and application of the multi-tiered system of support framework came from immersing myself into the role of a school-based social work student. Through the guidance of my agency supervisor and the mental health team, the idea of this framework became clearer and more tangible to work from in practice. Learning the processes, observing the mental health team in their roles, and seeing how the students were supported through classroom promotion, group prevention, and one-on-one intervention was enlightening for me in understanding the full range of the multi-tiered system of support framework in practice. From these experiences I gained an understanding of the purpose of this model and how it can be beneficial and accessible to students in the education system.

One of the advantages that I see from utilizing the multi-tiered system of support framework in schools is that it keeps the Ontario education system, particularly the school mental health system, accountable to maintain focus on all three levels of support for children. Moreover, it includes staff promotion into its model, thus enforcing a responsibility that attention is given to educating the teaching and support staff on topics related to mental health in schools.

One of the challenges, which can also function as a strength, is that in essence it is just a structure that programming is plugged into. With this in mind, the school setting and the school-based mental health services are only as absorbed with trauma-informed awareness and practices as the programming within it allows (Hoover et al., 2018). Therefore, the programming that is picked plays a major role in what mental health cultures and perspectives are created in the schools.

Developing my clinical skills in trauma-informed care within schools was also done through the review of literature. A particular area of focus I took from the literature is the importance of building a safe therapeutic relationship with children who have experience trauma (Bath, 2015; Carello & Butler, 2015; Herman, 2015; van der Kolk, 2014). While working within the schools, I began a mindful practice of how I used my body language, voice, words, and attention when around the students. Part of this was putting care into making unique and authentic connections with each student (Dods, 2013) I worked with and presenting as welcoming to the students in the hallways. In reflection, this made a huge difference in my practice. Although it is challenging to come from a trauma-informed perspective in all situations, especially when the behavioural model is comfortable to me and readily accepted in a school setting, I was very aware of my emotion and behaviour regulation signals and purposely tried to commit to a trauma model in those moments of challenge. For example, during a group I was facilitating, a student was making negative comments about the activity we were doing, getting out of their seat, and refusing to do the worksheet. I was mindful of the fact that this was distracting and frustrating to me and internally I struggled with the idea of whether utilizing the behavioural model could be beneficial. I recognized that it would have been easy for me to use behavioural strategies to set limits, increase the child's work completion, and increase the time

they stayed in their seat. However, I also recognized that this would likely not support their emotional needs (Nash et al., 2016) or build safety within our relationship (Dorado et al., 2016; Herman, 2015). Instead of attending to the behaviour of the student that I perceived to be disruptive, I attended to my own regulation and affect (Costa, 2017) in order to convey calmness and compassion to the student. As such, I used deep breathing and self-talk to help me self-regulate. I smiled at the student, spoke in a calm and relaxed tone of voice, validated their feelings about the activity, and expressed that I was just happy to have them with us today and that completing the activity was not necessary. I tried to mitigate power (Carello & Butler, 2015; Herman, 2015; Wolpow et al., 2009) and increase the child's sense of control (Perry & Daniels, 2016) by asking for their feedback on what they didn't like about the activity or what they found challenging, I suggested that they could modify the activity to suit their preference, and I offered my assistance. Although the student continued to get out of their seat, they stopped complaining about the activity, and chose to complete the parts of the activity they wanted to do. They also modified the activity by drawing instead of writing and they asked me for help with explaining some of the instructions. At the end of this session, the student wanted to show me the drawings that they completed from this activity. As can be evidenced from this example, self-reflecting in the moment and intentionally choosing a trauma lens was a major part of my learning and how I worked towards my goal of increasing my skills in providing trauma-informed care to students. Supervision also allowed for this reflection, which will be discussed in more detail in the next section.

My practicum learning was also enhanced by being trained by other professionals through the various training opportunities I was able to attend. I attended the 2019 Sexual Assault Awareness & Education Conference as well as a self-regulation workshop, both of which

were hosted by the Greater Sudbury Police Service. Although these events were hosted by the Greater Sudbury Police Service, the guest speakers at these events were professionals, including those with lived experience, that were external to their organization. In addition, I completed online training modules offered through School Mental Health Ontario on topics regarding how to support students' mental health in the classroom setting (School Mental Health Ontario, 2019). Furthermore, I also viewed some trauma-specific online presentations during The Brain Change Summit covering topics such as safety connections and resilience (Sounds True, 2019).

Experience with clinical supervision. On a weekly basis I was provided with clinical supervision from my agency supervisor. Within supervision meetings, we reviewed my caseload, what my direction was for each student and group on my caseload, and discussed and addressed any questions. This was a very beneficial and worthwhile experience for me. I felt very comfortable and supported by my agency supervisor, so I was able to learn a lot from supervision as I felt safe in asking questions and having discussions (Asakura & Maurer, 2018).

Supervision provided me with a platform to expand my clinical practice. One of the areas in which I wanted to develop was utilizing more art-based activities into my clinical work with students. Through supervision I was able to discuss my ideas that I wanted to try in practice, which prompted me to consider things I may not have thought about prior to our discussion. For example, I was working with a young student who was experiencing a lot of emotions following a major life change. I wanted to help the student visualize their emotions and found an activity that was in one of the reading materials (Australian Childhood Foundation, 2010) my supervisor had provided to me. In this activity the child labelled an emotion they felt about the life event and picked out a coloured balloon that they thought represented that emotion for them. The balloon was inflated to the size that represented the felt presence of the emotion in their life in

regards to this event. This was repeated until we were no longer able to come up with any more emotions that pertained to the event. The balloons were hung up in the clinical room as per the student's wishes, as a visual that they could see each week. Through discussing this concept further in supervision, I decided this may be a good activity to redo at the end of our sessions together to provide the student with a visual representation on how their feelings have changed or stayed the same over our work together.

Likewise, supervision also helped me refine my practice. This was done through discussing my own reflections on the strengths and challenges that I encountered in my clinical practice experiences. In supervision I was able to reflect on a challenge I was having with a young student who was a survivor of trauma. I was experiencing difficulty prompting the student to say more than a few words in sessions and I wasn't confident they were getting anything of value from the activities we were doing. Through reflection in clinical supervision I was able to identify that I needed to take a step back from the psychoeducation and skills training piece of the practice and go back to the basics of trauma practice; building a safe relationship (Bath, 2015; Carello & Butler, 2015; Herman, 2015; van der Kolk, 2014). By focusing on building a safe and trusting relationship with the child, through playing games, spending time talking about their interests, telling them about my interests, and using humor, I was able to build a relationship in which they were able to be more verbally engaged during our sessions and appeared more comfortable.

Additionally, clinical supervision provided me with a space to discuss the questions that I sought to answer during my practicum experience and within this paper. Having the ability to engage in professional consultation and feeling comfortable in asking questions and challenging structures and processes provided a basis from which my critical analysis could be formed. My

supervisor's willingness to be supportive of my inquiries, provide me with answers, and suggest differing perspectives aided in my learning process. Although my critical analysis was not fully formed by the completion of my practicum experience, the backbone was developed and I was open with my agency supervisor about my analysis. Although, I developed my analysis by myself, it would be unjust to say that my agency supervisor did not play a role as having the ability to discuss my observations and analysis in clinical supervision was very helpful. For example, I would often contemplate the difficulty of separating the behavioural model and trauma model from each other within a school setting. Supervision allowed for me to process my analysis with a professional in the field who could also pose challenges for me to consider. Although I suspect that my agency supervisor would agree with some parts of my analysis while also having differing opinions on other elements, I feel that it would be unfair for me to speak on behalf of my agency supervisor on whether or not they agreed with my conclusions.

Primary Models used in the SCDSB

Through my practicum experience with the Sudbury Catholic District School Board (SCDSB) I was able to identify three primary models which were used in schools with child survivors of trauma. Of the three models I identified, the two I determine to be supportive to child survivors are the trauma model which includes the use of trauma-informed practices (TIPs) and the multi-tiered system of support framework. The trauma model was used quite reliably by the SCDSB, which was very encouraging to see, and the multi-tiered system of support framework included many trauma-informed elements within the programming. Through my observations and reflection, the behavioural model was identified as the one primary model that functions to further harm students who have experienced trauma. All of these areas are discussed further through amalgamating my practice experiences with the literature in the field.

The trauma model and TIPs. It was evident by the atmosphere and practices within the four SCDSB elementary schools that I worked in that trauma awareness was becoming more established in the school system than when I attended primary school. The presence of this awareness is occurring both inside and outside of the classroom. Some of the ways the trauma model was evident in the schools was through the trauma-informed practices (TIPs) that were being utilized. Those that are discussed in this section are supportive classroom equipment, trauma-informed teaching practices, and relaxation rooms.

Supportive classroom equipment. Upon starting with the SCDSB one of the first signs that identified to me that the trauma model and TIPs were being used was the supportive equipment that was present within the classrooms. As previously discussed, part of trauma-informed teaching is creating a classroom environment that is supportive to the needs of students who are survivors of trauma (Brunzell et al., 2015; Wright & Ryan, 2014). Hence, many classrooms contained sensory aids which help students who have been exposed to trauma self-regulate (Whiting, 2018). Many teachers had created calm atmospheres within the classroom through their décor and dim/natural lighting. Visual representations of emotions and self-monitoring visual aids were posted in many of the classrooms, and some teachers had created a comfortable area in their room that could be used by students as a safe space. Designing a place that is safe for trauma survivors, and is perceived to be safe by survivors, has been acknowledged as something that is essential for helping children heal from trauma (Quiros & Berger, 2015). In doing so, one must consider how all elements of an environment create physical safety (Quiros & Berger, 2015). Consideration of the selection of furniture, the décor in the room, and creating consistency in daily activities are all important for the establishment of safety (Quiros & Berger, 2015). It was not uncommon to see children throughout a classroom sitting on different types of

chairs including the classic plastic school chairs, yoga ball chairs, vinyl cushioned chairs, active seating stools, and high-top stools. Similarly, in one of the newer schools the desks were also designed in order to be adjustable to different heights. Some classrooms had a few standing desks for students to use as needed and a specialized stationary exercise bike with a tabletop attached. Some students also had specialty elastic bands that attached to their desk or chair legs to act as a tool for physical regulation. To present lessons that engaged students in learning activities and helped to support survivors of trauma, teachers used different mechanisms (Wright & Ryan, 2014) including whiteboards, smartboards, iPads, and flip charts.

During my time with the SCDSB, I witnessed students regularly utilizing the specialized equipment, as needed. In one class, I saw a student use the stationary bike during the math lesson, doing their work on the tabletop attached to the bike. Incorporating physical outlets into the classroom allows the brain and body to regulate incoming information, stimulation, and reactions through rhythmic exercise, which was previously noted as being helpful for children who experience heightened arousal as a result of exposure to trauma (Brunzell et al., 2015). In this particular classroom, it appeared that the students could utilize the bike as they saw fit, and did not need to ask permission to do so from the teacher. Similar practices were observed in other classrooms, with students accessing standing desks or the safe space during lessons, as needed. I suggest that providing students who have experienced trauma free access to supportive classroom equipment not only builds a safe environment (Quiros & Berger, 2015; Wright & Ryan, 2014) and grows self-regulation (Brunzell et al., 2015; Whiting, 2018), but it develops agency within the child (van der Kolk, 2014). Giving students who have experienced trauma the opportunity to determine what they find helpful in attaining their own regulation and providing

them with the keys and freedom to access these strategies when needed (van der Kolk, 2014) honours them with the safety and means to build agency.

Trauma-informed teaching. Not only did teachers set up classroom environments that were thoughtful to the various physical regulatory needs of their students, via supportive classroom equipment, but many of them also used trauma-informed teaching practices. Through casual conversations with teachers and/or witnessing teachers engaged with students, many authentic trauma-informed teaching practices were witnessed. In my experience, teachers were aware that many of the children they taught considered school to be their safe place (Brunzell et al., 2015). Further to this, many teachers seemed to take ownership of being a consistent supportive figure for their students.

Teachers can be powerful figures in a child's life; their ripple effect present long after the moment in time that they occupied has passed. I attended a professional development lunch-and-learn presented by a school-based social worker and another mental health teammate on building mentally healthy classrooms. During this professional development session presenters had asked teachers to tell a partner about their favourite teacher growing up. As a collective, the group recognized that their favourite teachers were the ones who showed that they cared for them. This is an essential piece of trauma-informed teaching as it is what builds the foundation for safety in the classroom (Wright & Ryan, 2014) and is a reason that I believe that care is such a powerful tool.

One of the most beautifully executed trauma-informed teaching moments I witnessed during my experience with the SCDSB was during a grade five math class. The classroom environment was mindful to the sensory experience of the children in the class. Many environment-based practices that can be used to support children in the classroom who have

experienced trauma were utilized by this teacher. Such practices as natural or dim lighting, playing calming music, and having tranquil décor (Brunzell et al., 2015) were being used. Additionally, a calming nature video was playing on the smartboard and the teacher used a handless microphone. The microphone allowed the teacher to speak in a calm voice with a regular volume, ensuring every student could hear them without them having to raise their voice, which is helpful for students who have been exposed to trauma (Costa, 2017). The teacher started the class off by leading a guided meditation. The students in their classroom settled into this meditation practice with ease, as this was an activity they practice regularly. This exercise included deep breathing practices which are beneficial for children who have experienced trauma (van der Kolk, 2014). The students seemed to enjoy this practice and afterwards they appeared visibly calm. The children were then presented with an unplanned five-minute timed math quiz. Following the quiz, the teacher immediately apologized if the activity caused any students to feel an increase of anxiety or stress and informed that it was not the intention. The teacher opened the floor up to feedback on how that experience was for the students. Every student who wanted to provide feedback was given a chance to speak, and the teacher validated each student's comments or feeling after they spoke (Wright & Ryan, 2014). The students appeared comfortable speaking about their feelings in a class discussion. They were eager to share both the positives they experienced and the challenges they encountered with the math activity. When all the students were done sharing, the teacher validated the summary of their comments and feelings (Wright & Ryan, 2014) and provided a rationale for the unplanned timed quiz. Using mindfulness practices and discussing their experience with stress provides space in the classroom for self-regulation to be practiced which helps students in becoming situated to learn (Brunzell et al., 2016). Following this discussion, the teacher transitioned into the math lesson, and as the

research suggested, the class appeared engaged in the lesson, focused, and calm (Brunzell et al., 2016). By the teacher making space in their practice and classroom for the development of physical, mental, and emotional safety (van der Kolk, 2014) they were building a safety relationship with their students (Bath, 2015; Carello & Butler, 2015; Herman, 2015; van der Kolk, 2014) and creating a therapeutic setting where children who have experienced trauma can begin to heal (Herman, 2015; van der Kolk, 2014), and learning can happen (Carello & Butler, 2015).

Relaxation rooms. Many of the elementary schools with the SCDSB have relaxation rooms that students can use when needed, with the support of an education assistant (EA). Of the four schools where I was placed, three had relaxation rooms, and they were utilized daily. These rooms appear to be similar to the Monarch Room, which was discussed earlier (Baroni et al., 2016). Like the Monarch Room, these relaxation rooms were equipped with various items to support self-regulation and increase relaxation (Baroni et al., 2016), including sensory toys; a comfortable setting; and emotion-based visuals, books, and games. The schools that had a relaxation room each gave their room a unique name, all of which conveyed comfort. Having a name for the room that was soothing seemed to help decrease the stigma associated with the rooms. Similar to the Monarch Room, the students and staff seemed to view these rooms as positive areas, not punitive settings (Baroni et al., 2016). The relaxation rooms were used by the EAs frequently throughout the day to support students. From my experience with the SCDSB, these rooms appeared to work very well for students, while also de-escalating situations. During one event, I witnessed a student begin to cry in the middle of a class lesson and start yelling at their peers and teacher. The EA provided gentle comfort to the student and asked them if they wanted to go to the relaxation room with the EA, to which the student agreed. The student and

EA came back to the classroom fifteen minutes later and the student appeared calm, returned to their seat, and was engaged in the class for the remainder of the period. As seen in this example, supporting children who have experienced trauma through the use of supportive means, such as relaxation rooms, instead of punitive measures allows students to stay in school and develop self-monitoring and self-regulatory abilities (Baroni et al., 2016).

Multi-tiered system of support framework. I observed the current multi-tiered system of support framework used by the SCDSB staff to support a student survivor of trauma. At the promotion level (tier one), an evidence-based program on self-regulation was provided to this student's classroom by a member of the mental health team. This program included psychoeducation on emotions and developing skills that can help children regulate their emotions and states of arousal. This program provided support for not only this student, but their entire class, and provided tools for the teacher to use to support and encourage the student's regulation (Costa, 2017). Additionally, the student was being supported at the prevention level (tier two) through a small group offered at school that focused on psychoeducation in regards to emotions and stress, recognizing how these experiences impact our bodies, and building self-regulation skills. This group was cofacilitated by myself and a school-based social worker. This group was grounded in the trauma model. During each group session, mindfulness techniques were practice as they have been linked to improving children's development of self-regulation (Brunzell et al., 2016) and sense of safety within their own bodies following trauma (van der Kolk, 2014). These practices included deep breathing, guided meditation, and the use of mindful senses. Although structural barriers of school-based resources prevented the SCDSB mental health team from being able to provide the intervention level (tier three) support to this student, it was arranged for a community-based social worker to come into the school to provide the one-on-one services for

this child. In order to ensure continuity of care the school-based social worker and community-based social worker consulted with each other.

When the multi-tiered system of support framework is activated to support students who have been exposed to trauma, the programming and assistance that is provided becomes trauma-informed (Hoover, 2019). Adopting a trauma-specific program that is compatible with the multi-tiered system of support framework, such as the HEARTS (Dorado et al., 2016) or REWIRE (Costa, 2017) programs that were discussed earlier, could be a beneficial addition for the students and staff within the SCDSB. These types of programs would support the implementation of promotion, prevention, and intervention that is trauma-informed and that supports students, staff, and families while also looking at the systemic components that contribute to the challenges many child survivors of trauma face at school (Costa, 2017; Dorado et al., 2016).

The behavioural model. Although the SCDSB's mental health team does not use the professional practice of the behavioural model, the presence of the perspective seems to be one of the main models used throughout the school system to try and help support students, including those who have experienced trauma. However, the behavioural model has been identified as a model whose use can further harm children who have experienced trauma because instead of addressing the factors that lead to and maintains their hurt, it can provide a platform for identifying fault in the child (Costa, 2017). Throughout my practicum experience I saw the behavioural model present in a few different situations regarding students who have been exposed to trauma.

Firstly, the behavioural model is founded in positivist knowledge (Moore, 2013), thus diverse cultural practices are not represented in this model (Malott, 2016). The presence of

positivism is camouflaged well within in our Western society because the underpinnings of this society were created by its use (Kincheloe & Tobin, 2009). Thus, it often goes unnoticed (Kincheloe & Tobin, 2009). By not acknowledging the oppression that exists within these practices, we continue to condone and exacerbate oppression that marginalized child survivors of trauma face. Positivism oppresses Indigenous individuals as it demands control and superiority over non-dominant discourses, cultures, and beliefs (Kincheloe & Tobin, 2009). In one example I experienced as a practicum student, a behavioural assessment was completed by an outside agency and recommendations were provided with the intention of supporting an Indigenous child at home and in school. The behavioural assessment was based on the observations that took place both at school and at the child's home, and through consultation with school staff and the child's family member. Although school staff may understand that inequality of marginalized groups leads to challenges at school, systemic racism occurs when educational staff endorse the need for professional community consultation even though the power difference between the professional and the individual leads to further oppression (Green, 2017). In this way, schools who endorse the use of the behavioural model and enlist the assistance of external professionals to do so, oppress marginalized children and families within a school setting who do not fit into its mold, by not considering the discrepancy in power and the knowledge of the family's practices, beliefs, and perspectives. Instead, the Western positivist knowledge is separated from being linked to a culture (O'Neill, Fraser, Kitchenham, & McDonald, 2018). This portrays it as an all-knowing entity of knowledge, whereas Indigenous discourse and practices are seen as cultural (Kincheloe & Tobin, 2009). When coupled with systemic racism, the behavioural model can be oppressive to racial minority students who are survivors of trauma. As such, the harm of child survivors can be continued by the behavioural model, although it can hide behind the intention to provide

individuals with assistance. This realization seems to go unrecognized, even amongst the workers that utilize the behavioural model. The effects of historical trauma (O'Neill et al., 2018) and the systemic influence that continues to oppress Indigenous children attending schools today is not considered in the behavioural model. It has been suggested that in order to create a trusting environment for survivors of trauma, cultural diversity needs to be acknowledged and this knowledge must be led by individuals who are culturally-informed (Quiros & Berger, 2015). Ways in which I suggest the SCDSB could ensure Indigenous child and family needs are being attended to in culturally competent ways would be to hire Indigenous school-based social workers and/or ask the child and family if they would like the Indigenous education workers included in the case conferences and planning of support. Additionally, to help with planning for Indigenous students, I suggest that the SCDSB would benefit from hiring Indigenous Knowledge Keepers. Importantly, the knowledge, perspectives, and recommendations of Indigenous Knowledge Keepers, Indigenous school-based social workers, and/or Indigenous education workers need to be held in high regard, as it would be for any Western professionals.

In another sense, the behavioural model can segregate, exclude, and punish children who have "behaviours", from everyone else (Costa, 2017; Slee, 2013). This leads to the "othering" of students (Arndt, Gibbons, & Fitzsimons, 2015), including those who may experience dysregulation due to hyperarousal as a result of trauma. For example, in order to better support the students who were having difficulty in cooperative play at recess which was resulting in altercations, some children were routinely kept inside during recess. It is typical for students who have experienced trauma to not be allowed to play or engage in peer-based social activities due to their behaviour (Costa, 2017). With staff supervision, these identified children gathered together inside to have a social break during lunch time and at recesses. On top of these social

breaks, a separate recess schedule was arranged for this group, so they could also have an opportunity to go outside. Although this arrangement was setup to maintain student safety and provide extra support for the students who were having difficulty self-regulating at recess, many of whom have experienced trauma, it resulted in segregation and *othering* amongst their peers. As a result, this group of students may be viewed as a club for bad kids by other students. This exclusion can lead children to feel unwanted (Nash et al., 2016) and reaffirm the common belief amongst children who have experienced trauma, that they are bad (Herman, 2015).

Furthermore, the behavioural model is a perspective that is focused on improving the deficits of an individual (Lanas & Brunila, 2019) and as a result, it may look for an explanation of these deficits in the form of formal diagnosis (Costa, 2017). When utilizing the behavioural model at school, children and families are blamed for the issues that are identified, as these issues are never considered to stem from school (Lanas & Brunila, 2019). Thus, when professionals work within a behavioural model it is associated with feelings of blame and inadequacy for the child it intends to support (Ardoin, Wagner, & Bangs, 2016). For example, a parent meeting was held to discuss the school's behavioural and developmental observations of a child, review the classroom supports that had been put in place for the student, and encourage the parent to arrange a doctor appointment for their child. Although it was acknowledged that the observations may be a result of the child experiencing a known traumatic event, the school considered the "deficits" important information for the parent to consult with a doctor about in order to rule out other concerns. This example supports the tendency acknowledged in the literature for schools to recommend that student survivors of trauma see a doctor to look into potential diagnoses due to their behaviour and difficulty with academic tasks (Costa, 2017). With the focus being on the deficits of the child, the parent appeared understandably overwhelmed and

emotional. Additionally, the parent likely felt blamed and judged as they reassured us that they were a good parent and trying to do the best they could to support their child's needs.

The above three examples that I experienced with the SCDSB depict how the behavioural model in schools can further harm child survivors of trauma. Through this reflection this model has been identified to be culturally incompetent (Malott, 2016), exclusionary (Costa, 2017; Slee, 2013), and deficit-focused (Lanas & Brunila, 2019). As such, the model does not support the empowerment of student and family strengths nor does it show any focus on attending to the needs of the child in order to recover from trauma; needs such as building safety and agency.

How School-Based Social Work Reflects the Behavioural Model

With the behavioural model being one of the primary models that was observed to be present in the schools, it is no surprise that at times school-based social workers can also reflect this model in their practice and can perpetuate the harm experienced by child survivors of trauma. Self-reflection is necessary for anti-oppressive practice (Isaksson & Sjöström, 2017) and of great importance for school-based social work practice. Although I observed few instances of student survivors being exposed to further harm as a result of the use of the behavioural model in school-based social work practice, it is important to reflect upon these examples in order to add to the literature that critically analyzes school-based social work practice and acknowledge the harm that can also be enacted in this profession.

Provided that school-based social workers do mental health promotion in schools by administering classroom programming, they can also reflect the behavioural model's strategies in classroom management. From my practice experience with the SCDSB, it seemed that school-based social workers were at times seen as another adult figure by staff and students. This put school-based social workers in an awkward position of acting as a partnering adult in the system

to fill an authority figure type-role. For example, I was observing while a school-based social worker provided an education session in a class that had recently experienced a distressing event. The classroom was unsettled and the supply teacher was trying to get the class to pay attention. The teacher asked me to walk around the classroom as a way to help them manage the room. I agreed to do this, and although I was mindful of my body language, I made sure to smile at the students when I walked by them, and I did not redirect any behaviour, I can acknowledge that in that moment I used my power as a representative of school-based social work in a harmful way towards children who had experienced trauma. Power used in this way, attempts to change behaviours from those that belong to the individual to those that reflect the norm (Lilja & Vinthagen, 2014). As a result, it works to teach the child to scrutinize, improve upon, and/or punish their own behaviour (Lilja & Vinthagen, 2014). In essence, when school-based social workers use their power to engage in the ideals of the behavioural model with students, including those who are survivors of trauma, we are using ourselves as a mechanism of power to create children into mechanisms of power that will progress societal goals (Lilja & Vinthagen, 2014). Under trauma theory, this is not meeting the needs of the child who has experienced trauma.

In a similar way, a school-based social worker can be seen as a mental health worker who can support a student's mental health needs with the underlying goal of changing their behaviours to be more appropriate for the classroom. This is likely supported by the idea that appropriate classroom behaviour translates into the child being more capable of learning, as it has been suggested that behavioural challenges at school impact a child's education (Bettencourt, Gross, Ho, & Perrin, 2018). In one instance, a teacher was experiencing difficulty with a student who was refusing to follow directions and refusing to go to the office. The teacher contacted the school-based social worker and I to come into the classroom to try and have the student leave the

classroom to talk with us. The student refused to leave the classroom or engage with us, however they stayed in the classroom without further escalation. The teacher asked that we talk with the school leadership and advocate for the student to be sent home. As such, the concerns were brought to the leadership's attention, who decided that it was in the student's best interest to be supported in-school. Although school-based social workers are sometimes seen as individuals who can be used to address student behaviour, engaging in this type of practice puts the school-based social worker in the position of serving the school as their client instead of the student (Gherardi & Whittlesey-Jerome, 2018). Filling this type of role likely decreases the sense of safety the child feels in relation to the school-based social worker.

Furthermore, sometimes the behavioural model infiltrates the school-based social work one-on-one sessions. For example, during a one-on-one session a student was refusing to participate in the activities and discussion, despite the school-based social worker trying to adapt the session to the student's interests. The education assistant (EA) was also in attendance to make the student more comfortable. The school-based social worker and EA developed a reinforcement plan that if the student was to engage in the session for a set amount of time then the EA would allow them to go to the relaxation room afterwards to use the iPad before returning to class. Although the intention behind utilizing behavioural strategies in session was to encourage the child to engage in therapeutic activities, this may counteract the safety relationship because a safe relationship includes survivor agency (van der Kolk, 2014) without the use of professional authority (Bath, 2015). Instead, the use of behavioural approaches in therapy persuades the child into complying with adult demands and likely encourages the child to think of therapy as something that has to be endured opposed to something that is enjoyable and therapeutic. Trauma-informed clinicians need to appreciate the importance of a therapeutic

relationship that makes space for building trust, breaking down judgment, and examining power (Becker-Blease, 2017). This includes considering these factors when attending to children who appear disengaged or oppositional in order to discover how engagement can be built (Becker-Blease, 2017).

In schools, there is a hidden curriculum that is made up of unspoken rules that pertain to the expected social functioning of students (Konieczka, 2013). These rules may not be explicitly taught, but it is assumed that these expectations are known by students (Konieczka, 2013). The intent of the hidden curriculum is to shape students into fitting the norms of economic society (Konieczka, 2013). Reflecting on the experiences shared above, when school-based social workers are looked at as another adult in the system and are asked to—or independently—use their power to assert authority with students to maintain the hidden curriculum it compromises their intended role. This affects a school-based social worker's ability to build rapport, create safety in their relationships with students, and understand student behaviours through the lens of trauma. Social workers need to be careful when engaging in behavioural modification strategies in schools, as it has been noted that reflection needs to be given to the root of these efforts (Lanas & Brunila, 2019). How we perceive and address behaviour can be political, and dominant cultural norms may be guiding our understanding of undesired behaviour (Lanas & Brunila, 2019). Thus, when addressing student behaviour, we risk harming students by having non-dominant cultural norms be at the root of what we are trying to supress (Lanas & Brunila, 2019).

Challenging the Pathologization of Behaviours using Trauma Theory

In order for a school to hold the trauma model as the primary model that is used to support children who have experienced trauma, school-based social workers must reflect on how trauma theory can be used to challenge the pathologization of behaviours of child survivors of

trauma on a systemic level as well as an independent level. On a systemic level, during my practicum experience I witnessed social justice advocacy when a school-based social worker challenged the systemic procedures that sought to pathologize the behaviours of students, many of whom had experienced trauma, in order to access school-based mental health services. The system in place required the identification of student behaviour as prerequisite for a referral to school-based mental health services. Although the majority of the schools were lenient with the language within the procedure, it did at times, act as a barrier for children to obtain support. The referral process established that the school leadership must receive a document filled out by the teacher identifying the behaviours of concern that warrant a referral for school-based mental health services. Following this, the document would be kept on the student's Ontario Student Record (OSR). I suggest that labelling behaviour on their OSR acts as a systemic way in which schools oppress and *other* children who have experienced trauma (Fleer & González Rey, 2017). If this process is followed then it is required that students need to have documented behavioural concerns, which labels children with deficits before they can be provided with support. Many of these children have likely been exposed to trauma. As we know, the impact of trauma can be expressed by children in internalized and externalized ways (Bloom, 2014a; Greeson et al., 2014; Herman, 2015; Music, 2014; Putnam, 2006; Teicher et al., 2017; Vasilevski & Tucker, 2016). However, students with externalized behaviours are more likely to be connected with mental health services (Splett et al., 2018) and pathologized with mental illnesses (Brunzell et al., 2015). By advocating for procedural change, the school-based social worker was working in a trauma-informed way by seeking to change the structural components that negatively impact students who have experienced trauma, identifying that this referral process blamed and pathologized children who may have been exposed to trauma and were expressing the impact in externalized

ways. Further, by advocating for this procedure to change, this school-based social worker was also identifying that children who have experienced trauma can express the impact of trauma in internalized ways (Greeson et al., 2014; Herman, 2015; Music, 2014; Teicher et al., 2017; Vasilevski & Tucker, 2016) and thus, would not "qualify" for a school-based mental health referral, despite their need of support being no less than children expressing externalized behaviours.

Additionally, I noticed that there were times in which the pathologizing of student behaviour needed to be challenged on an individual level, using trauma theory. Two different examples will be used to help depict how depathologizing student behaviours can be done through the understanding of trauma theory and how trauma influences child behaviours due to hyper- and hypoarousal (Bloom, 2014a; Wilkinson, 2017).

In the first example, I will discuss how defiant behaviour can be pathologized in schools and challenged with trauma theory. During my practicum experience, a referral that was received indicated a need for counselling services based on defiant behaviour in class. The referral specified that the student was not following the direction of the teacher on how to complete the assigned work and the student walked out of the classroom without permission. This referral supports what has been found in the literature about the tendency for student's behaviours to be pathologized when they are defiant towards their teacher (Lanas & Brunila, 2019). The school-based social worker connected with the referral source in order to obtain a more complete view of why the child was being referred for services. Psychoeducation was provided to the staff involved as it was understood by the school-based social worker that students can be labeled pathologically based on their behaviour, which may be a response to challenges from the unequal power within the student-teacher relationship and/or structural and societal factors (Lanas &

Brunila, 2019). The school-based social worker provided education about the influence of trauma on behaviour. Additionally, they encouraged staff to consider the influencing factors in the child's life that may be leading to the challenges in class. The school-based social worker suggested that the child may benefit from support to help in the process of recovery from trauma, instead of behavioural management concerns. Knowing that behaviours that could be considered challenging function as a safeguard for children (Nash et al., 2016) when they are feeling unsafe (Bloom, 2014a), we can argue that defiance in the classroom may actually be in the children's best interest. The lack of control the student in this example may have felt could have led them to feel insecure and unsafe. An environment that nurtures choice and control is important for children who have experienced trauma (Perry & Daniels, 2016). Conversely, the power and behaviours that were exercised by the teacher in this example likely acted as a trauma trigger and made the child feel unsafe in the relationship which may have resulted in the fight-flight-freeze response being biologically activated in order to maintain the child's safety (Bloom, 2014a; Crosby et al., 2016). In order to build a safe relationship between student and teacher, teachers needs to work to mitigate power imbalance (Carello & Butler, 2015; Wolpow et al., 2009).

The second example illustrates how trauma theory can also help challenge the tendency to assume that a student has a mental illness based on their behaviours. In a school setting, staff may be concerned with the behaviours that they see children portray and draw conclusions that these behaviours are due to an underlying mental illness (Tishelman, Haney, Greenwald O'Brien, & Blaustein, 2010). For example, during my practicum experience a number of school staff were concerned with the behaviours of a student and had particular concern with the student's eating habits. A referral had been submitted for this student to meet with the school-based social worker. As mentioned in the literature, school staff approached the school-based

social worker in order to express their concern about the child's behaviour (Tishelman et al., 2010). Though it may not be recognized, consults of this nature can lead to informal assessments (Tishelman et al., 2010). In this example, the teacher and other support staff were concerned that the behaviours being expressed were the result of a serious mental illness. Having the awareness of trauma theory, the school-based social worker was able to challenge the use of diagnostic labels for what was being observed. The school-based social worker was able to educate the staff during the conversations on ways in which trauma can impact a child, one of which being changes in eating habits (Bloom, 2014a; Breland, Donalson, Dinh, & Maguen, 2018; Herman, 2015; Trottier & MacDonald, 2017). I suggest that trauma theory can be used to challenge the classification of "disordered" eating through the theory's understanding of hyper- and hypoarousal. It has been suggested that experiencing a lack of control and intrusive negative thoughts can result in disordered eating (Trottier & MacDonald, 2017). Understanding that hyper- and hypoarousal plays a part in the experience of dysregulation (Bloom, 2014a; Wilkinson, 2017) we can present an alternative explanation that eating habits can change as a result of the dysregulation experienced as a result of the trauma.

Based on the information discussed, trauma theory appears to be a powerful tool that can be used to challenge the pathologization of behaviour that student survivors face in a school setting. Along with challenging the need for labels, it can be used to examine systemic structures and decrease barriers in accessing school-based mental health support. This can be done by appreciating that children can express the impact of trauma in both externalized and internalized ways (Bloom, 2014a; Greeson et al., 2014; Herman, 2015; Music, 2014; Putnam, 2006; Teicher et al., 2017; Vasilevski & Tucker, 2016). Further, using trauma theory on an individual basis can depathologize students who are being negatively labelled for defiant behaviours that are typical

and helpful in maintaining their own safety during times when they feel unsafe and or when their self-determination is violated (Bloom, 2014a; Carello & Butler, 2015; Nash et al., 2016; Perry & Daniels, 2016). Lastly, trauma theory can also challenge the tendency for students to be informally labeled with psychopathology by school-based staff due to their behaviour (Tishelman et al., 2010) through understanding the affects hyper- and hypoarousal have on behaviour (Bloom, 2014a; Wilkinson, 2017).

Microaggressions in a School Setting and Trauma

To further understand the oppression that students who are survivors of trauma face within schools it is important to consider microaggressions that they can experience within the system. As previously discussed, the experience of childhood trauma is associated with structures of oppression such as sexism (Easton et al., 2014; Herman, 2015; Thoresen et al., 2015), heterosexism (Clements-Nolle et al., 2018; D'haese et al., 2016), colonialism (Haskell & Randall, 2009), ageism (Westman, 2019), and classism (Lefebvre et al., 2017). Being exposed to these structures of oppression can be traumatizing by themselves (Wilkin & Hillock, 2014); however, children who are oppressed within these structures are also at a greater risk of experiencing childhood trauma (Clements-Nolle et al., 2018; Haskell & Randall, 2009; Herman, 2015; Lefebvre et al., 2017). Compounding the harm that results from a child experiencing trauma, are the microaggressions that some student survivors can face. During my practice experience a few of the microaggressions I noticed were colourblindness, microinvalidations, and undersexualization.

Indigenous culture is acknowledged and celebrated in many ways in the Sudbury Catholic District School Board (SCDSB) schools through a daily land acknowledgement during morning announcements, the Canadian anthem routinely played in Ojibwe, Indigenous teachings provided

to all students by the Indigenous Education department staff, Indigenous art and artifacts present in some schools, and the Ojibwe language course that is offered in some of the schools. However, paternalistic colourblindness was also observed in which it was thought that the dominant culture could help the non-dominant racial students (Matias & Lious, 2015). As previously noted, colourblindness happens when race is not recognized (Matias & Liou, 2015). Thus, the lived experiences of individuals who belong to racial minority groups are considered to be unrelated to race or unaccepted within the dominant discourse (Matias & Liou, 2015). Despite colourblindness not acknowledging racial differences it views individuals from racial minority groups as needing help from the dominant culture (Matias & Liou, 2015). The beliefs that individuals of privileged identities hold about themselves—that they act out of logic and they are not prejudice—rationalizes instance of microaggressions (Sue et al., 2007). As such, microaggressions conceal racism (Sue et al., 2007). One way colourblindness is carried out is through the supportive practices of schools being grounded in the dominant White culture (Blitz et al., 2016). Without critical analysis, such efforts of "support" may appear helpful. However, the needs and lived experience of individuals who belong to racial minority groups are unique to that of White culture (Blitz et al., 2016). Therefore, when dominant cultural norms are held as the standard measure of "equality" in care then students belonging to racial minority groups may be subjected to unequitable treatment (Blitz et al., 2016) based on their needs and experiences. This was seen in the example previously discussed in this chapter (see the subheading titled, "The behavioural model" for more detail) in which an Indigenous child and family was being supported through behavioural therapy services. The support being provided was grounded in the dominant discourse, with the microaggressive messaging being that the dominant cultural practices could help the student without recognition of the effectiveness and relevance of

Indigenous knowledge, culture, and supports. Although staff may endorse the idea that every student is treated the same, the definition they hold of what equality means is measured against the benchmark of the dominant society (Blitz et al., 2016). This creates a home for the silent presence of systemic racism towards marginalized children, adding to the aggressive acts children who are survivors of trauma endure.

In regards to microaggressions experienced by lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) youth, during my practicum experience, I noticed the presence of microinvalidations. The aggressions of microinvalidations are acted out by minimizing the reality of the oppressive experiences that LGBTQ individuals face or failing to recognize them at all (Munro et al., 2019). Within the SCDSB, the presence of LGBTQ students and space lay silent and invisible in a number of ways, such as the absence of an LGBTQ peer and ally group within the schools or invalidating the idea that one should exist (Munro et al., 2019). Additionally, undersexualization appears present in the way of a “don’t ask, don’t tell” (Platt & Lenzen, 2013, p. 1024) mentality within the system culture. Although LGBTQ students could talk openly in sessions with school-based social workers, there did not seem to be another venue for such expression, belonging, and acceptance. Despite the SCDSB teaching staff being very supportive of their students, and my assumption that many would be welcoming and supportive of LGBTQ students, the microinvalidations and undersexualization that exists in the SCDSB are acts of aggression towards LGBTQ students, and causes further harm to student survivors of trauma who identify as LGBTQ. The presence of these microaggressions in the SCDSB could be related to the religious orientation of the organization and the heterosexism that can be associated with such beliefs (Moore, 2017).

Appreciating the increased rate of trauma exposure for sexual minority (Clements-Nolle et al., 2018) and Indigenous children (Haskell & Randall, 2009) it is important that the school setting is not adding to the oppression and harm of these children through systemic microaggressions. Microaggressions can lead sexual minority children to feel unseen (Munro et al., 2019) which may convey to them that this part of their identity is bad. This is in opposition to what trauma theory requires from a school environment. Instead, trauma-informed schools see their students and learn about who they are (van der Kolk, 2014). Furthermore, to truly attain racial equality, where the differences in experience and need based on race are acknowledged and the unique requirements of each student in the school community are met, it is also important to appreciate and celebrate the cultural diversity of students (Blitz et al., 2016). To me, this means incorporating the different ways children identify themselves in various areas of their life, such as practices and beliefs, how they find belonging, and what experiences they have. Culturally-informed individuals need to be leading in the educational system (Quiros & Berger, 2015). Without this, retraumatization of racial minority children, and more specifically Indigenous children, can occur (Quiros & Berger, 2015).

Although I identified only a few instances of microaggressions while with the SCDSB, it is likely that because I hold many privileged identities, numerous instances of microaggressions went unrecognized. One reason for this could be that individuals who have privileged identities are often blind to the presence of systemic oppressions that individuals from marginalized groups face. Further, the systemic oppressions that exist within the dominant culture cater to my privilege identities and thus are seen as something I, and other people who share the same privilege(s), look at as normal. However, by utilizing a critical anti-oppressive view we can

identify the importance of recognizing and understanding how microaggressions impact student survivors of trauma at school.

Trauma-Informed Professional Development for Teachers

My agency supervisor and I agreed that I would create a trauma-informed PowerPoint presentation that I would present to teachers at each of the four schools in which we worked. A lunch-and-learn was scheduled at each school in order to accommodate teachers being able to attend during their lunch break. The lunch-and-learns were voluntary and they were held in a common area of each school, such as a library or a learning lounge. The presentations were purposefully not held in the lunch rooms so that I did not interfere with the teachers' ability to use their lunch break area and so they would not feel obligated to attend because I was presenting in the room where they were eating lunch.

Preparing the professional development sessions. During my time with the Sudbury Catholic District School Board (SCDSB) I was able to connect with teachers from various schools and informally talk about teaching today's students. In general, teachers seemed to recognize the gravity of trauma within their classrooms. As the literature supports, they identified trauma as being something that was a significant barrier to their ability to teach (Brunzell, Stokes, & Waters, 2018). I had a few informal discussions with teachers to determine what they would be interested in learning about, in effort to make the material relevant to their needs and interests. Some expressed that any information would be great to hear, even if they may have heard it before. Others thought it would be helpful to learn about the warning signs that they could look for, which may help them in identifying students who may have experienced trauma. Commonly, teachers wanted to know what they could do to support the students in their classrooms who may be survivors of trauma. Additionally, there was some interest in being

informed about the services that are available in the Sudbury community for supporting children who have experienced trauma. As such, these elements were incorporated into the lunch-and-learn presentation.

A review of the literature was done to accumulate information about trauma that would be relevant for a school-based setting. Some of the literature materials used were provided to me by my agency supervisor. The literature guided the development of the presentation based on what it suggested to be critical in trauma-informed professional development and for creating trauma-informed workplaces, systems, schools, and teaching practices. As such, the content focused on providing education on the influence trauma has on children and groups, on the brain and learning, common warning signs of trauma exposure, the importance of making trauma-informed knowledge part of the system, how classrooms and teachers can support student survivors, the importance of becoming aware of and mitigating triggers, and community resources (Cole, Eisner, Gregory, & Ristuccia, 2013; Cole et al., 2009; Crosby, 2015; Iachini et al., 2016; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014). The information was summarized into a PowerPoint presentation (see Appendix A for the presentation slides) along with a resource pamphlet (see Appendix B for the resource pamphlet) which was provided to attendees at the sessions.

Advertising for the lunch-and-learns was done various ways in order to inform teachers about the session. Each school had the professional development session marked on their staff calendar so staff were aware in advance. I created an advertising flyer (see Appendix C for the advertising flyer) that provided information on where and when the lunch-and-learn would be taking place and what information would be discussed at the session. The flyers were printed and left on the lunch room tables a week before the session was being held at the prospective school.

As well, a reminder about the session was provided to teachers via morning announcements on the day of the scheduled lunch-and-learn.

Presenting the professional development sessions. The four professional development sessions were presented on April 16, April 25, May 1, and May 6, 2019. Each lunch-and-learn presentation was 30 minutes long. The presentation started with a land acknowledgement and the importance of doing so was explained in relation to how historical trauma continues to impact Indigenous students in schools today in terms of the increased rate of trauma and discrimination that they face (Bombay & Anisman, 2009; Bombay et al., 2014; Clark, 2016; Gone, 2013; Haskell & Randall, 2009; Matheson et al., 2019). Other topics covered in the presentation were defining trauma, causes of trauma, the impact of early trauma on brain development, the impact of trauma on a child's regulation, how trauma can affect students in school, what teachers may notice in children who have experienced trauma, trauma-informed classroom strategies, and community resources available in Sudbury for children who have experienced trauma.

Although the attendance was low, the presentation appeared to be well received by the attendees. The attendees seemed eager to learn more about how they could support student survivors of trauma in their classrooms. Most had some prior knowledge on trauma information and were already implementing some of the trauma-informed practices, such as posting visual schedules, assisting students in labelling emotions, creating safe spaces in their classrooms, and building genuine relationships with their students. Teachers seemed to be aware that they were the primary safe person for some of their students and they appeared to understand and appreciate the significance of this role. Through the discussions that were had during the sessions, it was evident that caring for students provided meaning to their work as teachers. Teachers recognized that supporting the emotional wellness of their students is just as, or more

important than academic learning. However, teachers also identified that it is challenging for them to distinguish behaviour from trauma and the internal struggle of whether they should be implementing behaviour management strategies or trauma-informed practices in various situations. The literature identifies that it is common for teachers to find it difficult in juggling their teaching responsibilities with the emotional needs of student survivors in their classrooms (Brunzell et al., 2018), which was also supported by the staff discussions within the professional development sessions.

While presenting the material, I was very mindful that I did not want to sound like I was coming from a place of expertise, blame, or judgement. Knowing that teachers often have much of the capacity to support student survivors in their classrooms prior to trauma-informed professional development (Cole et al., 2009), I tried to promote and highlight the preestablished skills and strengths of teachers throughout the presentation. Additionally, I would build off of these strengths to further address how trauma-informed practices could be integrated into their already established strengths. For example, I highlighted the strength of many teachers in creating visual schedules in their classrooms to help support children through transition times. Through this example, I not only commended their skills in supporting students in this way, but I also took the opportunity to educate on the importance of predictability for children who have experienced trauma and how teachers can support students who have experienced trauma by identifying when a change in the routine will occur and teaching children to develop the skill of prediction (Wright & Ryan, 2014). This could possibly be done by informing the student about environmental cues that may indicate a transition will soon occur, such as when the teacher starts collecting the worksheets from students who are done their work.

Time was provided for discussion at the end of the presentation, however, given the time allotted during lunch the discussion time was limited. Attendees seemed to have a lot of interest in this area and were engaged in discussions about how they saw the impacts of trauma in their classroom and in brainstorming trauma-informed practices that they could try. I think it would be very valuable to have more time to accommodate discussions about childhood trauma and trauma-informed practices in schools. Providing teachers with space and time for discussions surrounding this content would likely be helpful in promoting a trauma-informed culture within the schools. The trauma-informed presentation that I developed for this lunch-and-learn was mainly psychoeducational. Based on the literature suggesting that professional development goals should be directed by teachers themselves (Patton, Parker, & Neutzling, 2012), at the beginning of each presentation I asked what the teachers were hoping to learn more about in regards to trauma, so I may be able to speak to those areas in the presentation. However, much of the participant input at the beginning of the presentation was reserved. If I was to do it again, I would have made more space in the presentation for exploring discussion questions and allowing more opportunity for teachers to guide the topics and reflective discussions. This modification is suggested because I recognized the value of the content covered in the short discussion time and according to some of the pertinent findings from a systematic review on professional development for teachers, learning must be self-directed, interactive, encourage professional partnerships to work towards systemic change, build understanding and teaching practices, and be led in a supportive way that allows for autonomy (Patton, Parker, & Tannehill, 2015). One benefit to presenting the material as I did, was that it appeared that providing psychoeducational information prompted teachers' discussions and inquisitions around the content. As such, I suggest that psychoeducational content be provided in a way that supports autonomy and

develops skill and knowledge while enhancing professional development through incorporating elements of self-direction, interaction, and partnership.

Attendance of the professional development sessions. Despite my best efforts in promoting and creating the lunch-and-learn presentation, the sessions were not well attended. The first session did not have any attendees, the second session had three attendees, and the third and fourth sessions had one attendee each. In response to the low turnout, the principals all agreed to distribute the lunch-and-learn brochure via email so that some of the information was being provided to their staff. Upon reflection there are a few things I would change in order to try and increase the attendance. For example, engaging face-to-face with more teachers about the lunch-and-learn in the weeks leading up to the session may have increased the interest in attending. Additionally, it may have been helpful to collect more input from teachers about the information that they were interested in learning.

Furthermore, structural components likely played a part in the low attendance. As teachers have reported to me as well as in the literature, their work days are chaotic and overloaded with duties (Skaalvik & Skaalvik, 2015) and they may need their lunch break to recharge before having to go back into the classroom. From my experience, many teachers used their lunch break to go for a walk or work out, which is supported by the literature. For example, Wessels and Wood (2019) indicate that physical activity helps improve the wellness of teachers. Thus, hosting a professional development session during their break may not be conducive to the wellness needs of teachers. Furthermore, compensation was not provided by the schools for teachers who attended professional development sessions over their lunch break. Although one school entered the attendees' names into a draw each time they engaged in a professional development activity throughout the year for a chance to win a small prize at the end of the year,

it was likely not incentive enough for teachers to give up their lunch break. Additionally, some teachers informed me that they were unable to make the professional development lunch-and-learn because they had school-based extracurricular commitments that they volunteered their time to over the lunch break. Given that the sessions were being held late in the school year it is also likely that teachers were becoming worn out from the school year. Lastly, at the time stress levels were very high in the schools as a result of many Ontario teachers experiencing job loss following the change in the provincial government. With teaching jobs being cut and threatened, attending a professional development session was likely the least of many teachers' concerns given that as of May 2, 2019 the SCDSB had provided 23 teachers with notice that their jobs were being eliminated (Ulrichsen, 2019).

Critical Analysis of Supporting Child Survivors in a School Setting

Acknowledging that I have an educational background and work history grounded in the behavioural model, I have done a lot of reflection this year on whether this model can be used to support child survivors of trauma in schools, and if so, how? Costa (2017) recognized that the idea of how a school system could support children without the use of a behavioural perspective is a difficult concept to imagine because the systems and culture that have been built caters to this discourse instead of more emotionally and neurologically responsive models such as the trauma model. After deep reflection into my personal biases, which both support and refute this model's ability to assist individuals, the knowledge I have about the behavioural model and practices used to support children who have been exposed to trauma, along with the literature in the field, my overall consensus is that despite the good intentions of many of its users, the behavioural model acts as the primary model used by the Sudbury Catholic District School Board (SCDSB) that further harms children who have experienced trauma. With that said, I want

to distinguish what I mean when I talk about the behavioural model, because I also acknowledge that some trauma-informed practices, although they may not identify as such, have behavioural principles within them. One example of this is modifying the environment to be more supportive to children. As I reflect on the behavioural model, I am reflecting on the collective idea of the behavioural model which supports the operationalization (Armstrong, 2019), observation, assessment (Bal, 2018), behaviour-based intervention (Bal, 2018; Costa, 2017), and pathologization of children's behaviours (Costa, 2017) that diverge from what are considered to be desirable (Bal, 2018). All of which seems to be done without considering the influence that trauma and societal structures have on a child.

At the crux of the behavioural model is the ability to manage behaviour (Costa, 2017). In my opinion, using behavioural management for child survivors of trauma can be very damaging to the ability to form a safe and trusting relationship between the child and the school-based social worker or supporting adult. When I reflect on how this model relates to the trauma model/theory, I cannot help but conclude that the behavioural model is oppressive and detrimental to the relationship between the child and the school-based social worker or supporting adult. My thought process in reaching this conclusion is that behaviour management tries to overthrow a child's innate drive and ability to protect themselves from trauma, trauma triggers, and the people—adults in particular—who may threaten their safety. The very behaviours we seek to eliminate could be the very behaviours they need for ensuring their protection (Wright, 2017). When implementing behavioural management strategies aimed to decrease behaviours as a result of hyper- or hypoarousal, we are suppressing the child's voice or their actions that function to stand up for themselves, protect themselves, keep themselves safe, and maintain their power, dignity, and control during and following trauma. This ability is

something I have termed as “threat intelligence”: the refined superpower of their brain and body to detect, protect, and pursue (Costa, 2017) in the face of threat and/or trauma. Not acknowledging the threat intelligence of a child survivor and instead teaching children to “obey” under the hidden curriculum is dangerous. The hidden curriculum that expects students to follow unspoken rules of normative social behaviour (Konieczka, 2013) furthers the harm experienced by child survivors. The behavioural model does not empower child survivors, provide them with a sense of safety with adults, or support their protective disobedience (Costa, 2017). Instead, I argue that it teaches children that they will continue to be dominated in relationships instead of protected. What plays a role in this dominance is the hierarchical value that is assigned to school staff and students based on the discrepancy in age, experience, and position (Snir, 2016) which relates to the experience of ageism (Mullaly & West, 2018). What comes with this, is the doctrine that adults are superior to children within the Westernized hierarchical view of the adult-child relationship (Snir, 2016), which can be seen in the Western education system today. Within the Western education system, students are viewed as being less informed and therefore less capable of, and entitled to, self-determination (Snir, 2016). This assigns roles to adults and students within the Western education system and it dictates and enforces the adult definition of meaningful and valuable knowledge and how this knowledge is acquired (Snir, 2016). In my opinion, this arrangement will never allow for healing because a child who has experienced trauma needs safety (Herman, 2015); domination will never feel safe. For these reasons, I do not believe the behavioural model fits within the trauma model, as building safety and trust is not at the center of its existence.

Recognizing that I do not believe the behavioural model has a place in the trauma model, I appreciate that structurally the Western school system, which exists within a neoliberal

paradigm, will have difficulty expelling the behavioural model from its functioning. The education model expects and requires the production of work from students, such as completing assignments, attaining grades, and performing on the standardized Education Quality and Accountability Office (EQUAO) testing (MacDonald-Vemic & Portelli, 2018). The behavioural model, within a neoliberal perspective is used to mold child behaviour into something that will fit into and contribute to the economic market (Arndt et al., 2015; Marshall, 1996). Therefore, students who jeopardize this goal, due to disruptive behaviours, are at risk of being segregated (Armstrong, 2019). Arndt et al. (2015) suggested that behaviour management is used to preserve the economy through cultivating desired behaviours in children.

Additionally, school-based social workers also play a role in the harm of child survivors of trauma through the use of the behavioural model. One reason that could contribute to school-based social workers falling into supporting such a model that perpetuates harm is the current landscape of their work. School-based social workers report that one aspect of their job that makes it challenging to fulfill the role to the extent at which they would like to is that they are often providing social work services to more than one school (Phillippo, Kelly, Shayman, & Frey, 2017). This finding is accurate to my experience as a school-based social work student and it leads me to consider how the systemic constraints of having a large caseload across different sites guides school-based social workers to endorse behavioural aspects into their work as a means to meet the demands of their job quickly. Similar to the way that the neoliberal paradigm within the school system requires production from students (MacDonald-Vemic & Portelli, 2018), it also demands production from school-based social workers. However, I would suggest that the production of school-based social workers is measured in the “treatment” of students. As such, the school system nurtures a production-line type of treatment system which requires the

performance from school-based social workers and children. The pressure to support such a large caseload within the constraints of the school system may lead to school-based social workers incorporating the behavioural model into their practice in order to meet the demands of the job by encouraging the students in meeting the goals, within the allotted time. Based on the demands of their job and the unpredictable nature of school-based social work, clinicians have reported that in order to function in their job they have to be clear about what they see their job as entailing and tackle items in order of importance (Phillippo et al., 2017). This could include school-based social workers considering whether their practice will include the behavioural model or whether this is something they will challenge within their practice.

Not everyone is going to agree with the idea of removing punitive behavioural measures from the education structure (Walkley & Cox, 2013) to be replaced by an anti-oppressive trauma-informed approach. Based on my practicum experience, I speculate that the majority of school staff would not believe that it is possible for the education system to move away from the behavioural model entirely. One reason I suspect that this would be the overall consensus is because school staff may feel that the behavioural model, and the behavioural management strategies it offers, is necessary for them to be able to support the number of children they do, given the limited resources that they have. It is likely that school staff rely on the behavioural model to provide structure and organization for the large number of students they support while also helping them meet their employment objectives and providing services to students (education, mental health support, etc.). Based on my practicum experience, I presume that many school staff are not aware of the ambitions of the behavioural model or the harm that the behavioural model can have on students, including those who are survivors of trauma. In my experience, school staff wanted to support their students and did so using the approaches that

were known to them and that they believed were in the best interest of the child. However, I suggest that it is important that school staff examine the foundations of both the behavioural model and the trauma model in order to make a better-informed decision on their practice approach. Despite the prevailing acceptance of the behavioural model in the education system, school staff need to be aware that by using behavioural practices they are supporting the hidden curriculum.

Although replacing the behavioural model with the trauma model poses a challenging task given its dominance in the education system, I believe it is possible and that the change has already begun to happen. I suspect that as our Western neoliberal society becomes more trauma-aware, there will be a stronger push towards using the trauma model in schools instead of the behavioural model, as it will be acknowledged as the best way to maintain the future economy. Despite my intentions of wanting to change the education system in order to better support child survivors of trauma and help them heal, I am aware that the widespread change may come from the desire and power of the neoliberal Western economy.

In order for schools to adopt a trauma-informed model it is necessary that there is buy-in from all parties involved, and particularly important is the investment of the school leadership (Walkley & Cox, 2013; Wiest-Stevenson & Lee, 2016). Through the examples discussed in this reflection chapter on the use of the trauma model including trauma-informed practices (TIPs,) and the multi-tiered system of support framework, and challenging the pathologization of behaviours in students who have experienced trauma, it appears that progress is being made towards becoming more trauma-informed in the Sudbury Catholic District School Board (SCDSB). Given the current political climate under a conservative provincial government, one of the threats I see to this model truly taking off is the lack of resources in the system to aid teachers

in supporting the individualized needs of students (Skaalvik & Skaalvik, 2015), as well as the limited mental health resources, including school-based social work professionals. However, it has been said that the culture of a school system can be therapeutic (Wang & Degol, 2016), and that is what every school has control of no matter who is in the political office. Nurturing a trauma-informed culture within schools would provide children who have been exposed to trauma, and every other child, with a supportive space to learn (Cole et al., 2013).

Summary

This chapter explores my insights into my practicum experience as it relates to my role as a school-based social work student, the questions that guided me through to the end of my practicum and into this explorative paper and how I sought the answer to these questions, my goals during my practicum experience and how I was able to achieve these goals, and my experience with clinical supervision. Through the use of my practice experiences with the Sudbury Catholic District School Board (SCDSB), the trauma model and trauma-informed practices (TIPS) is identified as one of the primary models used within the schools to support child survivors of trauma through the use of supportive classroom equipment, trauma-informed teaching, and relaxation rooms. Additionally, the multi-tiered system of support framework is also identified as a primary model that is used to support child survivors of trauma in schools through utilizing trauma-informed promotion, prevention, and intervention strategies. The behavioural model is identified as the primary model that functions to further harm child survivors of trauma in schools through the interventions relying on the dominant discourses of Western society, the segregation and *othering* of children, and its focus on deficits. Moreover, a critical look at school-based social work suggests that the behavioural model at times impacted clinical practice through filling an authority-figure role, acting as a support to teachers who

request school-based social work services for behavioural concerns, and enlisting behavioural strategies to engage children in one-on-one sessions. A discussion explores how the pathologization of student behaviour could be challenged using trauma-theory on a systemic level through social justice advocacy, and on an individual level through psychoeducation for staff through learning the influence of the fight-flight-freeze response and hyper- and hypoarousal on behaviour. Further attention is paid to the microaggressions that were observed during my practicum experience, such as colourblindness, microinvalidations, and undersexualization which oppresses and compounds the harm experienced by child survivors of trauma who identify as a sexual minority and/or who are Indigenous. This chapter also explores my experience creating and presenting the trauma-informed professional development lunch-and-learn sessions for teachers, which was the intervention provided during this practicum. Reflective consideration is given to the limited attendance at the professional development sessions. Lastly, I provide a detailed summary on my position to these issues and how they have impact on school-based social work practice, school culture, and child survivors.

Chapter 4: Conclusion

After completing my practicum with the Sudbury Catholic District School Board (SCDSB) working as a school-based social work student and exploring my initial questions on what trauma-informed practices (TIPs) and primary models are used by the SCDSB to inform their practice in supporting students who have been exposed to trauma; to what extent school-based social work in this setting reflect certain models that function to further harm student survivors, such as the behavioural model, and its relationship to understanding student experiences through the lens of trauma; and how trauma theory could be used to establish alternatives to pathologization in regards to children within schools who have experienced trauma; I am left with the simple yet complex question – now what? The exploration of these question in the previous chapter brought about some answers; however, further thought into what implications these answers bring to light need to also be considered. The concluding chapter will address the implications for school-based social work practice and schools.

Implications for School-Based Social Work Practice

After considering everything that has been discussed within this paper, it should come as no surprise that I argue that advocacy for social justice needs to be the crux of school-based social work practice in order to support child survivors of trauma while they are at school. Although Briggs (2013) wrote about school-based psychologists, the following information that is presented is easily transferrable and, in my opinion, critical to school-based social work practice. Briggs (2013) argued that working within the multi-tiered system of support framework, school-based social workers can effect change in pursuit of egalitarianism by not only advocating for students on an individual level, but also pushing for structural developments and introducing clinical expansions. This is an important aspect of school-based social work

practice because children who have experienced trauma can benefit from positive changes being made to the components of the education system, including its operations, guidelines, and processes (Crosby, 2015). In order to ensure the continuous pursuit for social justice within the school system, Briggs (2013) suggests that a fourth tier be added into the multi-tiered system of support framework called “tier zero”. The aim of this tier would be to make progress in areas of social justice by acting upon political and judicial realms (Briggs, 2013). I would agree with Briggs’ (2013) recommendation, as the macro level social justice piece is something that seems to be missing in the school-based social work practice. This is likely because the multi-tiered system of support framework, as it stands right now, does not cover such tasks within roles of mental health staff, including school-based social workers. Anti-oppressive trauma-informed school-based social workers must remember that the structural systems within society oppress already marginalized individuals. Thus, society outside of the education system has direct influence on the children within the education system who have experienced trauma. The challenging living conditions faced by marginalized adults in our community, are the same conditions their children are living in (Bettencourt et al., 2018). Therefore, Bettencourt et al. (2018) highlighted that the experience of poverty, precarious housing, dangerous living areas, and stress are impacting children who are coming to school. School-based social workers must not forget that advocating for macro-level change is an important part of their professional practice (Gherardi & Whittlesey-Jerome, 2018). In this way, Gherardi and Whittlesey-Jerome (2018) suggested that school-based social workers should consider themselves to work “with” the school, not “for” the school.

Additionally, when working on a multidisciplinary team in health care, Ambrose-Miller and Ashcroft (2016) identified that it is necessary for social workers to determine how they

define themselves as a social work professional, which I suggest is also important for school-based social workers. Considering the mix of perspectives that multidisciplinary teams bring to coworking relationships, navigating working relationships can be a complex matter. As such, school-based social workers may find it challenging when their ideals and practices do not align with the members on their team who come from other disciplines (Ambrose-Miller & Ashcroft, 2016). Ambrose-Miller and Ashcroft (2016) noted that working relationships can be especially hard when the social worker sides with the individual they serve instead of their team members, which can result in turmoil between staff (Isaksson & Sjöström, 2017). I can appreciate how relationships between school-based social workers and other school staff from various disciplinary backgrounds, working within a Westernized school system, can create challenges. In my opinion this can be of particular difficulty when there is a discrepancy in perspectives between school staff endorsing the trauma model versus the behavioural model when handling a situation with a student. My reasoning for this is because the values, application, and outcome of these two models are so different, with the former being focused on creating safety and agency (Bath, 2015; Carello & Butler, 2015; Dorado et al., 2016; Herman, 2015; van der Kolk, 2014) where the latter is focused on management of undesired behaviours (Armstrong, 2019; Costa, 2017). This means that school-based social workers need to be able to effectively navigate coworking relationships despite the possibility of conflicting views while appreciating and understanding that their guiding ethics as a social work professional requires that they put the needs of the individual(s) that they are working with at the forefront of their practice (OCSWSSW, 2018). Thus, school-based social workers need to continuously recommit to advocating for the good of the student body and the support of child survivors of trauma, despite the challenges that may arise from working within a multidisciplinary setting.

Implications for Schools

The literature in the field acknowledges the momentous impact schools can have on a child's recovery from trauma (Bath, 2015; Costa, 2017; van der Kolk, 2014). Moving a school system towards a trauma-informed culture requires more than just the commitment of school-based social workers. This process requires a school-wide effort from all parties involved. It has been suggested that awareness is essential when trying to make the school staff, the school environment, and the practices more trauma-informed (Crosby et al., 2016). This requires school staff to introspect on how they view and respond to the conduct of students in their classrooms and how much they know about the influence of trauma on children (Crosby et al., 2016). This introspection also needs to be done on an organizational level, in which consideration is given to the domination of the behavioural model (Krapfl, 2016) and how this impacts children who have been exposed to trauma. In order to infuse a trauma-informed perspective into schools the employees need to be educated on trauma (Crosby, 2015). Creating a culture which is trauma informed would support the whole student body as well as staff (Cavanaugh, 2016; Cole et al., 2013; Costa, 2017).

With the behavioural model being identified in this paper as the primary model used within the SCDSB that further harms children who have experienced trauma, a shift away from this model is needed. Disciplinary methods of the behavioural model further harms students who have experienced trauma (Baroni et al., 2016). The segregation, othering, and pathologizing of child survivors of trauma within the school system that occurs as a result of the behavioural model is less than what child survivors need and deserve. Through the continued use of the behavioural model children are put at risk of being retraumatized and/or unsupported by the education system (Costa, 2017). Instead, providing supportive measures in schools for children

who have experienced trauma can build relationships, keep them in school, and teach them to self-regulate (Baroni et al., 2016).

In effort to support moving away from using the behavioural model in schools, it is suggested that schools adopt a system-wide trauma-informed program. As the mental health programming in the education system is offered within the multi-tiered system of support framework, it is recommended that each level of the multi-tiered system of support framework (promotion, prevention, and intervention) is trauma-informed. Adopting a trauma-informed system-wide program that fits into the multi-tiered system of support framework may provide school staff with a greater sense of guidance during such a transition. Programs such as HEARTS and REWIRE could be beneficial options for guiding schools in becoming trauma-informed in order to better support children at school who are survivors of trauma. The benefits of these programs are that they have been created for the school system to be able to function with the multi-tiered system of support framework, they provide trauma-informed support to students and staff, they build self-regulation in students, and they incorporate trauma-informed professional development, among other supporting elements (Costa, 2017; Dorado et al., 2016).

Concluding Thoughts

Throughout this paper, which evolved from my practicum experience with the Sudbury Catholic District School Board (SCDSB), I have explored the area of childhood trauma as it relates to a school setting and school-based social work practice. What I discovered through this exploration was that the SCDSB does a wonderful job at supporting students who have experienced trauma within their schools through the utilization of the trauma model including trauma-informed practices (TIPs) and the multi-tiered system of support framework as their primary models of support for students who have experienced trauma. The trauma model was

evident within the system through the use of supportive classroom equipment, trauma-informed teaching, and relaxation rooms. The multi-tiered system of support model was identified as an additional primary model of support for students who have experienced trauma through the use of trauma-informed promotion, prevention, and intervention strategies that are performed by the mental health team, including the school-based social workers. However, reflection on the multi-tiered system of support framework revealed that this model can vary in the extent to which it is trauma-informed and thus in its ability to support children at school who are survivors of trauma, making it only as trauma-informed as the practices utilized within each tier. The overarching model that is used by the SCDSB that further harms child survivors of trauma was identified to be the behavioural model. The reason it was identified as a model that perpetrates harm is because it is based in Westernized knowledge and discourse and does not consider cultural diversity (Malott, 2016; Moore, 2013), it *others* survivors from their student peers (Arndt et al., 2015), and it is deficit-focused (Lanas & Brunila, 2019). Consideration into how school-based social work practice reflected the behavioural model revealed that at times school-based social workers filled the role of an authority figure within the school system, a support to staff in addressing student behaviour, and utilized behavioural strategies within one-on-one sessions with students to engage them in the material. With all of this information considered, trauma theory was used to depathologize the behaviour of students on both a system level and on an individual level. A factor that compounds the violence experienced by students who are survivors of trauma are the microaggressions in which they are exposed to at school such as colourblindness, microinvalidations, and undersexualization. Lastly, within this paper I reflected on the creation and presentation of the trauma-informed professional development lunch-and-

learn for teachers, along with the structural factors that were thought to have led to the low attendance.

Knowledge from the literature has been integrating into my clinical practice experience as a practicum student with the SCDSB. After reflecting on all that has been learned—academically, clinically, and personally—I cannot help but be drawn back to the foundational work of Herman (2015), despite all the therapy modalities that exist for helping child survivors recover from trauma, nothing can rival the power of establishing safety in relationships and agency. As trauma exposure is not always something that is known, school-based social workers and school staff need to work to nurture safe relationships and instill agency with each student. Agency is built by allowing and teaching children to become aware of their emotions and sensory experiences, and by beginning to understand and trust the feelings that are triggered within their body (van der Kolk, 2014). For children who have been exposed to trauma, agency is important for regaining the sense of control that is often taken from them as a result of the trauma (Berkowitz, 2012; Herman, 2015). School-based social workers and the school system have the privileged opportunity to make positive impacts on the life of children who have experienced trauma. This privilege should not be underappreciated, nor should the influence of schools and school-based social workers be looked at as insignificant, as “at their best, schools can function as islands of safety in a chaotic world” (van der Kolk, 2014, p. 353) for children who have experienced trauma.

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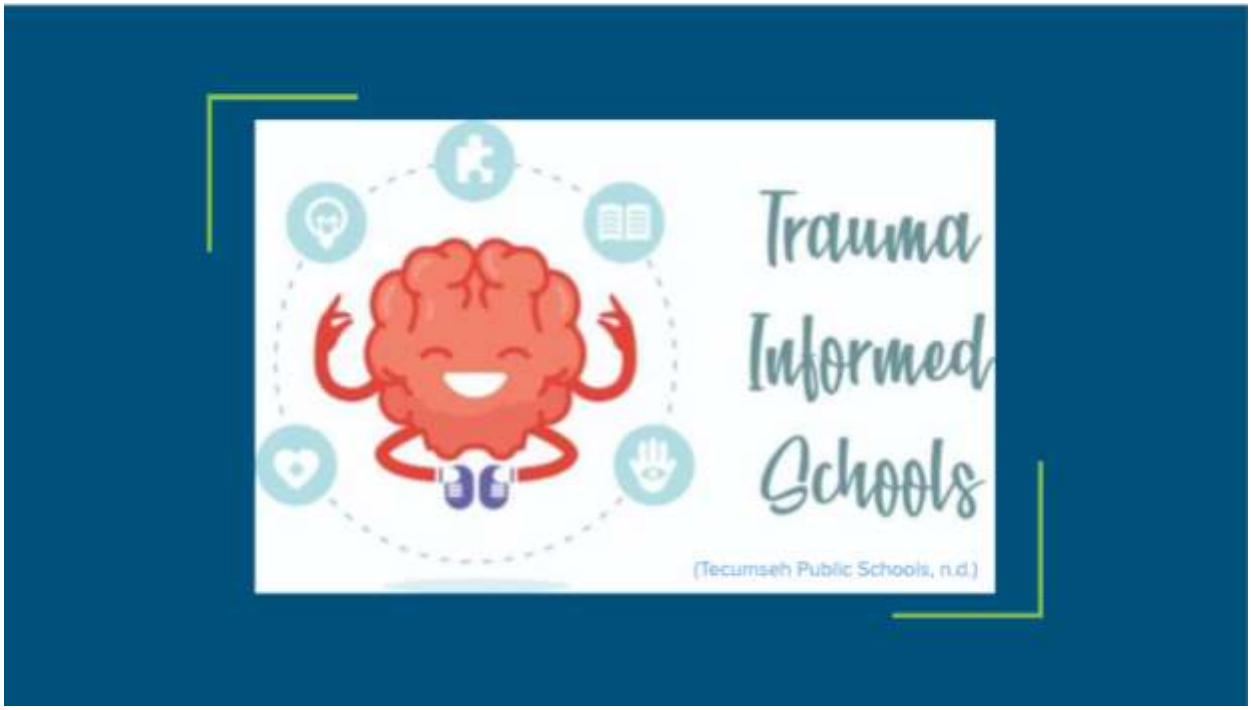
Appendices

Appendix A

Lunch-and-Learn Presentation



What is Trauma?

"...results 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,*** [and/]or ***spiritual well-being***."[19]

(Adapted from 70-30 Campaign, n.d.)

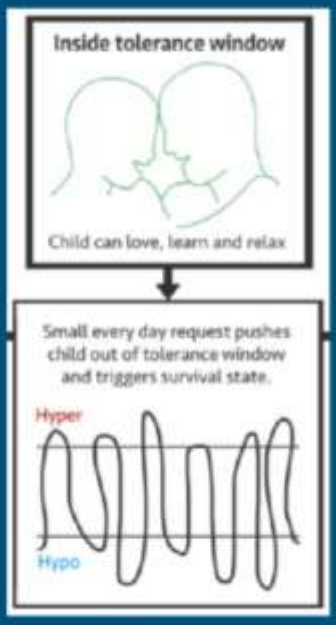
Brain Development

- Neurons that are used mature = neural connections [17]
- Neurons that are not used = die = without establishing connections [17]
- The good news is that the brain is malleable
- The brain functions to keep us alive under threat [5]
- When a threat is detected, the survival brain kicks on and higher order cognitive function is not available [5]

Connections Matter, n.d.

Behavioural Regulation

- Constant stress = Hyperarousal or Hypoarousal
- Their reactions have assisted in maintaining their survival in threatening situations, however, in non-threatening situations these behaviours are seen as inappropriate [4]



(Adapted from Beacon House, n.d.)

Impact of Trauma in Classrooms

Triggers at school may not be obvious [4]

Overactive brain = attention & learning challenges [4]

Difficulty with memory [6] & retaining information [4]

Drop in school work [3]

Anger & low self-esteem [17]

Australian Childhood Foundation, 20

Sensitive & reactive to stress [6]

Difficulty regulating thoughts, actions [16], & emotions [19]

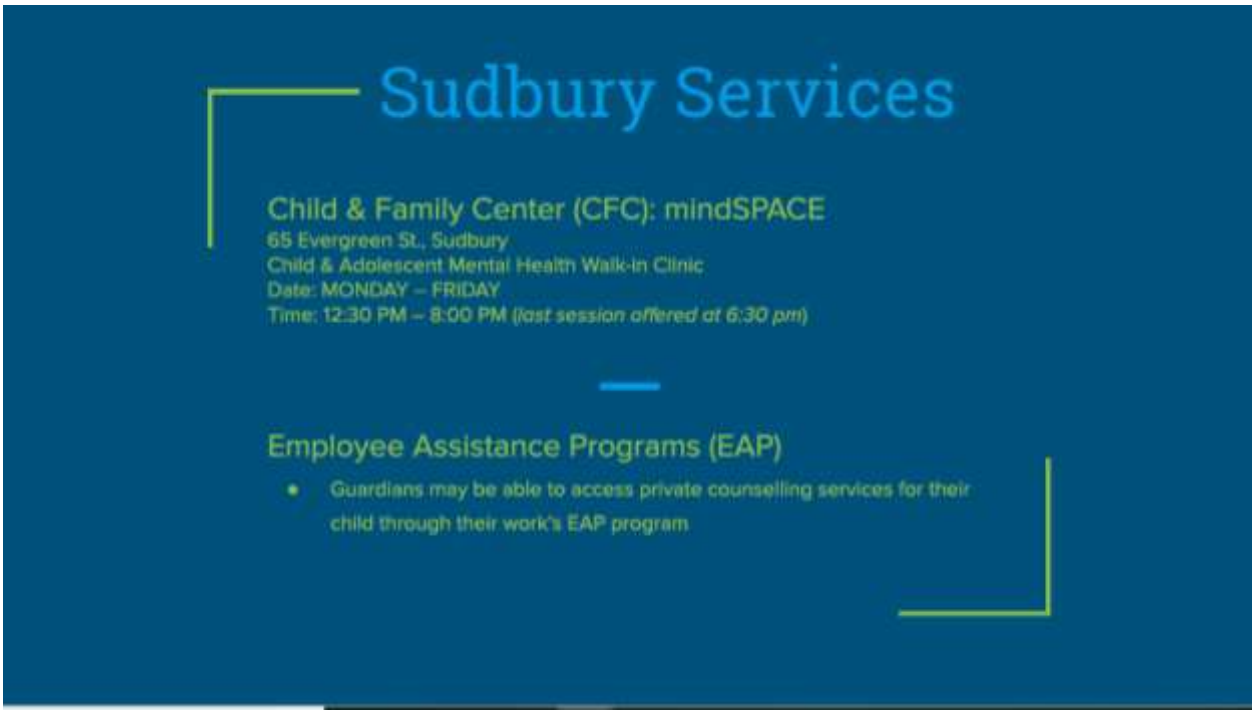
Rule breaking & social difficulties [11]

Often get into trouble due to difficulties with behaviours & inattention leading to higher rates of suspension [17]


You May Notice...
How do I scream "Pay attention to me!" without actually screaming "Pay attention to me!!!"
someecards
user card
Anxiety, depression, and withdrawal [11]
Difficulty sleeping [12]
"... new fears, separation anxiety, ... loss of interest in normal activities, ... somatic complaints, and irritability" [3]
Believe themselves to be inherently bad [13]
Emotional detachment from others and themselves [13]
Risky behaviour (i.e. purging, overeating, sex, exposure to dangerous situations, self-harm, and use of drugs and alcohol) [6, 13]


TRAUMA-INFORMED COMPASSIONATE CLASSROOM
1
CREATE A SAFE SPACE
Consider not only physical safety but the children's emotional safety as well.
2
ESTABLISH PREDICTABILITY
Write out a schedule and prepare children for transitions. It helps create a sense of security and safety.
3
BUILD A SENSE OF TRUST
Follow through with your promises and in situations where changes are unavoidable be transparent with your explanations.
4
OFFER CHOICES
Empower students and offer "power with" rather than "power over" strategies.
5
STAY REGULATED
Help your students (and yourself!) stay in the "Resiliency Zone" to promote optimum learning. Have regulation tools ready to help students bumped out of the zone into either hyperarousal (angry, nervous, panicky) or hypoarousal (numb, depressed, fatigued).
6
INCLUDE INDIGENOUS CONTENT & CULTURE
Shows Indigenous students that they belong, are important, and are represented in the classroom (Johnson, 2014). Learn about Indigenous historical trauma and the impact it has on current generations (Johnson, 2014).
ECHO PARENTING & EDUCATION
(Adapted from Echo, 2017)


TRAUMA-INFORMED
COMPASSIONATE CLASSROOM
7
BUILD POSITIVE RELATIONSHIPS
Initiate engagement with the student, show genuine care, be mindful of the changes in student's emotions/behaviours, and establish an authentic relationship unique to the student (Dods, 2013).
8
PROMOTE REGULATION THROUGH RHYTHM
1. Provide students with short "brain breaks" (2-5min) to do something physical (scheduled and as needed).
2. Provide students the opportunity for physical movement before talking to them about their behaviour.
3. Teach the importance of a calm heart rate in science, health, and math (Brunzell, Stokes, & Waters, 2016).
9
TEACH ABOUT STRESS, COPING, & SELF-REGULATION TOOLS
Talk about stress, coping skills, and introduce a self-regulation scale/tools. Have students learn to identify stress in their own body, promote the use of coping skills, and self-monitoring (Brunzell, Stokes, & Waters, 2016).
10
INCORPORATE MINDFULNESS
Use breathing, meditation, visualization, and sensory awareness with students. Can be used as a "brain break" (Brunzell, Stokes, & Waters, 2016).
There's really only one DON'T
Let's not punish kids for behaviors that are trauma symptoms.
ECHO
PARENTING & EDUCATION
(Adapted from Echo, 2017)


Sudbury Services
Child & Family Center (CFC): mindSPACE
65 Evergreen St., Sudbury
Child & Adolescent Mental Health Walk-in Clinic
Date: MONDAY – FRIDAY
Time: 12:30 PM – 8:00 PM (last session offered at 6:30 pm)
Employee Assistance Programs (EAP)
Guardians may be able to access private counselling services for their child through their work's EAP program

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Appendix B

Lunch-and-Learn Resource Pamphlet

Importance of Trauma-Informed Schools

According to Canadians between 18-24 years-old, 36% reported experiencing abuse during childhood (Findlay and Sunderland, 2014).

The learning of children who are survivors of trauma can be impacted by having to manage trauma triggers within the classroom environment (Crosby, Somers, Day, & Baroni, 2016). This makes it difficult for them to fully engage in the learning activity at hand (Crosby et al., 2016).

Establishing safety, connection, and self-regulation skills can be provided by any adult who works with children (Bath, 2015). Trauma-informed teaching incorporates emotional learning and relationship building elements (Crosby et al., 2018) in order to create safety and provide support within the classroom for children who have experienced trauma.

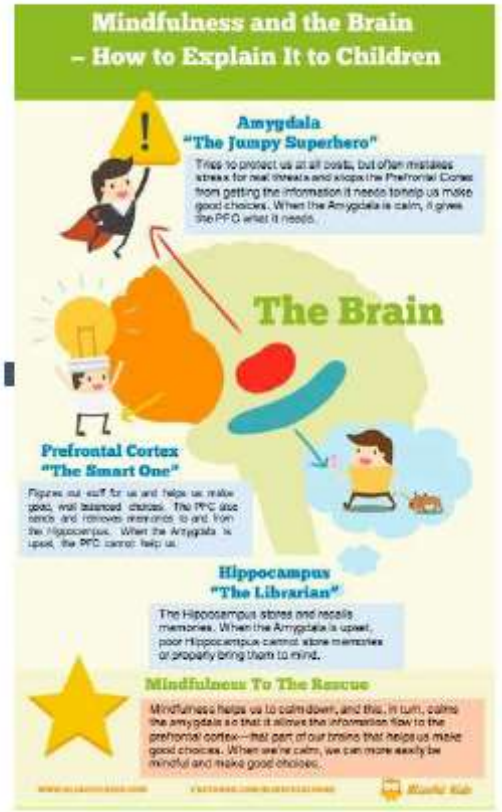
Helpful Resources

The Three Pillars of TraumaWise Care: Healing in the Other 23 Hours
www.traumebevisst.no/kompetanseutvikling/filer/23_4_Bath3pillars.pdf
- Article for professionals who work with children, on creating a safe space

Undertanding Trauma: Learning Brain vs. Survival Brain
www.youtube.com/watch?v=KoqaUANGvpA

Blissful Kids
www.blissfulkids.com/mindfulness-and-the-brain-how-to-explain-it-to-children/
- Resource for teaching mindfulness to kids

Trauma and Learning Policy Initiative (TLPI)
www.traumasensitiveschools.org
- Provides videos and readings on the impact of trauma on learning and supporting children in the classroom



"...people will forget what you said, people will forget what you did, but people will never forget how you made them feel."
– Maya Angelou

Appendix C

Lunch-and-Learn Advertising Flyer


Trauma-Informed Schools
School Two
April Lunch-and-Learn
Topic:
TRAUMA-INFORMED SCHOOLS
When:
April 25 at 12:15am-12:45pm
Where:
Library
What will be covered:
What is Trauma?
Brain Development
Impact of Trauma on a Child's Brain
Impact of Trauma on Behavioural Regulation
Impact of Trauma in the Classroom
Importance of Relationships
Building Trauma-Informed Compassionate Classrooms
Identifying + Regulating Trauma Behaviours
Supports for Children & Families


Trauma-Informed Schools
School Three
May Lunch-and-Learn
Topic:
TRAUMA-INFORMED SCHOOLS
When:
May 1, 2019 at 12:15am-12:45pm
Where:
Learning Lounge
What will be covered:
What is Trauma?
Brain Development
Impact of Trauma on a Child's Brain
Impact of Trauma on Behavioural Regulation
Impact of Trauma in the Classroom
Importance of Relationships
Building Trauma-Informed Compassionate Classrooms
Identifying + Regulating Trauma Behaviours
Supports for Children & Families


Trauma-Informed Schools
School Four
May Lunch-and-Learn
Topic:
TRAUMA-INFORMED SCHOOLS
When:
May 6, 2019 at 12:15am-12:45pm
Where:
SERT's Office
What will be covered:
What is Trauma?
Brain Development
Impact of Trauma on a Child's Brain
Impact of Trauma on Behavioural Regulation
Impact of Trauma in the Classroom
Importance of Relationships
Building Trauma-Informed Compassionate Classrooms
Identifying + Regulating Trauma Behaviours
Supports for Children & Families